NHS STW/SSOT Integrated Care Board

PUBLIC

Agenda Papers

MEETING
30th April 2026 13:30

PUBLISHED
23rd April 2026

Integrated Care System
Shropshire, Telford and Wrekin

Staffordshire and Stoke-on-Trent Integrated Care System

NHS
NHS Shropshire, Telford and Wrekin
NHS Staffordshire and Stoke-on-Trent

Shared Agenda for Meetings in common of:

NHS Shropshire, Telford & Wrekin
NHS Staffordshire, Stoke-on-Trent

ICB Boards in Common

Thursday, 30 April 2026 / 13:30pm

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

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

	Agenda Item	Lead	Purpose	Format	Time
OPENING MATTERS					
(1)	Welcome and Apologies	Chair		Verbal	13:30
(2)	Declarations of Interest: To declare any new interests or existing interests that conflict with an agenda item	Chair		Verbal	
(3)	Minutes from previous meetings:	Chair		Enc.01	
(4)	Matters Arising / Actions from previous meetings	Chair		Enc.02	
(5)	Questions from members of the public	Chair		Verbal	
(6)	Resident Story	Mish Irvine		Enc.03	13:40
STRATEGIC DEVELOPMENT AND OVERSIGHT					
(A)	**ICB Cluster:**				
(7)	Chair Report	Chair		Verbal	14:00
(8)	CEO Report	Simon Whitehouse		Enc.04	14:10
(9)	Operational Plans	Claire Skidmore		Enc.05	14:20
(10)	Operating Model	Dr Lorna Clarson		Enc.06	14:30
(11)	Neighbourhoods and Place	Phil Smith		Enc.07	14:50
(12)	Risk and SBAF Strategy	Mish Irvine		Enc.08	15:15
	BREAK – 10 minutes				15:25
(B)	**STW Only:**				
(13)	Equality, Diversity and Inclusion Update	Vanessa Whatley Mish Irvine		Enc.09 Enc.10	15:35
GOVERNANCE AND PERFORMANCE					

(14)	Integrated Performance Report	Claire Skidmore	D/I	Enc.11	16:05
(15)	'Triple A' Board Committee Highlights Reports a) In Common: Finance Committee Quality and Performance Committee Strategic Commissioning & Transformation Committee People, Culture and Inclusion Committee b) SSOT: Staffordshire & Stoke-on-Trent Health and Care Senate	 Mike Lawton Cheryl Etches Trevor McMillan Mish Irvine Dr Rachel Gallyot	 A A A A A	 Enc.12 Enc.13 Enc.14 Enc.15 Enc.16	16:20
ANY OTHER BUSINESS					
(16)	Any Other Business – notified in advance to Chair	Chair	D	Verbal	16:30
(17)	Review of new or amended risks following discussions in the meeting	Chair	D/A	Verbal	16:35
(18)	Meeting Effectiveness: • Have we upheld the behaviours agreed in the Leadership Compact? • Has there been any learning and how we can improve going forward?	Chair	S	Verbal	16:45
	Date and time of next meeting: Thursday, 25 June 2026 at 13.30pm				

Mr Ian Green, OBE
Cluster Chair
NHS Shropshire, Telford and Wrekin
NHS Staffordshire, Stoke-on-Trent

Mr Simon Whitehouse
Cluster *Chief Executive*
NHS Shropshire, Telford and Wrekin
NHS Staffordshire, Stoke-on-Trent

Shared Meeting Minutes of
NHS Shropshire, Telford and Wrekin Integrated Care Board
NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Thursday, 26th March 2026 at 1.30
Room 1, 1st Floor, Wellington Civic Offices, Larkin Way, Tan Bank, Wellington, Telford, TF1 1LX

Present:

Ian Green OBE (IG)	Chair (Meeting Chair), NHS STW & NHS SSOT
Simon Whitehouse (SW)	Chief Executive Officer, NHS STW & NHS SSOT
Claire Skidmore (CS)	Deputy Chief Executive Officer and Chief Finance Officer, NHS STW & NHS SSOT
Cheryl Etches OBE (CE)	Non-Executive Member, NHS STW
Roger Dunshea (RD)	Non-Executive Member, NHS STW
Shokat Lal (SL)	Non-Executive Member, NHS SSOT
Vanessa Whatley (VW)	Interim Chief Nursing Officer, NHS STW
Heather Johnstone (HJ)	Interim Chief Nursing Officer, NHS SSOT
Dr Rachel Gallyot (RG)	Interim Chief Medical Officer, NHS STW & SSOT
Joanne Williams (JW)	Trust Partner Member and Chief Executive Officer, The Shrewsbury and Telford Hospital NHS Trust and Shropshire Community Health NHS Trust
Dr. Ian Chan (IC)	Primary Care Partner Member, NHS STW
Dr Joanna Chan (JC)	Primary Care Partner Member, NHS SSOT
David Sidaway (DS)	Local Authority Partner Member and Chief Executive Officer, Telford and Wrekin Council
Simon Constable	Trust Partner Member & Chief Executive, University Hospitals of North Midlands (virtually)
Dr. Lorna Clarson (LC)	Chief Officer of Strategy and Improving Outcomes, NHS STW & NHS SSOT
Mish Irvine (MI)	Chief of Staff, NHS STW & NHS SSOT

In Attendance:

Liz Lockett (LL)	Chief Nurse, Midlands Partnership University NHS Foundation Trust (virtually)
Dr Tony Ahmed (TA)	GP Partner (Dental), NHS SSOT
Tanya Miles (TMS)	Interim Chief Executive Officer, Shropshire Council (Virtually)
Andrew Morgan (AM)	Chair in Common, Shropshire Community Health NHS Trust and Shrewsbury & Telford Hospital NHS Trust
Terry Gee (TG)	Healthwatch, Telford and Wrekin
Lynn Cawley (LCY)	Healthwatch Shropshire
Clare Trenchard	Healthwatch Stoke-on-Trent (virtually)
Anna Mather (AMR)	Healthwatch (virtually)
Paul Winter (PW)	Associate Director of Corporate Governance, NHS STW & SSOT
Adele Edmonson (AE)	Head of Communications & Engagement, NHS STW & SSOT
Claire Colcombe (CC)	Board Secretary, NHS STW

Apologies:

Neil Carr	Trust Partner Member and Chief Executive Officer, Midlands Partnership University NHS Foundation Trust
Trevor McMillan OBE	Non-Executive Member, NHS STW
Mike Lawton	Non-Executive Member, NHS SSOT
Dr Paul Edmonson-Jones	Transformation Director, NHS SSOT

Jon Rouse	Local Authority Partner Member and Chief Executive Officer, Stoke-on-Trent City Council
Pat Flaherty	Local Authority Partner Member and Chief Executive Officer, Staffordshire County Council
Siobhan Heafield	Non-Executive Member, NHS SSOT
Simon Fogell	Chief Executive, Healthwatch
Dr Buki Adeyemo	Trust Partner Member and Chief Executive Officer, North Staffordshire Combined Healthcare NHS Trust
Phil Smith	Chief Delivery Officer, NHS STW & NHS SSOT

Minute No. ICB-26-03-001 – Welcome & Apologies

01.1 IG formally opened the meeting and welcomed all members, partners and attendees. IG confirmed that the meeting was being conducted in a hybrid format and that the agenda and supporting papers had been circulated in advance to enable appropriate preparation and scrutiny.

001.2 IG noted that this meeting marked the final Board attendance of Siobhan Heafield (Non-Executive Member, NHS SSOT) and Simon Fogell (Chief Executive, Healthwatch). The Board formally recorded its thanks for their contributions, particularly noting Siobhan Heafield's leadership on quality assurance during a period of transition and Simon Fogell's role in strengthening public voice and engagement.

001.3 Apologies as listed in the agenda were noted. No additional apologies were received.

Minute No. ICB-26-03-002 – Members' Declarations of Interests

002.1 Members had previously declared their interests, which were listed on the ICB's Register of Interests and available to view on the website at:

Register of Interests - NHS Shropshire, Telford and Wrekin (shropshiretelfordandwrekin.nhs.uk)

ICB Master COI Register January 2026

002.2 Members were invited to declare any new interests or identify any existing conflicts of interest relating specifically to the agenda items for the meeting. No additional declarations or conflicts of interest were reported.

002.3 Members were reminded that, should any conflict become apparent during the discussion of individual agenda items, they should declare it at the relevant point in the meeting.

Minute No. ICB-26-03-003 – Minutes of Previous Meeting

003.1 The minutes of the meetings held on 29 January 2026, and 9 February 2026 were considered by the Board.

003.2 SW noted a minor textual correction, advising that references to "IA" in the minutes should be amended to correctly read "IG". No other amendments were proposed.

Action: Minor textual amendments to be made, replacing "IA" with "IG". - (CC)

RESOLVE: **The NHS Shropshire, Telford and Wrekin Integrated Care Board and NHS Staffordshire, Stoke-on-Trent Integrated Care Board APPROVED the**

minutes as an accurate record of proceedings, subject to the agreed amendment.

Minute No. ICB-26-03-004 – Matters Arising/Actions from previous meeting

004.1 IG reviewed the action log and provided assurance that several actions arising from previous meetings had either been completed or were addressed through items on the current agenda.

004.2 Action Minute No. ICB-26-01-001b – Leadership Compact - was confirmed as completed and formally closed, having been adopted by both ICBs.

004.3 Action Minute No. ICB 29-01.007 – ICB Cluster Chief Executive Report - relating to clarification of digital text services and associated responses from relevant teams was also confirmed as complete.

004.4 Action Minute No. ICB 29-01.008 – Residents/Community Story - relating to an update on end-of-life care and Neighbourhood development was discussed. IG confirmed that there remained strategic and system interest in this area and that it was important the Board considered the topic in the context of Place-based development and partnership working. It was therefore agreed that a substantive discussion would be scheduled for a future Board meeting.

004.5 Minute No. ICB 29-01.010 – Short- and Medium-Term Planning – relating to a further meeting for final approval of the Board Assurance Statement was confirmed as completed and formally closed, having taken place on 9th February 2026.

004.6 IG further confirmed that actions relating to the System Board Assurance Framework (SBAF), Public Voice and Meeting Effectiveness were being addressed through the current or forthcoming agendas.

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RESOLVE: **The NHS Shropshire, Telford and Wrekin Integrated Care Board and NHS Staffordshire, Stoke-on-Trent Integrated Care Board NOTED the update on actions and matters arising and AGREED that completed actions be formally closed.**

Minute No. ICB-26-03-005 – Questions from members of the public

005.1 The Board was advised that eight questions had been received from members of the public.

005.2 IG confirmed that responses would be prepared and issued in due course, published on the ICB websites, and that a link to the responses would be included within the published minutes to ensure transparency.

Questions can be found here: NHS STW/SSoT Board - Public Questions

Minute No. ICB-26-03-006 – Chair's Report

006.1 The Chair's report, previously circulated, was taken as read.

006.2 IG advised that Neil Carr, Simon Constable, Joanne Williams and Dr Buki Adeyemo had been formally appointed as NHS Provider Partner Member Representatives to the Board, each aligned to a different ICB, while retaining the ability to contribute fully across the agenda.

006.3 IG further confirmed that Provider Chairs had been advised that they were welcome to attend and contribute to Board meetings even where not formal members, and that discussions were

ongoing with local authority leaders and NHS Chief Executives regarding attendance and engagement.

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006.5 No questions were raised on the report.

RESOLVE: **The NHS Shropshire, Telford and Wrekin Integrated Care Board and NHS Staffordshire, Stoke-on-Trent Integrated Care Board RECEIVED the report and were ASSURED the leadership are working on each topic as raised.**

Minute No. ICB-26-03-007 – Chief Executive Report

007.1 The Chief Executive's report was taken as read, with several key points highlighted for assurance.

007.2 An update was provided on the clustering work and the associated Management of Change process. SW acknowledged colleagues leaving the organisation through voluntary redundancy and expressed thanks for their significant contributions. It was noted that the Management of Change process was now progressing for all remaining staff, with a clear timeline in place.

007.3 The Board noted the Staff Survey results, which demonstrated that engagement had largely been maintained across both ICBs despite the challenges of the past 12 months. Credit was given to leaders and teams for supporting staff through a period of sustained organisational change and significant uncertainty.

007.4 Members were advised that the April Board meeting would include a substantive discussion on the ICB Operating Model, focusing on the organisation's role as a Strategic Commissioner and how this would be delivered in practice.

007.5 SW highlighted the successful exit of SaTH from the Recovery Support Programme, recognising this as a significant milestone achieved through strong collaboration across the system. It was noted that no providers across the cluster were now rated at the lowest level of the Oversight Framework, while acknowledging that further improvement on the consistent delivery of the NHS constitutional standards was still required.

007.6 Updates were also provided on improvements in General Practice access, Dentistry, and Urgent and Emergency care. While continued challenges were recognised, progress was evident across all areas.

007.7 The Board was informed that the Prescription Ordering Direct service had been formally decommissioned. Thanks were extended to the staff who had delivered the service over several years and to general practice colleagues for supporting the transition.

007.8 Provider representatives reflected positively on the progress made, particularly in relation to quality improvement and staff morale, while emphasising the need to sustain momentum. Members discussed the importance of continued support for General Practice, including timely access, continuity of care, and the reduction of Secondary Care waiting times to release capacity.

007.9 Partners requested clear communication on senior leadership appointments as the Management of Change process progressed, to support effective system working. Members also asked for more granular data on General Practice appointment capacity, to identify further improvement opportunities.

007.10 SW acknowledged these points and confirmed that partner engagement and detailed updates would be provided as appointments were confirmed. Future Board and strategy sessions would further explore Primary Care, Neighbourhoods, Dentistry, and Community Pharmacy as part of strengthening system resilience.

007.11 No further questions were raised.

RESOLVE: **The NHS Shropshire, Telford and Wrekin Integrated Care Board and NHS Staffordshire, Stoke-on-Trent Integrated Care Board RECEIVED the report and were ASSURED the leadership are working on each topic as raised.**

Minute No. ICB-26-03-008 – Patient Story – CAMHS: Logan's Story

008.1 The Board received and viewed a patient story focusing on Logan, a young person with lived experience of mental ill health who has been supported by CAMHS and the MPFT Transitional Care Team. The story was presented via a recorded interview with Logan sharing his experiences.

008.2 The Board was advised that the story was particularly timely given the imminent introduction of a new CAMHS contract and provided valuable insight into transitional care as young people move from Children's to Adult services. Members noted the strong alignment with the 10-Year Plan and the emphasis on early intervention, prevention, and continuity of support for children and young people with mental health needs.

008.3 Logan described his experience of mental ill health, including depression, anxiety and OCD, and the impact of bullying and isolation, particularly during his transition to university. He outlined the importance of recognising the need for help, accessing support initially through friends and family, and subsequently via his GP and CAMHS services. Logan spoke positively about the support received from the Transitional Care Team, highlighting the value of non-clinical, community-based conversations which helped rebuild confidence, reduce isolation, and support recovery.

008.4 Members reflected on the importance of trusted relationships, early help, and personalised support delivered in environments that feel safe and accessible to young people. The Board recognised the skill involved in delivering therapeutic conversations that are perceived as informal but have a significant clinical and emotional impact.

008.5 Discussion highlighted the risks associated with the transition from children to adult services and the need for a system-wide approach to minimise disengagement during this period. Members emphasised that while Logan had strong family and social support, not all young people have similar networks, particularly those with additional vulnerabilities, including language barriers and social isolation.

008.6 Questions were raised regarding the scalability of the Transitional Care Team model across the wider system, links with suicide prevention programmes, inclusion and equity of access, and the potential for learning from this model to inform transitions in other services, including long-term physical health conditions.

008.7 Representatives from MPFT confirmed that suicide prevention was a core workstream across the system, with strong links to Public Health, schools, and Health and Wellbeing Boards. It was noted that early engagement, lived-experience roles, school-based interventions, and

community-based outreach were key components of the approach. The ambition to expand transitional care provision and reduce the number of young people requiring escalation into adult services was reaffirmed.

008.8 The Board expressed its sincere thanks to Logan for his courage in sharing his story and acknowledged the positive impact of lived-experience narratives in shaping service design and improvement. Members also thanked MPFT staff for their ongoing work in delivering compassionate, preventative, and person-centred care.

RESOLVE: **The NHS Shropshire, Telford and Wrekin Integrated Care Board and NHS Staffordshire, Stoke-on-Trent Integrated Care Board:**

- **NOTED the challenges faced by young people during transitions between children's and adult mental health services**
- **RECOGNISED the positive impact that the Transitional Care Team has had in Logan's case**
- **CONSIDERED the learning for future service development in Shropshire, Telford and Wrekin**

Minute No. ICB-26-03-009 – Updated NHSE ICB Collaboration Agreement and Joint Working Agreement

009.1 LC introduced the item concerning the updated NHS England ICB Collaboration Agreement and Joint Working Agreement.

009.2 Members were advised that, from April 2027, ICBs will assume statutory responsibility from NHS England for commissioning Specialised Services, Health and Justice services, and screening and vaccination programmes. These functions represent a significant financial and operational portfolio and require commissioning expertise delivered at appropriate scale. In response, the National Planning Framework recommends the establishment of an Office of Pan-ICB Commissioning (OPIC) within each region, to retain specialist commissioning capability and enable commissioning across larger footprints where required.

009.3 In the Midlands, the OPIC will be hosted by the Birmingham, Solihull and Black Country cluster of ICBs. The Collaboration Agreement sets out the governance framework for the development of OPIC, including the establishment of a Midlands Joint Collaborative Committee. This committee is required because some services will transfer fully to ICB accountability, while others will be delegated during the transition period, with NHS England retaining accountability until legislative change.

009.4 The Board noted that the ICB would be represented on the Joint Collaborative Committee by a nominated Executive Member, to be confirmed. Regular assurance reports would be provided to the Board on the establishment and operation of OPIC, hosting arrangements, and the management of service transfer. A number of supporting sub-groups will sit beneath the Joint Collaborative Committee, including groups for acute specialised commissioning, mental health, learning disabilities and autism, quality, and finance and contracting.

009.5 Members sought and received assurance that, while governance arrangements would operate at regional level, individual ICBs would remain accountable for their responsibilities. It was confirmed that funding for OPIC sits outside core ICB allocations and that staff transferring from NHS England specialised commissioning would do so following a defined transformation and change process. No material financial risks were identified at this stage.

009.6 Discussion emphasised the importance of active ICB participation in the governance and sub-group structures to ensure that commissioning decisions align with local strategic priorities and population health needs. Members also noted opportunities for improved pathway design and potential efficiencies through the new arrangements.

009.7 It was noted that minor administrative corrections were required to the Collaboration Agreement, including amendments to ICB address details, prior to formal signing.

009.8 The Board considered the recommendations and agreed to approve the updated Collaboration Agreement and associated terms of reference, noting that formal approval is required by the end of April 2026. The Board also endorsed the joint working arrangements to support the 2026/27 transition year.

RESOLVE: **The NHS Shropshire, Telford and Wrekin Integrated Care Board and NHS Staffordshire, Stoke-on-Trent Integrated Care Board:**

- **APPROVED the updated NHSE ICB Collaboration Agreement, including the terms of reference of the Midlands Joint Collaborative Committee;**
- **NOTED that formal approval is required by April 2026; and**
- **ENDORSED the implementation of the joint working arrangements for the 2026/27 transition year.**

Minute No. ICB-26-03-010 – Involvement Update

010.1 The Board received a verbal update on patient and public involvement, provided in response to an action from the previous meeting and a query from Healthwatch regarding assurance of ongoing involvement in commissioning. It was noted that work is ongoing to finalise the ICB Operating Model and Commissioning Cycle, and that a verbal update was therefore provided at this stage.

010.2 AE outlined how patient and public involvement underpins the four stages of the Strategic Commissioning Cycle, in line with the NHS Long Term Plan and Strategic Commissioning Framework. This includes understanding population need, shaping commissioning intentions, influencing procurement and contracting, monitoring delivery and evaluating impact. The approach also supports Neighbourhood health development and fulfils the statutory duty on both ICBs to involve people and communities in service planning and delivery.

010.3 The Board was advised that patient and public involvement has been mapped across the Commissioning Cycle and that existing arrangements across Staffordshire, Stoke-on-Trent and Shropshire, Telford and Wrekin have been reviewed to identify strengths, opportunities to build on current approaches, and gaps requiring further development. Early engagement has taken place with partners including Healthwatch and the VCSE sector, with reference to learning from the King's Fund report on the future of patient voice and the importance of independent engagement.

010.4 Members welcomed the progress made and emphasised the importance of building on existing engagement frameworks, improving coordination across the system to reduce duplication and engagement fatigue, and strengthening mechanisms to share and triangulate feedback from multiple sources, including Providers, frontline staff, complaints, MPs and informal patient interactions. The need to improve reach into seldom-heard groups, working populations and communities less likely to engage through traditional methods was also highlighted.

010.5 It was agreed that a joint Cluster-wide Patient and Public Involvement Strategy and supporting framework will be developed, aligned to NHS England guidance, the Neighbourhood Health Framework and the Strategic Commissioning Cycle. This will include clear principles, governance and evaluation arrangements, and will be brought back to the Board for further consideration once engagement with partners and communities has taken place.

Action: *Develop and bring to a future meeting a joint Patient and Public Involvement Strategy and framework to the Board (Leads: MI / AE).*

RESOLVE: **The NHS Shropshire, Telford and Wrekin Integrated Care Board and NHS Staffordshire, Stoke-on-Trent Integrated Care Board NOTED the verbal update.**

Minute No. ICB-26-03-011 – 5 Year Strategic Commissioning Plans

011.1 LC introduced the five-year Strategic Commissioning Plans for NHS Shropshire, Telford and Wrekin ICB and NHS Staffordshire and Stoke-on-Trent ICB. It was noted that the plans respond to the NHS England Planning Framework requirement to move from annual planning to a medium-term approach, setting out the ICBs' strategic intent and commissioning role over the next five years.

011.2 Members were advised that the plans are informed by population needs assessment and supported by population health improvement plans and clinical strategies. They focus on delivery of the three core NHS transformation shifts: hospital to community, treatment to prevention, and analogue to digital; alongside two locally prioritised shifts: improving access to services and strengthening value and productivity.

011.3 Key priorities under hospital to community include development of integrated neighbourhood teams for adults and children, expansion of urgent community response and virtual wards, increased community-based diagnostics and elective activity, and enhanced support for people with long-term conditions, mental health needs, and complex care requirements. Digital priorities include improving digital maturity and interoperability, enabling Shared Care Records and digital care plans, supporting remote monitoring and digital triage, and ensuring action to address digital exclusion. Prevention priorities include targeted interventions on smoking, obesity, hypertension, mental ill health and respiratory disease, improving uptake of screening, immunisations and vaccinations, and strengthening early years support through family hubs and best-start pathways, with a continued focus on Core20PLUS5.

011.4 Members also noted planned priorities in urgent and emergency care, end-of-life care, elective recovery, diagnostics, mental health crisis alternatives, CAMHS reform, and improvements to neurodevelopmental diagnostic pathways.

011.5 The Board noted that delivery of the plans is underpinned by a financial strategy targeting a minimum of 2% annual efficiency and productivity, supported by a move towards value-based commissioning. This includes clear outcome measures, robust evaluation frameworks, and the ability to redirect resources away from lower-value interventions where appropriate.

011.6 Key enablers identified within the plans include workforce sustainability, estates optimisation, inclusion and equality, research and innovation, data sharing and strong safeguarding partnerships. The Board recognised the importance of maintaining system resilience while delivering change at pace.

011.7 During discussion, members emphasised the importance of:

- Strengthening joint commissioning with local authorities;
- Clear public communication on what the plans will mean for residents;
- Consistency across the two plans;
- Addressing cross-boundary patient flows and inequalities in service access;
- Progressing delegation of budgets and responsibilities to place;
- Ensuring workforce capacity and provider readiness for transformation; and
- Maintaining collaborative behaviours across the system.

011.8 The Board welcomed the plans as a strong foundation and acknowledged that they would continue to evolve, including further iterations informed by NHS England feedback, partner engagement and progression towards closer system integration.

011.9 IG summarised key themes for further development, including joint commissioning, Place-based working, meaningful public engagement, tackling inequalities, and balancing ambition with operational resilience. Members expressed support for the plans and thanked officers and teams for the work undertaken.

RESOLVE: **The NHS Shropshire, Telford and Wrekin Integrated Care Board and NHS Staffordshire, Stoke-on-Trent Integrated Care Board:**

- **APPROVED the Five-Year Strategic Commissioning Plans for Shropshire, Telford and Wrekin ICB and Staffordshire and Stoke on Trent ICB 2026/27 to 2030/31 as the strategic direction for the system.**
- **AGREED that progress will be monitored through regular Board updates, Committee oversight and the systemwide performance and risk framework.**

Minute No. ICB-26-03-012 – Integrated Performance Report

012.1 CS introduced the Integrated Performance Report, noting that the end of the financial year was approaching. Members were advised that there were no material or significant changes to report at this stage. Both systems remained on track to deliver the previously reported financial positions.

012.2 From a financial perspective, NHS Staffordshire and Stoke-on-Trent ICB was on course to deliver a break-even system position, while NHS Shropshire, Telford and Wrekin ICB was forecasting a small system surplus of £2.3m. Both systems continued to adhere to agreed capital expenditure plans. It was also noted that preparations were underway for year-end processes, including External Audit and reporting to the Audit Committee.

012.3 Key performance highlights were then outlined:

Elective Activity

NHS England had provided additional funding to support March “sprint” activity to maximise year-end delivery. This included additional theatre lists, weekend activity, accelerated diagnostics, pathway validation and use of external capacity where appropriate. Early indications were positive, particularly at SaTH and UHNM, though ongoing challenges remained at The Robert Jones and Agnes Hunt Orthopaedic Hospital, especially for longer wait cohorts, which continued to be closely monitored with NHS England.

Cancer Performance

Significant improvement was noted at SaTH over the previous 12 months. UHNM remained behind plan but was expected to recover through year-end actions. Members were reminded that cancer performance also relies on prevention, early diagnosis and screening uptake. The Board noted the launch of the National Cancer Plan in February and highlighted successful local initiatives, including a men's health event at Stoke City Football Club and continued outreach using the cancer bus across the system footprint.

Urgent and Emergency Care

Improvements were reported in ambulance response times, with Category 2 response times improving to 30 minutes in Shropshire, Telford and Wrekin and 23 minutes across Staffordshire and Stoke-on-Trent in February. However, ambulance handover delays remained a significant challenge, with average handover times exceeding the 45-minute standard at both SaTH and UHNM. Work was ongoing to address handover delays and improve four-hour performance, which, although showing some improvement, remained below desired levels.

012.4 Members received an update on winter resilience, noting that overall performance during the most recent winter had improved compared with the previous year. While progress had been made, particularly following the introduction of new handover processes with the ambulance service, it was acknowledged that performance remained below required standards and further work was needed to prepare for the next winter period.

012.5 The Board was also advised of impending industrial action by Resident Doctors in the post-Easter period. Planning was underway to mitigate the combined impact of the Easter Bank Holidays and industrial action on elective activity and to maintain resilience across urgent and emergency care pathways. The Board would be kept informed of any material impact.

012.6 Clarification was provided regarding a reported capital underspend within Shropshire, Telford and Wrekin, which related primarily to agreed reprofiling of national programmes and did not impact the overall agreed financial position.

012.7 No further comments or questions were raised.

RESOLVE: **The NHS Shropshire, Telford and Wrekin Integrated Care Board and NHS Staffordshire, Stoke-on-Trent Integrated Care Board NOTED and DISCUSSED the contents of the report.**

Minute No. ICB-26-03-013 – Transition Committee Update Report

013.1 SW introduced the Transition Committee Update Report and noted apologies for absence from the Committee Chair.

013.2 The Board was advised that much of the content had been reflected earlier in the Chief Executive's report. Key areas of focus included the governance arrangements in place to oversee transition activity and the work undertaken to support colleagues through the voluntary redundancy process.

013.3 Members noted that the workforce glidepath had been updated to reflect the impact of the nationally agreed NHS pay award. As a result, the previously stated target had been revised, with a clear glidepath now established to reach a workforce expenditure position of £19.55 per head of population.

013.4 The Board was updated on ongoing work with CSU colleagues and NHS England in relation to the transfer of functions, the closure of CSU arrangements, and the development of shared services. Preparatory work for the potential future merger continued in parallel, recognising that this remains subject to a formal process and further approvals.

013.5 SW confirmed the intention to bring further updates on transition activity back to the Board for assurance as work continues.

013.6 No questions or concerns were raised by members.

RESOLVE: **The NHS Shropshire, Telford and Wrekin Integrated Care Board and NHS Staffordshire, Stoke-on-Trent Integrated Care Board were ASSURED that the Transition Committee is managing the complex transition work programme, is tracking and manging the issues and risks associated with the transition.**

Minute No. ICB-26-03-014 – 'Triple A' Board Committee Highlights Reports

014.1 IG introduced the Committee Highlight Reports and advised that work continued to align committee arrangements across both ICBs. Members were informed that while some committees were already meeting in common, others would transition more gradually, with the majority expected to meet jointly over the coming months.

Finance and Performance Committee

Apologies were noted from the Committee Chair. It was reported that key finance, performance, activity and workforce matters had already been discussed under earlier agenda items. The Committee had considered the more technical elements of the plan, which were expected to receive NHS England sign-off in the coming weeks. These would then be brought to the next Board meeting for consideration.

RESOLVE: **The NHS Shropshire, Telford and Wrekin Integrated Care Board and NHS Staffordshire, Stoke-on-Trent Integrated Care Board NOTED the contents of the report.**

Audit Committee

The update focused on year-end closure for 2025/26 and preparations for External Audit. Ongoing engagement with External and Internal Audit providers was reported. The Committee was functioning effectively as an 'In Common' committee across both ICBs, with assurance provided that financial controls and audit preparations were in a strong position.

RESOLVE: **The NHS Shropshire, Telford and Wrekin Integrated Care Board and NHS Staffordshire, Stoke-on-Trent Integrated Care Board NOTED the contents of the report.**

Remuneration Committee

No matters of concern were raised. The Committee had spent the majority of the meeting considering matters relating to the Voluntary Redundancy process, which had been covered elsewhere on the agenda.

RESOLVE: **The NHS Shropshire, Telford and Wrekin Integrated Care Board and NHS Staffordshire, Stoke-on-Trent Integrated Care Board NOTED the contents of the report.**

Strategic Commissioning and Transformation Committee

The Board was asked to ratify a decision relating to the procurement of the new Wheelchair Service for Staffordshire and Stoke-on-Trent. It was confirmed that a robust procurement process had been undertaken and scrutinised by the Committee, resulting in the award of the contract to Ross Auto Engineering Limited trading as Ross Care, for an initial three-year term with the option to extend for a further two years. The Board agreed to ratify the decision.

RESOLVE: **The NHS Shropshire, Telford and Wrekin Integrated Care Board and NHS Staffordshire, Stoke-on-Trent Integrated Care Board NOTED the contents of the report and RATIFIED the approval of the Contract Award to Ross Auto Engineering Limited for 3 years with an optional two year extension.**

Quality and Performance Committee – Shropshire, Telford and Wrekin

The Committee noted progress in several areas, including improvements in urgent and emergency care risk ratings and children and young people's palliative care provision. Positive progress was also reported in reducing long waiting times for children's services. The cardiovascular, renal and metabolic strategy had been supported by the Committee and referred onward for further consideration.

Members were updated on work underway to explore how Quality and Performance Committee arrangements could meet in common across both ICBs, recognising the close interdependency between quality and performance measures.

RESOLVE: **The NHS Shropshire, Telford and Wrekin Integrated Care Board and NHS Staffordshire, Stoke-on-Trent Integrated Care Board NOTED the contents of the report.**

Shropshire Integrated Place Partnership

The most recent meeting focused on the new children and young people's mental health contract. Members welcomed the emphasis on prevention, early intervention and integration, while noting ongoing concerns around access. Actions were agreed with the provider to provide assurance on implementation and quality as the service transitions.

RESOLVE: **The NHS Shropshire, Telford and Wrekin Integrated Care Board and NHS Staffordshire, Stoke-on-Trent Integrated Care Board NOTED the contents of the report.**

Telford and Wrekin Integrated Place Partnership

The Board noted feedback from a well-attended Place-based workshop involving system partners. Discussion focused on Neighbourhood health, shifting care closer to home, mental health transformation and the role of the voluntary and community sector. Members welcomed progress on Neighbourhood initiatives, including the deployment of mobile services delivering health, employment, education and safety support directly within local communities.

RESOLVE: **The NHS Shropshire, Telford and Wrekin Integrated Care Board and NHS Staffordshire, Stoke-on-Trent Integrated Care Board NOTED the contents of the report.**

People, Culture and Inclusion Committee – Shropshire, Telford and Wrekin
The Committee noted the launch of the Work Well programme, commissioned by the Department for Work and Pensions, aimed at supporting people with health-related barriers to employment. The Board recorded thanks to MI for her leadership of the Committee and noted plans to develop future joint committee arrangements across both ICBs.

RESOLVE: **The NHS Shropshire, Telford and Wrekin Integrated Care Board and NHS Staffordshire, Stoke-on-Trent Integrated Care Board NOTED the contents of the report.**

Quality and Safety Committee – Staffordshire and Stoke-on-Trent
Key issues included ongoing challenges with the timeliness of health assessments for looked-after children. While progress had been uneven, work continued to establish a clear improvement trajectory, supported by quality improvement approaches and shared learning across the Cluster.

It was noted that this marked the final 'Triple A' report for this Committee, with system quality arrangements continuing through an evolving shared Committee model. The Board was asked to ratify several policy approvals made under delegated authority, including the Integrated Health and Social Care Support Protocol, the Complaints, MP Letters and Concerns Policy, and the Quality Impact Assessment Policy. The Board agreed to endorse these decisions.

RESOLVE: **The NHS Shropshire, Telford and Wrekin Integrated Care Board and NHS Staffordshire, Stoke-on-Trent Integrated Care Board NOTED the contents of the report and RATIFIED the following policies: the Health & Social Care Integrated Health and Social Care Support Protocol, the Complaints, MP Letters and Concerns Policy, and the Quality Impact Assessment Policy.**

Staffordshire and Stoke-on-Trent Health and Care Senate
Updates were provided on Medicines Optimisation decisions, including pathway updates and approval of cost-effective generic medications delivering financial savings. Plans were outlined to expand the Senate's scope and membership to support future joint working across both ICBs.

RESOLVE: **The NHS Shropshire, Telford and Wrekin Integrated Care Board and NHS Staffordshire, Stoke-on-Trent Integrated Care Board NOTED the contents of the report and RATIFIED the following decisions:**

- **The Senate had previously virtually approved decisions a) to d) and f) and noted items e) to g) from the October integrated Medicines Optimisation Group (IMOG) meeting and that decision was endorsed in the meeting.**
- **The Senate approved IMOG decisions a) to d) from the meeting on 5th November and decisions f) to l) from the meeting held on 3rd December 2025.**

014.2 The Committee Chairs and members were thanked for their work, and the Board emphasised the importance of committee assurance in supporting effective governance as arrangements increasingly move to shared models.

Minute No. ICB-26-03-015 – ICB Cluster – Joint SBAF and Risk Register Report

015.1 MI introduced the Joint System Board Assurance Framework (SBAF) and Risk Register report, emphasising the importance of Board oversight of system-level risks. Members were advised that the report presented a consolidated view across NHS Shropshire, Telford and Wrekin ICB and NHS Staffordshire and Stoke-on-Trent ICB.

015.2 PW introduced the report and explained that nine consolidated strategic risks had been developed through a process of rationalising and harmonising the legacy strategic risks from both ICBs. The aim of this work was to establish a clear, coherent and system-wide risk narrative to support effective assurance at Cluster level. The detailed paper was taken as read.

015.3 Members were advised that the methodology applied involved aligning the legacy strategic objectives from both ICBs into four shared strategic objectives, consistent with the ICB's statutory purpose. The consolidated strategic risks (SBAF 1–9) had been mapped against these objectives, enabling clearer oversight of delivery and risk exposure across the system.

015.4 The Board noted that the SBAF represented a year-end position and reflected partial assurance overall, recognising that while progress had been made across all risk areas, a high level of risk remained as the two systems continued to transition towards greater alignment. The Board was advised that the SBAF and risk register should be regarded as living documents and would continue to evolve.

015.5 Future development proposals included:

- Using a forthcoming Board development session to agree the cluster's strategic objectives for 2026/27 and align these with commissioning priorities;
- Developing a shared Cluster-wide Risk Appetite statement to support greater consistency in risk identification and escalation;
- Exploring improvements to reporting formats, including potential quarterly dashboard based reporting through a new risk management system, to enhance clarity and reduce duplication.

015.6 Board members welcomed the work undertaken, acknowledging the complexity of consolidating two established risk and assurance frameworks. Strong support was expressed for a Board workshop to further refine the approach, particularly given the importance of risk management to overall governance and audit assurance arrangements.

015.7 Members highlighted the need for:

- A streamlined and proportionate approach to risk management;
- Consistent application of scoring and tolerance across the cluster;
- Clear ownership of strategic risks;
- Ensuring quality and safety risks remain prominent within the framework; and
- Avoiding excessive volume of risks that could obscure strategic focus.

015.8 Clarification was sought and provided on how the Board would agree its future Risk Appetite, with reference to established good-governance approaches and sector best practice. It was confirmed that this would be developed as part of the proposed Board development session.

015.9 IG concluded that the Board did not need to finalise the framework at this stage, but endorsed the principles, methodology and direction of travel. It was agreed that further refinement would take place through collective ownership, Board development work and ongoing iteration.

Action: *A further development of the consolidated framework and Cluster-wide Risk Appetite to be progressed through a future Board development session.*

RESOLVE: **The NHS Shropshire, Telford and Wrekin Integrated Care Board and NHS Staffordshire, Stoke-on-Trent Integrated Care Board NOTED the methodology used to consolidate the SBAF.**

Minute No. ICB-26-03-016 – Any Other Business

016.1 IG advised that no items of any other business had been notified in advance and invited members to raise any additional matters.

016.2 No further business was raised.

Minute No. ICB-26-03-017 – Review of new or amended risks following discussions in the meeting

017.1 IG drew the Board's attention to a number of new and emerging risks identified during the meeting.

017.2 The Board was advised of the imminent introduction of a new national Dental Contract, due to come into effect on 1 April. It was noted that the contract had not been piloted or tested and was being implemented nationally. Members acknowledged that this posed a risk of operational challenge and potential disruption, with implications for dental service delivery and patient access locally. The Board agreed that it would be important to understand the impact of the contract on commissioning intentions, Neighbourhood working, and outcomes for the local population, and to ensure risks were managed proactively.

017.3 Members were also advised of emerging risks relating to General Practice, noting correspondence from the British Medical Association (BMA) to GP practices concerning the 2026/27 GP Contract, indicating resistance to aspects of its imposed terms.

017.4 In addition, the Board reiterated the ongoing risk associated with industrial action, previously discussed during the meeting. While mitigation measures were in place across provider organisations, members recognised that the potential impact on service delivery remained significant and required continued oversight.

RESOLVE: **The NHS Shropshire, Telford and Wrekin Integrated Care Board and NHS Staffordshire, Stoke-on-Trent Integrated Care Board:**

Minute No. ICB-26-03-018 – Meeting Effectiveness

018.1 IG invited feedback on the effectiveness of the meeting, including views on the hybrid format.

018.2 Members attending virtually reported that, while in-person attendance remained preferable, the virtual format had worked adequately and did not prevent meaningful participation. No technical issues were raised, and attendees confirmed that audio quality and engagement were satisfactory once on-screen visibility had been resolved.

018.3 IG noted the importance of ensuring reliable hybrid arrangements going forward, recognising the need to support cross-system working and inclusive participation across the Cluster.

018.4 Positive feedback was received on the quality and timeliness of meeting papers, in particular the documentation relating to the five-year Strategic Commissioning Plans, which members considered clear and helpful.

018.5 IG confirmed that the next meeting would take place on 30 April at 1:30pm and thanked members for their contributions.

16:08 – Meeting Closed

Date and Time of Next Meeting

Date: Thursday, 30th April 2026
Time: 1.30pm
Location: Midlands Partnership NHS Foundation Trust Headquarters Boardroom, Mellor House, St George's Hospital, Corporation Street, Stafford, ST16 3SR.

ACTION STATUS K
ACTION DUE
ACTION PENDING
ACTION

NHS Shropshire, Telford and Wrekin
NHS Staffordshire and Stoke-on-Trent

Shropshire, Telford and Wrekin
Staffordshire and Stoke-on-Trent ICB
Board Meeting in Common - HELD IN PUBLIC

Meeting Date	Agenda Item	Action	Due Date	Responsible Officer	Outcome/update
29/01/2026	Minute No. ICB 29-01.008 – Residents/Community Story – NHS Staffordshire, Stoke on Trent – End of Life Care	Provide an update on end of life care and neighbourhood development at a future public Board meeting. IG confirmed that there remained strategic and system interest in this area and that it was important the Board considered the topic in the context of place based development and partnership working. It was therefore agreed that a substantive discussion would be scheduled for a future Board meeting.	**TBC**	**Simon Whitehouse/Board Strategy Session**	
26/03/2026	Minute No. ICB-26-03-003 – Minutes of Previous Meeting	Minor textual amendments to be made, replacing "IA" with "IG".	**COMPLETED**	**Claire Colcombe**	
26/03/2026	Minute No. ICB-26-03-010 – Involvement Update	Develop and return a joint patient and public involvement strategy and framework to the Board.	**TBC**	**Mish Irvine / Adele Edmonson**	
26/03/2026	Minute No. ICB-26-03-015 – ICB Cluster – Joint SBAF and Risk Register Report	A further development of the consolidated framework and cluster wide risk appetite to be progressed through a future Board development session.	**May-2026**	**Mish Irvine / Paul Winter**	

NHS Shropshire, Telford and Wrekin
NHS Staffordshire and Stoke-on-Trent

Enclosure No: 03

Report to:	**Integrated Care Board**					
Date:	**30 April 2026**					
Title:	**Lived Experience: Essential Criteria | A Spoken Word**					
Presenting Officer:	Mish Irvine, Chief of Staff					
Author(s):	Imogen Hyde, Senior Communications and Engagement Manager					
Document Type:	Other		If Other: Video Clip			
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:

To share Leanne's insights into being a person of "lived experience" who is involved in service change. Leanne was one of the first CAMHS lived experience workers in the UK.

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

(3) Implications:	
Legal or Regulatory	The areas discussed reflect ICB Statutory Duties and Functions
CQC or Patient Safety	The video highlights opportunities to support improvements in patient safety
Financial (CFO-assured)	N/A for the report, although the topics covered each have financial implications
Sustainability	N/A for the report
Workforce or Training	N/A – no specific training implications; workforce matters are 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:

Assessment	Completed?	If No / N/A – Rationale	If Yes – Outcome & Date Reported / Signed off
DPIA	☐ Yes ☐ No ☒ N/A	Click or tap here to enter text.	*Reported to IG Committee:* Click or tap to enter a date.
EIA	☐ Yes ☐ No ☒ N/A	Click or tap here to enter text.	*Outcome and date of completion:* Click or tap here to enter text.
QIA	☐ Yes ☐ No ☒ N/A	*(enter rationale, per ICB QIA Policy, that it does not impact on quality of services)* Click or tap here to enter text.	*SRO sign-off, outcome & date of completion:* Click or tap here to enter text.
Has there been Public / Patient Involvement?	☒ Yes ☐ No ☐ N/A		Click or tap here to enter text.

(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:

Leanne shares her experiences, via a spoken word performance, available to watch on YouTube: https://www.youtube.com/watch?v=wWMUO-10lhU

(7) Recommendations to Board / Committee:

To consider Leanne's insights and experience when involving service users in future programmes of work.

Enclosure No: 04

Report to:	Integrated Care Board
Date:	30 April 2026
Title:	CEO Report
Presenting Officer:	Simon Whitehouse, CEO
Author(s):	Kate Manning and Imogen Hyde

Document Type:				**Action Required (select):**			
Report	☒	**Business Plan**	☐	**Information (I)**	☒	**Discussion (D)**	☐
Strategy	☐	**Policy**	☐	**Assurance (S)**	☐	**Approval (A)**	☐
Other	☐	*(please describe)*		**Ratification (R)**	☐	*(check as necessary)*	

Is the decision within SOFD powers & limits	**Yes**	☐	**No**	☒
Any potential / actual Conflict of Interest?	**Yes**	☒	**No**	☒
If Y, the mitigation recommendations:	*E.g. Staff have Financial + Non-Financial Professional Interests which can be managed by recording those in minutes and allowing presence in discussions with recusals from formal decisions*			
Any financial impacts: ICB or ICS?	**Yes**	☐	**No**	☒
If Y, are those signed off by and date:	*E.g. Chief Finance Office, dd-mmm-yyyy*			
Any impacts on ICB Undertakings?	**Yes**	☐	**No**	☒
If Y, are those signed off by and date:	*E.g. Chief Finance Office, dd-mmm-yyyy*			
Appendices:	None			

(1) Purpose of the Paper:

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

It includes a general update from the Chief Executive as well as a specific focus on portfolio areas and enabling functions across NHS Staffordshire and Stoke-on-Trent ICB and NHS Shropshire, Telford and Wrekin ICB.

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

Expand as necessary if the report went to multiple meetings

(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:

	Completed?			If N - N/A, Rationale	If Y, Outcome / Date Reported & Signed off
DPIA	**Yes**	**No**	**N/A**	Click or tap here to enter text.	
	☐	☐	☒		
EIA	**Yes**	**No**	**N/A**	Click or tap here to enter text.	
	☐	☐	☒		
QIA	**Yes**	**No**	**N/A**	*E.g. per QIA Policy, that it doesn't impact quality of services* Click or tap here to enter text.	
	☐	☐	☒		

Has there been Public / Patient Involvement?	Yes	No	N/A	
	☐	☐	☒	Click or tap here to enter text.

(5) Integration with SBAF (for NHS SSOT) / Strategic Risks (SR, for NHS STW)

SBAF1	Responsive Patient Care - Elective	☒	**SBAF5**	High Quality, Safe Outcomes	☒
SBAF2	Responsive Patient Care - UEC	☒	**SBAF6**	Sustainable Finances	☒
SBAF3	Transforming Community Services	☒	**SBAF7**	Improving Productivity	☒
SBAF4	Reducing Health Inequalities	☒	**SBAF8**	Sustainable Workforce	☒
SR1	Strategic Collaboration & Partnership	☒	**SR4**	ICS Workforce (retention/wellbeing)	☒
SR2a	ICB & System Financial Balance	☒	**SR5**	Digital & Data Systems / Strategy	☒
SR2b	ICB & System RRL / CRL Plans	☒	**SR6**	ICS Strategic Response (e.g. EPRR)	☒

SR3	Reducing Health Inequalities	☒	**SR7**	ICS Socio-Economic Development	☒
			SR8	Patient & Public Involvement	☒

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

(7) Recommendations to Board:

☑ To receive the report and be assured the leadership are working on each topic as raised.

1.0 General Update

1.1 NHS Government Reset Programme

The Government NHS Reset Programme is progressing as planned, supported by strengthened governance arrangements across both NHS Shropshire, Telford and Wrekin (STW) and NHS Staffordshire and Stoke-on-Trent (SSOT) ICBs.

Management of Change (MOC) consultations for senior leadership and clinical roles have now concluded. The wider workforce MOC consultation commenced on 23 March 2026 and is scheduled to conclude on Sunday 17 May 2026**.** Based on the current timeline, outcomes should be confirmed and communicated by the end of quarter 2 2026**.** This is subject to change once the feedback from the consultation has been reviewed and responded to.

The future operating model is shared as a separate paper in this pack of papers and is aligned to the current ICB statutory duties and updated national expectations. Uptake of voluntary redundancy has reduced the requirement for compulsory changes, and the ICB remains on track to deliver the £19.55 per head running cost requirement during the 2026/27 financial year. The Transition Committee have received detailed updates on the glidepath for this work and are fully sighted on the assumptions being used to model our approach. The structure proposed for consultation is affordable within our reduced running cost. It should be noted that any delay to a future merged position or changes to roles and responsibilities will result in additional cost.

Subject to completion of consultation and final approvals, current planning assumptions anticipate that appointments to the new structure will commence from September 2026**.** The organisation is navigating a complex period of change in a structured and well-managed way, with a continued emphasis on staff support and long-term organisational stability.

As I referenced in my last update to the Board, there continues to be a significant number of colleagues leaving us through the voluntary redundancy route. This is a challenging and emotional period for all colleagues, and we are losing a significant amount of experience, knowledge and expertise as we say goodbye. I reiterate my thanks to each and every one of them and I wish them the very best for whatever choices they make next.

1.2 Five-Year Commissioning Plan (2026–2031)

Working in collaboration, NHS Shropshire, Telford and Wrekin ICB and NHS Staffordshire and Stoke-on-Trent ICB have each developed a Strategic Commissioning Plan for the period 2026–2031, reflecting the transition to a clustered operating model ahead of a proposed full merger in 2027.

Neighbourhoods are positioned as central to care delivery, with place-based partnerships, provider collaboratives, and Primary Care Networks identified as key delivery partners, and the ICB operating as a strategic commissioner. The plans are evidence-led and insight-driven, aligned to the NHS 10-Year Health Plan and national priorities, with clear delivery plans structured around the five major shifts**.** The Five-Year Commissioning Plan for both NHS SSOT and NHS STW have now been published and can be found on both respective websites.

In addition, we have created a short film summarising the Five-Year Plans.

1.3 Neighbourhood Health

The Department of Health and Social Care, working with NHS England, has published the Neighbourhood Health Framework, setting out a consistent national approach to delivering care closer to home, with an increased focus on prevention and partnership working.

Local development work with general practice, community services, local authorities, and the voluntary sector is strongly aligned with the framework. This includes the development of integrated, multidisciplinary neighbourhood teams and proactive support for people living with long-term conditions and frailty. There is a more detailed paper on the agenda that unpacks what this means for our area.

1.4 Work Well Programme

The Clustered ICBs have successfully secured funding through the DHSC and DWP Work Well programme and commenced work with partners to scope and co-design the three-year initiative. This national programme aims to improve people's health and employment outcomes by integrating local health, work and wellbeing support into a coordinated offer. We will build on strong foundations of existing programmes to co-create pathways and support that best meets the needs of our populations. I have personally been in dialogue with Telford College to further develop their approach on this agenda. We have strong partner support and commitment in this space, and this is an important opportunity for us as a collective group of partners to make a genuine difference locally.

1.5 STW Community and Acute Group

From 1 April 2026, Shropshire Community Health NHS Trust and The Shrewsbury and Telford Hospital NHS Trust have formally established the Shropshire, Telford and Wrekin Community and Hospitals NHS Group. The Trusts remain separate statutory organisations, but now operate under shared executive and non-executive leadership. The Group model is intended to strengthen collaboration across community and acute services, support the shift towards care closer to home, improve system flow, and enhance workforce and operational resilience. This development is aligned with the ICB's strategic priorities, including neighbourhood health, productivity, and reducing health inequalities.

1.6 Population Health Management

Population Health Management (PHM) has been launched across NHS STW as a core approach to understanding and addressing local need. Using linked, non-identifiable data from GP practices, hospitals, community and mental health providers, and local authorities, PHM will support more targeted service design and improved population outcomes. The use of data is underpinned by robust information governance arrangements, ensuring patient confidentiality and strong safeguards.

In SSOT, we have developed a linked dataset called Pathfinder that covers 95% of our practice population; a total of 1.08 million people. We are using Pathfinder to put PHM into action through the Locality Improvement Framework (LIF) which brings partners from VCSE, primary care and local authorities together to identify the biggest health inequalities affecting their communities and

develop joint plans to improve outcomes in Core20 neighbourhoods. The ICB has currently approved 8 of the 12 business cases across Staffordshire, with the final 4 locality plans, investing a total of £1.7m to improve health outcomes across Staffordshire and Stoke-on-Trent.

1.7 New Community Diagnostic Centre (CDC) is set to open in Hanley

A purpose-built Community Diagnostic Centre (CDC) is set to open in Hanley, Stoke-on-Trent. This will provide local people with faster and more convenient access to a wide range of diagnostic tests. The new centre, developed by UHNM, is located on the former Sainsbury's site in Hanley and is expected to open in April 2026.

Community Diagnostic Centres are part of a national NHS programme to bring diagnostic services closer to where people live, helping patients receive tests more quickly without always needing to attend a busy hospital site. The Stoke-on-Trent CDC will offer a wide range of diagnostic tests and specialist clinics, including:

- MRI scans
- CT scans
- Ultrasound
- X-rays
- Blood tests
- Endoscopy
- Cardiology and respiratory diagnostics
- Telescopic ENT procedures
- Children's asthma services
- Gynaecology One Stop Clinics
- Fibro-scanning

The centre is expected to deliver up to 85,000 tests and scans each year, helping thousands of patients receive quicker diagnoses and begin treatment sooner when required.

1.8 Update on GP Services for 2026/27

GP practices continue to be the main way most people access the NHS, and we want to make sure they can keep providing safe, reliable and high-quality care. In 2026/27, the GP contract includes provision to help practices see more patients, focus more on preventing illness, and support patients with the greatest need to be seen more quickly. These changes build on recent progress, where most people now find it easier to contact their GP.

GP practices will also continue working together through Primary Care Networks (PCNs). This partnership approach helps practices share staff and resources so patients can access a wider range of services locally. It supports better joined-up care, helps tackle health inequalities and remains an important part of the NHS's long-term plan for improving community health.

As with all parts of the health system, GP services remain under considerable pressure. The ICB will continue to work closely with GP colleagues to ensure that we have a strong, stable and

innovate local GP offer that meets the needs of the local population. The ICB will continue to be a strong advocate for high quality primary care but with that comes a clear expectation of what high quality local GP and primary care services need to look like.

Further resources to support the implementation of changes to the 2026/27 GP Contract can be found on: NHS England » GP Contract

1.9 Bliss Baby Charter Accreditation Programme

Congratulations to the Shrewsbury and Telford Hospital NHS Trust (SaTH) Neonatal Unit on achieving Gold Accreditation on the Bliss Baby Charter Accreditation Programme. The Bliss Baby Charter Accreditation Programme evaluates neonatal units across the UK against best practice standards designed to ensure that families are central to their baby's care. Gold Accreditation represents the highest level of achievement, highlighting the unit's commitment to delivering outstanding, family-centred care. To achieve this level, units must meet rigorous standards, including demonstrating at least 90% compliance across all Charter principles and passing an external assessment visit from Bliss and independent reviewers. This accreditation confirms that the SaTH neonatal team consistently provide safe, compassionate, and evidence-based care while embedding parents as true partners in their baby's daily care and decision making.

For the families, Gold Accreditation is a reassuring signal that they will receive personalised, supportive, and empowering care during what can be an overwhelming time. Units that achieve it are recognised for fostering environments where parents are encouraged to participate actively, such as through skin-to-skin contact, involvement in ward rounds, and shared decision making, which is shown to improve bonding, parental confidence, and long-term outcomes for babies.

1.10 Veteran Aware Accreditation

The Robert Jones and Agnes Hunt Orthopaedic Hospital (RJAH) has been reaccredited as a Veteran Aware Trust by the Veterans Covenant Healthcare Alliance for a further three years. RJAH has held Veteran Aware status continuously since 2018, demonstrating an ongoing commitment to meeting the needs of the Armed Forces community, in line with the Armed Forces Covenant.

The Trust continues to develop specialist provision through the Headley Court Veterans' Orthopaedic Centre and embedded staff training, supporting personalised care, workforce inclusion, and strong partnership working with local authorities and voluntary sector organisations. I would want to thank the Board and the leadership team at RJAH for their leadership and commitment to the work on this important agenda.

1.11 Social Care Academy success

More than 2,000 people, who care for adults, have signed up to access training through a new learning platform. The Social Care Academy was developed following a successful SSOT pilot last year, which saw the ICB, Skills for Care, Stoke-on-Trent City Council, and Staffordshire County Council work in partnership to bring high-quality training together in one easy-to-use online space. Care workers and providers can access the Social Care Academy on its website.

2.0 Medicines Optimisation

2.1 AnalyseRx – Digital Medicines Optimisation Solution

Staffordshire and Stoke-on-Trent ICB have approved funding for AnalyseRx, a new medicines optimisation platform developed by First Data Bank (FDB). This solution complements our existing digital tools—OptimiseRx and CoordinateRx—and forms part of our broader strategy to enhance safe, effective, and proactive medicines optimisation across the system.

Following successful pilots at Harley Street GP Practice and, more recently, with Newcastle North PCN, AnalyseRx has demonstrated clear value in supporting practices to identify and act on medicines optimisation opportunities at scale.

AnalyseRx is a proactive, intelligent digital tool designed to help practice teams quickly identify, prioritise, and action medicines optimisation interventions across the entire registered population. It is fully integrated with both EMIS Web and TPP SystmOne, providing seamless workflow support.

The system acts as a powerful aide-mémoire to support delivery of:

- ICB Medicines Optimisation Service Level Agreement (SLA)
- Care Quality Commission (CQC) requirements
- Medicines and Healthcare products Regulatory Agency (MHRA) guidance
- Quality and Outcomes Framework (QOF) indicators
- Drug and condition-specific monitoring requirements

It also provides evidence-based resources at the point of review, supporting safe clinical decision-making.

The rollout of AnalyseRx has now commenced across Staffordshire and Stoke-on-Trent ICB. The solution is being offered to all GP practices, with a full system-wide deployment expected to be completed by the end of Quarter 1, 2026/27.

3.0 Urgent and Emergency Care (UEC)

March continued to be a challenging month for UEC in SSOT, although pressures were less sustained than previous months. Several key metrics remained off plan so the focus continues to be on recovery of the core metrics for system partners.

During the month, the SSOT system has been preparing for the Easter Bank Holiday by coordinating an Integrated Care System (ICS) Bank Holiday plan led by the System Coordination Centre (SCC). System partners have also produced their own detailed plans, which work in conjunction with the system plan. The aim of the system plan is to ensure appropriate risks and impacts associated with the Bank Holiday period are mitigated as far as practically possible. Lessons learnt post the period will be coordinated by the SCC and our Emergency Preparedness, Resilience and Response (EPRR) ICB teams to support future learning and planning for these periods.

Alongside the Easter Bank Holiday planning, the system has been preparing for Resident Doctors Industrial Action (IA), which will take place from Tuesday 7 April until Monday 13 April. Similarly to

Bank Holiday planning, each system partner will coordinate their individual plans; however, the system plan will be coordinated by the SCC and EPRR teams within the ICB. Monitoring and oversight of the IA will be provided by the SCC alongside daily system calls and post the IA period, system de-briefs will be completed to support understanding of what went well and any learning for the system for any future periods of IA.

As the system moved out of the core Winter period, focus has shifted to de-escalation of the ICS Winter Plan for 25/26 with the system Winter Lessons learnt event in place for 6 May. This event will support the review of our plans for 25/26, identifying good practice and allow us to take forward relevant learning into our 26/27 Surge Planning. The outputs of this event will be presented through UEC and ICB governance following the event taking place.

In STW, the system-wide UEC improvement programme continues to progress, with a strengthened focus on whole-pathway flow and shared accountability across partners.

Work has shifted from a singular focus on headline metrics to a more granular understanding of patient flow across three critical stages:

1. Early identification and discharge planning,
2. First 24–48 hours of admission, and
3. Patients with extended lengths of stay (>48 hours delays).

This approach is enabling clearer ownership across acute, community and local authority partners, with targeted actions in each stage to reduce delays and improve patient experience.

There has been particular focus on:

- Improving discharge planning from admission, including embedding Expected Date of Discharge (EDD) discipline and earlier pathway allocation.
- Strengthening acute flow processes within the first 48 hours, including senior clinical decision-making, therapy input, and reducing internal delays.
- Addressing longer-stay cohorts, with system-wide escalation and improved alignment of community capacity, brokerage and pathway utilisation.

The establishment of the Community and Hospitals Group from April 2026 provides a significant opportunity to further align acute and community services, improving patient flow and reducing fragmentation across pathways.

In parallel, work is progressing to:

- Enhance system coordination arrangements, including development of a system Flow Centre approach.
- Strengthen front door streaming and same day emergency care (SDEC) to reduce avoidable admissions.
- Improve discharge performance and reduce length of stay, particularly for patients with complex needs.

Whilst demand and system pressures remain high, there is improved system alignment and a clearer trajectory for delivery as we move into 2026/27, with continued focus on delivering sustainable improvements in flow, patient outcomes and experience.

I would like to thank all colleagues involved in the recent response to the period of industrial action by Resident Drs. The local response was well led, well organised and kept most of the services functioning at full or near full capacity. I would also like to thank the public for still using NHS services during this period but for considering the best service to use to respond to their need.

4.0 Integrated Holistic Assessment Team

The SSOT Integrated Holistic Assessment Team (IHAT) was established in the autumn of 2024 as part of the All Age Continuing Care (AACC) Efficiency Programme. Since implementation, the team has delivered significant improvements across quality, safety, patient experience and financial sustainability. The team has driven a system-wide shift towards least restrictive care, reducing inappropriate 1:1 provision by over 63% in comparison to baseline data in March 2024, with improved safeguarding and compliance with best interest and Mental Capacity Act (2005) principles. Patients and families report better experiences through more person-centred, holistic care planning, enhanced multi-disciplinary team (MDT) involvement and implementation of alternative strategies such as assistive technology. Quality has been strengthened through regular reviews, phased reductions, increased clinical oversight and proactive case management. Financially, IHAT has delivered substantial cash-releasing savings and cost avoidance, with forecasted over-delivery of circa £8.7m in 25/26, demonstrating that improved outcomes and safety can be achieved alongside sustainable efficiency.

5.0 Planned Care

5.1 Lung Cancer Screening Programme

Following on from the successful launch of the Shropshire, Telford and Wrekin Lung Cancer Screening Programme, starting in Telford South in December 2025, the programme has been expanded to residents registered with GPs in Telford Central. Starting in April, people living in this area who meet the eligibility criteria (aged 55-74 and a smoker/ex-smoker) will be offered Lung Health Checks, with those assessed as being at high risk of developing lung cancer being offered a scan at a convenient local community location from May until December 2026. It is anticipated that the programme will then roll-out to the next location, Telford North, starting in November 2026.

This is an important preventative programme and one that is being delivered in the communities that need it the most. The focus on the service being as close to the neighbourhood as possible is an important one and aligns to our future direction of travel.

6.0 Mental Health

6.1 CAMHS STW Service Launch Update

The Child and Adolescent Mental Health Service Shropshire, Telford and Wrekin (CAMHS STW) launched as planned on 1 April 2026, delivered by Midlands Partnership University NHS Foundation Trust. The new NHS-led service replaces the previous BeeU model and marks the

start of a three-year transformation programme focused on improving access, providing earlier support and delivering more joined-up care.

Existing children and young people receiving support have experienced no change to their care and have not been required to opt in or be re-referred. Delivery is aligned to national i-THRIVE principles, with a focus on a single front door, clearer pathways, and reducing inequalities, particularly for children in care and those with SEND. Expansion of Mental Health Support Teams in schools and colleges continues, with full coverage planned by 2030.

Simon Whitehouse,

Chief Executive Officer

April 2026

Integrated Care System
Shropshire, Telford and Wrekin

Staffordshire and Stoke-on-Trent Integrated Care System

NHS
NHS Shropshire, Telford and Wrekin
NHS Staffordshire and Stoke-on-Trent

Enclosure No: 05

Report to:	ICB Boards in Common
Date:	30 April 2026
Title:	ICB Operational Plans
Presenting Officer:	Claire Skidmore, NHSSTW and NHSSSOT
Author(s):	Angela Parkes NHSSTW, Vicki Inch and Vikki Hawley NHSSSOT

Document Type:				**Action Required (select):**			
Report	☒	**Business Plan**	☐	**Information (I)**	☒	**Discussion (D)**	☐
Strategy	☐	**Policy**	☐	**Assurance (S)**	☒	**Approval (A)**	☐
Other	☐	*(please describe)*		**Ratification (R)**	☐	*(check as necessary)*	

Is the decision within SOFD powers & limits	**Yes**	☐	**No**	☐
Any potential / actual Conflict of Interest?	**Yes**	☐	**No**	☒
If Y, the mitigation recommendations:	*E.g. Staff have Financial + Non-Financial Professional Interests which can be managed by recording those in minutes and allowing presence in discussions with recusals from formal decisions*			
Any financial impacts: ICB or ICS?	**Yes**	☐	**No**	☒
If Y, are those signed off by and date:	*E.g. Chief Finance Office, dd-mmm-yyyy*			
Any impacts on ICB Undertakings?	**Yes**	☐	**No**	☒
If Y, are those signed off by and date:	*E.g. Chief Finance Office, dd-mmm-yyyy*			
Appendices:	Appendix A: Final five-year planning summary – STW and SSOT.			

(1) Purpose of the Paper:

Further to the 5 year plan narrative documents that were shared with the Boards in Common at their last meeting, this paper is presented to provide an overview of the 26/27 operational plan which comprises multi year finance and performance elements.

Both STW and SSOT ICBs submitted compliant multi-year capital and revenue (post deficit support funding) plans in February 2026, with minor updates made in March 2026 to reflect the most up to date contract and efficiency values.

Alongside submission of the finance plans, STW and SSOT ICBs submitted multi-year performance plans. Minor updates to the February 2026 submission were made in March 2026 to reflect agreed improvements to the delivery of some targets.

Plans were considered and signed off by Boards prior to submission.

In letters dated 7th April, NHSE Midlands confirmed that both ICB plans were rated as 'Compliant – with Conditions.' These conditions being in respect of non-compliance for a small number of activity targets.

Focus is now directed to delivery of the plans.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	Date
Draft position reviewed in private session previously.	

(3) Implications:	
Legal / Regulatory	No legal, regulatory or equality implications identified as a direct result of this report
CQC / Patient Safety	No patient safety implications as a direct result of this report
Financial (CFO-assured)	Both ICBs have submitted a balanced position for each year of the plan (which includes deployment of deficit support funding) Financial implications of the plan are outlined further in the plan summary in Appendix A.
Sustainability	No sustainability implications identified
Workforce / Training	No workforce implications identified
Equality & Diversity	No equality and diversity implications identified
Due Regard: Inequalities	n/a
Due Regard: wider effect	n/a

(4) Statutory Dependencies & Impact Assessments:

	Completed?			If N - N/A, Rationale	If Y, Outcome / Date Reported & Signed off
DPIA	**Yes**	**No**	**N/A**	Click or tap here to enter text.	*Reported to IG Committee:* Click or tap to enter a date.
	☐	☐	☒		
EIA	**Yes**	**No**	**N/A**	Click or tap here to enter text.	*Outcome and date of completion:* Click or tap here to enter text.
	☐	☐	☒		
QIA	**Yes**	**No**	**N/A**	*E.g. per QIA Policy, that it doesn't impact quality of services* Click or tap here to enter text.	*SRO sign-off, outcome & date of completion:* Click or tap here to enter text.
	☐	☐	☒		

Has there been Public / Patient Involvement?	Yes	No	N/A	
	☐	☐	☒	*Click or tap here to enter text.*

(5) Integration with SBAF (for NHS SSOT) / Strategic Risks (SR, for NHS STW)					
SBAF1	Responsive Patient Care - Elective	☒	SBAF5	High Quality, Safe Outcomes	☒
SBAF2	Responsive Patient Care - UEC	☒	SBAF6	Sustainable Finances	☒
SBAF3	Transforming Community Services	☒	SBAF7	Improving Productivity	☒
SBAF4	Reducing Health Inequalities	☒	SBAF8	Sustainable Workforce	☒
SR1	Strategic Collaboration & Partnership	☒	SR4	ICS Workforce (retention/wellbeing)	☒
SR2a	ICB & System Financial Balance	☒	SR5	Digital & Data Systems / Strategy	☒
SR2b	ICB & System RRL / CRL Plans	☒	SR6	ICS Strategic Response (e.g. EPRR)	☒
SR3	Reducing Health Inequalities	☒	SR7	ICS Socio-Economic Development	☒
			SR8	Patient & Public Involvement	☒

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

The 26/27 operational planning process has now concluded and the ICBs have received 'closedown' letters from NHSE on 7 April 2026. Both NHSSTW and NHSSSOT have been assessed as "Compliant with conditions due to non-compliance in activity submissions". Key points from the letter are outlined below:

	SSOT	STW
Oversight	Effective oversight of the delivery of the plans will be important to ensure that the ambitious trajectories are met. NHSE will review progress against the plans through the regional oversight arrangements, which include routine provider review meetings (PRMs), ICB cluster review meetings and other forums e.g. tiering calls, finance oversight meetings. This will ensure that there is continuous assurance, alignment across organisations, and transparent governance.	
Finance	NHSE were pleased to see that SSoT ICB have **submitted a balanced plan which includes £76.0m of deficit support funding** and note the risks described in your submission.	NHSE were pleased to see that STW ICB have **submitted a balanced plan which includes £32.5m of deficit support funding** and note the risks described in your submission.
Quality considerations for the delivery of Medium-Term Plans	The Medium-Term Planning framework sets out the key approach to transforming quality across the NHS with reference to the National Quality Board NQB) Quality Strategy, the introduction of modern service frameworks and a focus on patient and staff experience alongside outcomes. ICBs and providers must continue to implement the NHS Patient Safety Strategy and implement guidance from April 2026 as it is published. It is important that Equality and Quality Impact Assessments are undertaken for any proposed service changes and should be fully reflected in the management of identified risks.	
Next Steps	1. NHSE acknowledge that the data collection template for "Percentage of clinically urgent appointments seen on the same day" for the 2026/27 period is not expected until after the main planning round has concluded. As such, specific discussions may be needed around this area following issue of this letter. 2. The ICB Board to approve the medium-term plan submission and fully understand any risks, actions and mitigations required to deliver the finance, activity and workforce plans. Submitted activity plans including key commitments and areas of non-compliance are outlined in appendix 1 and will form part of ongoing performance management processes.	

Within the closedown letter the metrics that were non-compliant in the submission were identified. These metrics can be seen in table one for STW and table two for SSOT along with a narrative outlining the decision to submit a non-compliant metric.

Table 1: STW metrics identified as non-compliant in activity submissions *(Blue text denotes provider metric not part of ICB submission)*

Metric	Year	Target	Plan	Comment
Percentage of RTT waiting list within 18 weeks	Mar 28	82.9%	82.4%	The ICB has calculated the waiting list reductions required to achieve the RTT targets. There is not the additional investment available at this time to reduce the waiting list any further
Percentage of patients receiving a first definitive treatment within 62 days	Mar 27	80.0%	77.0%	The trajectory for the 62-day cancer standard is realistic and credible. The pathway has many complexities. Investment has been agreed by the ICB as requested by the provider to deliver as much improvement as possible in the timescales required, including for diagnostics capacity, but this needs time to realise the benefits.
	Mar 28	82.5%	80.0%	
Percentage of patients waiting for a diagnostic test or procedure for 6 weeks or more	Mar 27	4.5%	11.9%	The ICB is planning to achieve the target in Y3. Y1 and Y2 are dependent on the submissions from providers. The ICB has met the additional targeted investment requested by providers. Our diagnostic allocation was £900k in 26/27 and the ICB has invested £1.8m and any further investment is unaffordable.
	Mar 28	3.1%	6.5%	
4-hour A&E performance	Mar 27	82.0%	70.9%	SaTH plans show continuous improvement at a realistic level. Planning to achieve the national targets from the current baseline would not be credible or attainable.
	Across 27/28	83.0%	73.0%	
	Across 28/29	85.0%	77.1%	
Number of inappropriate adult out of area placements	Mar 27	0	11	There is currently no in-area capacity, and the system has allocated capital to develop some in-area capacity. In the meantime, the ICB will be contracting for 3 beds which will be out of area. Improvements are planned from Y2 onwards due to this additional capacity.
Reliance on mental health inpatient care for autistic adults	Mar 27	8	12	This plan was increased for Y1 in line with feedback from NHSE which moved it to non-compliance
Total waiting list	Mar 28	44,609	48,212	The ICB has calculated the waiting list reductions required to achieve the RTT targets. There is not the additional investment available at this time to reduce the waiting list any further
	Mar 29	33,832	41,031	
Percentage of handovers over 45 minutes	Av. across 26/27	0.0%	28.8%	The target of zero would not be realistic or achievable from the current baseline position (Jan26 was 49.3%, Feb 41.3%).
Percentage of handovers over 15 minutes	Mar 28	0.0%	72.0%	The target of zero would not be realistic or achievable from the current baseline position. (March 84.5%) 26/27 improving to 77%. The ICB is disappointed that there was no continued improvement in year 3.
	Mar 29	0.0%	72.0%	
Percentage of attendances for all A&E departments where the	Sept 26	95.0%	83.9%	The target of 96% would not be realistic or achievable from the current baseline position. The ICB is disappointed that there was no continued improvement in year 3.
	Av. across 27/28	95.0%	90.0%	

patient spent less than 4 hours – children	Av. across 28/29	95.0%	90.0%	
Average length of stay for patients in older adult acute mental health beds	Mar 27	100.3	112.0	This metric is reliant on the provider submission which did not achieve the required target. Improvements planned in subsequent years.
12-month admission rate for adults with learning disability and autistic adults	Q4 28/29	38.6	38.6	Does not achieve the year-on-year reduction in year 3. This metric is subject to small numbers.
12-month admission rate for under 18s with learning disability and autistic U18s	Q4 27/28	19.8	19.8	Does not achieve the year-on-year reduction in year 2 and 3. This metric is subject to small numbers.
	Q4 28/29	19.8	19.8	

Table 2: SSOT metrics identified as non-compliant in activity submissions *(Blue text denotes provider metric not part of ICB submission)*

Metric	Time point	Target	Plan	Comment
Percentage of RTT waiting list within 18 weeks	Mar 27	77.0%	70.8%	The ICB has calculated the waiting list reductions required to achieve the RTT targets and our main providers have committed to meet targets set by the NHSE. There is not the additional investment available at this time to reduce the waiting list any further.
	Mar 28	88.4%	80.5%	
4-hour A&E performance	Mar 27	82.0%	77.1%	UHNM plans show continuous improvement at a realistic level. Planning to achieve the national targets from the current baseline would not be credible or attainable.
	Av. across 27/28	83.0%	76.5%	
	Av. across 28/29	85.0%	85.0%	
Number of active inappropriate adult acute out of areas placements	Mar 27	0	16	The in-area capacity has been significantly reduced following the mandatory implementation of Project Chrysalis. Planning to achieve the target of zero from the current baseline would not be credible or attainable, in line with feedback from NHSE. The ICB planned to achieve the target by the end of Y3.
Reliance on mental health inpatient care for adults with a learning disability	Mar 27	11	15	This plan was increased in line with feedback from NHSE which moved it to non-compliance
Reliance on mental health inpatient care for autistic adults	Mar 27	6	9	This plan was increased in line with feedback from NHSE which moved it to non-compliance
Percentage of handovers over 45 minutes	Av. across 26/27	0.0%	31.2%	The target of zero would not be realistic or achievable from the current baseline position (Jan26 was 43.1%, Feb 36.3%).
Percentage of handovers over 15 minutes	Mar 28	0.0%	45.2%	The target of zero would not be realistic however we are working with the provider to ensure further ambition is added to their planning.
	Av. Across 28/29	0.0%	38.9%	
Percentage of attendances for all A&E departments where the patient spent less than 4 hours – children	Sept 26	95.0%	89.7%	Whilst below the target metric through their UEC improvement programme, UHNM are continuing to focus on improvements to deliver the planned performance position but recognise this will be difficult due to the baseline position and ongoing development works within the estate.
	Av. across 27/28	95.0%	89.4%	
	Av. across 28/29	95.0%	91.1%	

People with a learning disability and autistic people in mental health hospital with the longest lengths of stay	Q4 26/27	59.0%	63.0%	The regional planning team confirmed an issue with the denominator used in this metric and notified that the percentage figure will not be used in the assurance process, and assurance will instead be based solely on the numerators, which are reducing over the three years.
12-month admission rate for adults with learning disability and autistic adults	Q4 27/28	7.6	7.6	Whilst the system does not deliver a year-on-year reduction in year 2 compared against Q4 of year 1, the priority in year 2 will be to maintain the rate of 7.6 that was planned to achieve in Q4 of year 1. This metric is subject to small numbers.
Percentage of people aged 14+ on the QOF Learning Disability Register with an annual health check and health action plan	26/27 cumulative total	80.2%	79.0%	The steer on this metric is to increase the number of health checks with less focus on the percentage undertaken. The numerators have been agreed with the NHSE.

The full performance metrics submission can be seen in Appendix A.

(7) Recommendations to Board:

To note the final multi-year financial and performance metrics for the two ICBs. These have previously been agreed in private session and are now confirmed by NHSE.

NHS Shropshire, Telford and Wrekin
NHS Staffordshire and Stoke-on-Trent

Final Multi Year Plan Summary

30 March 2026

NHS Shropshire, Telford and Wrekin
NHS Staffordshire and Stoke-on-Trent

Finance Plan – Capital and Revenue

- Both STW and SSOT ICBs submitted compliant multi-year capital and revenue (post deficit support funding) plans in February 2026, with minor updates made in March 2026 to reflect the most up to date contract and efficiency values. These were considered and signed off by Boards prior to submission.

Capital Financial Plan

NHS STW ICB Primary Care Estates

- Primary Care operational CDEL of circa £1m/annum for GPIT/GP capital grants and the national primary care modernisation and utilisation fund £0.5m/annum.

NHS STW ICB Strategic Capital

- The priorities for the application of the national capital programme funding for ICB strategic capital of circa £1.7m per annum are One Health and Care Record, Population Health Management and Virtual Remote Monitoring systems.
- Other System Strategic Capital £44m total 26/27-28/29 = £24.5m for Diagnostics (CDC2), £1.4m UEC (Frailty SDEC), £14.1m MH PICU, £4m Community (Neighbourhoods)

NHS SSOT ICB Primary Care Estates

- Primary Care operational CDEL of circa £2.3m/annum for GPIT/GP capital grants and the national primary care modernisation and utilisation fund circa £1m/annum.

NHS SSOT ICB Strategic Capital

- The priorities for the application of the national capital programme funding for ICB strategic capital of circa £3.7m per annum are One Health and Care Record, Population Health Management, Virtual Remote Monitoring systems, Burntwood Health Centre and Single Intelligence Hub.
- Other System Strategic Capital £67m total 26/27-28/29 = £20m for Diagnostics (CDC2), £31.5m UEC (Various), £8m MH including PICU, £7.5m Community (Neighbourhoods)
- **In addition to the above there is also circa £3m per annum per ICB for Neighbourhood Capital which has been indicatively announced ahead of national guidance.**
- **This excludes provider operational capital, estates safety and other national capital programmes.**

Revenue Financial Plan

NHS STW ICB

- £1.5bn total allocation and spend, £1.2bn core programme, £8m running costs, £178m delegated primary care, £140m specialised commissioning.
- Opening underlying deficit £41m
- 2026/27 Efficiency target £31m - 100% fully developed/implemented
- Contract values 100% aligned and agreed at 01/04/26
- Gross risk £28m - £10m efficiency risk, cost risk £18m - £6m AACC, £4m Prescribing, £8m High-Cost Drugs - Fully Mitigated.

5-year underlying breakeven trajectory by 2030/31

In-year break even every year, utilising notified deficit support

Underlying Break Even within 5 Years

STW 2026/27 Revenue Finance Plan	2026/27 Plan £m	2027/28 Plan £m	2028/29 Plan £m	2029/30 Plan £m	2030/31 Plan £m
26/27 Underlying Position	**(29.5)**	**(25.9)**	**(17.8)**	**(8.1)**	**0.0**
26/27 In Year Position before DSF	**(32.5)**	**(24.4)**	**(16.3)**	**(8.1)**	**0.0**
Deficit Support Funding (DSF)	32.5	24.4	16.3	8.1	0.0
26/27 In Year Position after DSF	**0.0**	**(0.0)**	**(0.0)**	**0.0**	**0.0**

NHS SSOT ICB

- £3.39bn total allocation and spend, £2.64bn core programme, £18.6m running costs, £388.5m delegated primary care, £336m specialised commissioning.
- Opening underlying deficit £74.4m
- 2026/27 Efficiency target £62.3m - 73% fully developed/implemented
- Contract values – at 01/04/26, no material unresolved issues. Clear line of sight of the remaining gaps and route to resolution
- Net risk £28.3m - £25.3m efficiency risk, Cost risk net £3m - weight management £6m, prescribing £2.5m offset by £5.5m non recurrent mitigations.

5-year breakeven trajectory by 2030/31. In-year break even every year, utilising notified deficit support

SSOT Medium Term Revenue Plan	2026/27 Plan £m	2027/28 Plan £m	2028/29 Plan £m	2029/30 Plan £m	2030/31 Plan £m
2026/27 - Underlying Position	**-51.1**	**-35.6**	**-16.2**	**-9.3**	**-0.0**
2026/27 - In Year Position before DSF	**-39.0**	**-20.0**	**-13.3**	**-6.7**	**0.0**
Deficit Support Funding (DSF)	39.0	20.0	13.3	6.7	0.0
2026/27 In year position after DSF	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

NHS Shropshire, Telford and Wrekin
NHS Staffordshire and Stoke-on-Trent

3 Year Performance Plans

- Alongside submission of the finance plans, Both STW and SSOT ICBs submitted multi-year performance plans. Minor updates to the February 2026 submission were made in March 2026 to reflect agreed improvements to the delivery of some targets. These were considered and signed off by Boards prior to submission.

UEC – 26/27

			Final March submission - 26/27 metrics			Final March submission - 26/27 metrics			
Metric	**Metric ID**	**26-27 Target**	**NHS STW ICB**	**SaTH**	**RJAH**	**NHS SSOT ICB**	**UHNM**	**UHDB**	**RWT**
4hr A&E (%)	E.M.13	Every trust to maintain/improve to 82% by March 2027, with no lower than 80% as an average across the year.		70.93% at Mar 27 - profiling change			77.07% by Mar-27 73. 08% (26/27 av.)	82.00% by Mar-27 76.77% (26/27 av.)	82.10% by Mar-27 81.20% 26/27 av.
12hr A&E (%)	E.T.12	Higher % of patients admitted, discharged and transferred from ED within 12 hours across 2026/27 compared to 2025/26		Achieving 82.7% in April 26 improving to 85% in Mar 27, a 2.3% improvement.			92.27% (26/27) vs 25/26 FOT baseline of 91.11%	94.98% vs baseline of 94.51% (2025/26 FOT)	94.04% vs baseline of 93.66% (2025/26 FOT)
Cat 2 (mins)	*Collected in Ambulance Trust Submission*	Improve upon 2025/26 standard to reach an average response time of 25 minutes							
Average handover time (Total Handover time (ED and non ED)/No of handovers (ED and non-ED)	E.B.42	Year-on-year improvement in average handover time		Average handover time reduces from 55mins in Apr -26 to 45 mins in Mar- 27			1hr 3min 8sec vs baseline of 1hr 19min 22sec (25/26 YTD)	36min 51sec vs baseline of 39min 15sec for 2025/26 YDT.	41 mins
Percentage of Handovers over 45 Minutes	E.B.47	No handovers over 45 minutes through 2026/27		This reduces from 1055 in Apr-26 to 857 in Mar-27			31.23% (26/27)	18.73% (26/27)	20.62% (26/27)
Percentage of Handovers over 15 Minutes	E.B.48	N/A		This reduces from 2539,77%, in Apr-26 to 2469 in Mar-27, 72%			65.28% (26/27)	76.22% (26/27)	56.34%
Percentage of attendances at all type A&E departments where the patient spent less than 4 hours from time of arrival to admission / discharge / transfer for Children	E.M.13f	Achieve minimum 95% by Sep-26 and maintain 95% or higher from that point onwards		This increases from 85.54% in Apr-26 to 87% in Mar-27			89.68% (Sept-26)	95.00% (Sept-26)	91.56% (Sept-26)

UEC – 27/28

			Final March submission - 27/28 metrics			Final March submission - 27/28 metrics			
Metric	Metric ID	27-28 Target	NHS STW ICB	SaTH	RJAH	NHS SSOT ICB	UHNM	UHDB	RWT
4hr A&E (%)	E.M.13	National target of 83% as the average for the year		74.71% at Mar 28			77.62% by Mar-28 76.5% (26/27 av.)	83.0%	83.5%
12hr A&E (%)	E.T.12	Year-on-year % increases in patients admitted, discharged and transferred from ED within 12 hours		Achieving 86% in Q1 27/28 improving to 90% in Q4 27/28, a 4% improvement.			92.68% (27/28) vs baseline of 92.27% (26/27)	95.28% (27/28) vs baseline of 94.98% (26/27)	94.04% (27/28) vs baseline of 94.04% (26/27)
Cat 2 (mins)	*Collected in Ambulance Trust Submission*	Further improvement so that by the end of 2027/28 the average response time is 23 minutes							
Average handover time (Total Handover time (ED and non ED)/No of handovers (ED and non-ED)	E.B.42	Year-on-year improvement in average handover time		Average handover time remains at 45 mins in 27/28, but no improvement on Mar 27, this may be acceptable to maintain this level?			49min 14sec vs baseline of 1 hr 3min 8sec (26/27)	35min 43sec	39 mins
Percentage of Handovers over 45 Minutes	E.B.47								
Percentage of Handovers over 15 Minutes	E.B.48	Achieve 0 handovers over 15 minutes by Mar-28		This is 6872 in Q4 27/28, 72%. This is 72% throughout 27/28			45.22% (Q4 27/28)	73.77% (Q4 27/28)	100% (Q4 27/28)
Percentage of attendances at all type A&E departments where the patient spent less than 4 hours from time of arrival to admission / discharge / transfer for Children	E.M.13f	Maintain 95%		This is 90.01% in Q4 27/28. This is 90.01% through 27/28			<95% (each Quater 27/28)	95.00%	95.00%

UEC – 28/29

			Final March submission - 28/29 metrics			Final March submission - 28/29 metrics			
Metric	Metric ID	28-29 Target	NHS STW ICB	SaTH	RJAH	NHS SSOT ICB	UHNM	UHDB	RWT
4hr A&E (%)	E.M.13	National target of 85% as the average for the year		78.8% at Mar 28			85% by Mar-29 85% (26/27 av.)	85.00%	85.23%
12hr A&E (%)	E.T.12	Year-on-year % increases in patients admitted, discharged and transferred from ED within 12 hours		Maintaining delivery of 90% throughout 28/29			93.12% (28/29) vs baseline of 92.68% (27/28)	95.42% (28/29) vs baseline of 95.28% (27/28)	94.04% (28/29) vs baseline of 94.04% (27/28)
Cat 2 (mins)	*Collected in Ambulance Trust Submission*								
Average handover time (Total Handover time (ED and non ED)/No of handovers (ED and non-ED)	E.B.42	Year-on-year improvement in average handover time		Average handover time remains at 45 mins in 28/29, but no improvement on Mar 27, this may be acceptable to maintain this level?			38min 41sec vs baseline of 49mins 14sec (27/28)	34min 49sec	34 mins
Percentage of Handovers over 45 Minutes	E.B.47								
Percentage of Handovers over 15 Minutes	E.B.48	Achieve 0 handovers over 15 minutes by Mar-28		This is 6941 in Q4 28/29, 72%. This is 72% through 28/29			34.70% (Q4 28/29)	75.22% (Q4 28/29)	100% (28/29)
Percentage of attendances at all type A&E departments where the patient spent less than 4 hours from time of arrival to admission / discharge / transfer for Children	E.M.13f	Maintain 95%		This is 90.01% in Q4 28/29. This is 90.01% through 28/29			<95% (each Quater 28/29)	95.00%	95.00%

Planned Care – 26/27

			Final March submission - 26/27 metrics			Final March submission - 26/27 metrics			
Metric	Metric ID	26-27 Target	NHS STW ICB	SaTH	RJAH	NHS SSOT ICB	UHNM	UHDB	RWT
RTT 18 weeks (%)	E.B.40 (18 weeks)	Every trust delivering a minimum 7% improvement in 18-week performance or a minimum of 65%, whichever is greater (in order to deliver national performance target of 70%)	72% at Mar 27	70% at Mar 27	61.6% at Apr26 with a trajectory to 67.1% at Mar 27	Trajectory from NHSE = 77.0% (Mar-27) Submission = 70.8% (Mar-27)	70.3% (Mar-26)	67.2% (Mar-27)	69.6% (Mar-26)
	E.B.18 (52+ weeks)		138 at Apr 26 reducing to 59 at Mar-27, all under RJAH	0 at Mar 27	205 at Apr 26 reducing to 87 at Mar-27	541 (Mar-27)	612 (Mar-27)	0 (Mar-27)	537 by Mar-27
	E.B.3a (total list size)		Reducing from 62,436 (Mar 26) to 55,957 (Mar 27), a 10% reduction	Reducing from 34,072 (Apr 26) to 31,568 (Mar 27), a 7.3% reduction	Reducing from 15,699 (Mar 26) to 12,966 (Mar 27), a 17% reduction	Trajectory from NHSE = 116,245 (Mar-27) Submission = 111,877 (Mar-27)	61,732 (Mar-27)	85,521 (Mar-27)	61,077 (Mar-27)
Community Waits (%)	E.T.12	At least 78% of CHS activity occurring within 18 weeks	81.8% at Apr 26 with a trajectory to 92% at Mar 27.			Target = 78% (Mar-27) Submission = 84.2% (Mar-27)			
Increase diagnostic activity in line with provided activity and performance targets, with significant progress expected in 2026/27	E.B.26x	Achieve or exceed annual activity targets	Planning to achieve 8% above provided Annual Activity Target in 26/27			Meeting provided annual target (648,670)			
	E.B.28x	Every system delivering a minimum 3% improvement in performance or performance of 20% or better, whichever level of improvement is greater (in order to achieve national performance of no more than 14% of patients waiting over 6 weeks for a test)	12% performance with 1462 patients waiting over 6 weeks at Mar 27	12% performance with 1172 patients waiting over 6 weeks at Mar 27	5% performance with 40 patients waiting over 6 weeks at Mar 27	Target = 17.5% (Mar-27) Submission = 14.0% (Mar-27)	0.99% (Mar-27)	19.98% (Mar-27)	0.4% by Mar-27
	E.B.38	Every trust delivering 94% performance for 31-day standard by March 2027	Maintain 94% throughout 26/27	Maintain 94% throughout 26/27	Maintain 100% throughout 26/27 - note small numbers drastically impact percentage	Target = 94.0% (Mar-27) Submission = 94.5% (Mar-27)	94.77% (Mar-27)	94.10% (Mar-27)	94.19% by Mar-27
Cancer 62 day (%)	E.B.35	Every trust delivering 80% performance for 62-day standards by March 2027	77% at Mar 27	77% at Mar 27	Maintain 100% throughout 26/27 - note small numbers (1-2 patients) drastically impact percentage	Target = 80.0% (Mar-27) Submission = 80.4% (Mar-27)	80.47% (Mar-27)	80.04% (Mar-27)	80.27% by Mar-27
Cancer FDS (%)	E.B.27	Maintain performance against the 28-day cancer Faster Diagnosis Standard at the new threshold of 80%	80% at Mar 27	80% at Mar 27	72.7% at Apr26 with a trajectory to 89.2% at Mar 27	Target = 80% across 2026/27 Submission = 80.4% (2026/27)	80.51% (2026/27)	80.02% (2026/27)	80.17%

Planned Care – 27/28

			Final March submission - 27/28 metrics			Final March submission - 27/28 metrics			
Metric	Metric ID	27-28 Target	NHS STW ICB	SaTH	RJAH	NHS SSOT ICB	UHNM	UHDB	RWT
RTT 18 weeks (%)	E.B.40 (18 weeks)	Individual organisational level targets to bridge the ask between 2026/27 targets/plans and 92% constitutional standard to be met by end Mar-29	82.4% at Mar 28	81% at Mar 28	71.3% at Apr27 with a trajectory to 79.7% at Mar 28	Trajectory from NHSE = 88.4% (Mar-28) Submission = 80.5% (Mar-28)	**79.1% (Mar-28)**	**79.7% (Mar-28)**	80.6% (Mar-28)
	E.B.18 (52+ weeks)		Reduce to 0 by Mar 28	0 at Mar 28	Reduce to 0 by Mar 28	498 (Mar-28)	587 (Mar-28)	0	417 (Mar-28)
	E.B.3a (total list size)		Reducing from 54,680 (Q1 27/28) to 48,212 (Q4 27/28), a 12% reduction	Reducing from 30,693 (Q1 27/28) to 28,068 (Q4 27/28), a 9% reduction	Reducing from 12,932 (Q1 27/28) to 10,067 (Q4 27/28), a 22% reduction	Trajectory from NHSE = 90,012 (Mar-28) Submission = 89,500 (Mar-28)	59,865 (Mar-28)	75,955(Mar-28)	52,805 (Mar-28)
Community Waits (%)	E.T.12	At least 79% of CHS activity occurring within 18 weeks	Maintaining 92% through out 27/28			Target = 79% (Mar-28) Submission = 84.2% (Mar-28)			
Increase diagnostic activity in line with provided activity and performance targets, with significant progress expected in 2026/27	E.B.26x	Achieve or exceed annual activity targets	Planning to achieve 0.1% above Annual Activity Target in 27/28			Meeting provided annual target (709,245)			
	E.B.28x	Individual ICB level targets to bridge the ask between 2026/27 targets and 1% constitutional standard to be met by end Mar-29 - Note target is at ICB level, not provider level	7% performance with 749 patients waiting over 6 weeks at Q4 27/28	7% performance with 657 patients waiting over 6 weeks at Q4 27/28	3% performance with 23 patients waiting over 6 weeks at Q4 27/28	Target = 10.96% (Mar-28) Submission = 9.8% (Mar-28)	0.95% (Mar-28)	15.3% (Mar-28)	1.4% 2027/28
	E.B.38	Return to the 31-day standard of 96% by March 2028	Maintain 96% throughout 27/28	Maintain 96% throughout 27/28	Maintain 100% throughout 27/28 - note small numbers drastically impact percentage	Target = 96.0% (Mar-28) Submission = 96.1% (Mar-28)	92.83% (Mar-28) The national planning guidance states that Trust should deliver 96.0% BY March 2028. The Trust's performance at March 2028 is 96.3% and we believe we are therefore compliant with the	96.00% (Mar-28)	95.38% by Mar-28
Cancer 62 day (%)	E.B.35	Deliver performance against the 62-day standard at 82.5% by March 2028	80.0% at Mar 27	80.0% at Mar 27	100% at Mar 27 ** small numbers impact on performance. Average 86.3% for 28/29	Target = 82.5% (Mar-28) Submission = 82.6% (Mar-28)	79.48% (Mar-28) The national planning guidance states that Trust should deliver 82..5% BY March 2028. The Trust's performance at March 2028 is 82.9% and we believe we are therefore compliant with the	82.57% (Mar-28)	83.66% by Mar-28
Cancer FDS (%)	E.B.27	Maintain performance against the 28-day cancer Faster Diagnosis Standard at the new threshold of 80%	80% at Mar 28	80% at Mar 28	Averaging 86% per quarter in 27/28	Target = 80% across 2027/28 Submission = 80.0% (2027/28)	82.59% (2027/28)	80.00%	80.01%

Planned Care – 28/29

			Final March submission - 28/29 metrics			Final March submission - 28/29 metrics			
Metric	Metric ID	28-29 Target	NHS STW ICB	SaTH	RJAH	NHS SSOT ICB	UHNM	UHDB	RWT
RTT 18 weeks (%)	E.B.40 (18 weeks)	Achieving the standard that at least 92% of patients are waiting 18 weeks or less for treatment	92.1% at Mar 29	92% at Mar 29	92.1% at Mar 29	Trajectory from NHSE = 92.0% (Mar-29) Submission = 92.0% (Mar-29)	92.0% (Mar-29)	92.0% (Mar-29)	92% (Mar-29)
	E.B.18 (52+ weeks)		Reduce to 0 by Mar 29	0 at Mar 29	Reduce to 0 by Mar 29	241 (Mar-29)	320 (Mar-29)	0	87 (Mar-29)
	E.B.3a (total list size)		Reducing from 46,932 (Q1 28/29) to 41,031 (Q4 28/29), a 13% reduction	Reducing from 27,193 (Q1 28/29) to 24,568 (Q4 28/29), a 10% reduction	Reducing from 9,945 (Q1 28/29) to 7,441 (Q4 28/29), a 25% reduction	Trajectory from NHSE = 83,265 (Mar-29) Submission = 76,401 (Mar-29)	57,678 (Mar-29)	69,466 (Mar-29)	43,534 (Mar-29)
Community Waits (%)	E.T.12	At least 80% of CHS activity occurring within 18 weeks	Maintaining 92% through out 28/29			84.2% (Mar-29)			
Increase diagnostic activity in line with provided activity and performance targets, with significant progress expected in 2026/27	E.B.26x	Achieve or exceed annual activity targets	Planning to achieve 2% above provided Annual Activity Target in 28/29			Meeting provided annual target (719,765)			
	E.B.28x	Achieving the standard that no more than 1% of patients are waiting over 6 weeks for a test	1% performance with 89 patients waiting over 6 weeks at Q4 28/29	1% performance with 66 patients waiting over 6 weeks at Q4 28/29	1% performance with 7 patients waiting over 6 weeks at Q4 28/29	Target = 1% (Mar-29) Submission = 1% (Mar-29)	0.96% (Mar-29)	1% (Mar-29)	0.9% by 2028/29
	E.B.38	Maintain performance against the 31-day standard at 96%	Maintain 96% throughout 28/29	Maintain 96% throughout 28/29	Maintain 100% throughout 28/29 - note small numbers drastically impact percentage	Target = 96.1% across 2028/29 Submission = 96.0% (2028/29)	96.06% (2028/29)	96.01% (2028/29)	95.77% by Mar-29
Cancer 62 day (%)	E.B.35	Deliver performance against the 62-day standard at 85% by March 2029	85% at Mar 29	85% at Mar 27	100% at Mar 28 ** small numbers impact on performance. Average 86.3% for 28/29	Target = 85% (Mar-29) Submission = 86.7% (Mar-29)	87.66% (Mar-29)	85.05% (Mar-29)	85.21% by Mar-29
Cancer FDS (%)	E.B.27	Maintain performance against the 28-day cancer Faster Diagnosis Standard at the new threshold of 80%	80% at Mar 29	80% at Mar 29	Averaging 86% per quarter in 28/29	Target = 80% across 2028/29 Submission = 80.0% (2027/28)	84.62% (2028/29)	80.00%	80.20%

Primary Care – 26/27

			Final March submission - 26/27 metrics			Final March submission - 26/27 metrics			
Metric	Metric ID	26-27 Target	NHS STW ICB	SaTH	RJAH	NHS SSOT ICB	UHNM	UHDB	RWT
Primary Care Same Day (%)	E.D.27	Plans are not be collected for this year, requires professionals consultation	Not required in this submission			Not required in this submission			
Urgent Dental Appointments	E.D.28	37,427 appointments (STW), 80,090 (SSOT)	38,388			80,090			
Count of Pharmacy First Consultations	E.D.26	Reach or exceed target activity volumes for 2026/27	5,194 in Apr 26 increasing to 5,195 in Mar 27 - annual value of 62,059			186,074			

Primary Care – 27/28

			Final March submission - 27/28 metrics			Final March submission - 27/28 metrics			
Metric	Metric ID	27-28 Target	NHS STW ICB	SaTH	RJAH	NHS SSOT ICB	UHNM	UHDB	RWT
Primary Care Same Day (%)	E.D.27	Not required in this submission	Not required in this submission			Not required in this submission			
Urgent Dental Appointments	E.D.28	37,428 appointments	Not required in this submission			Not required in this submission			
Count of Pharmacy First Consultations	E.D.26	No target set	64,540			191,656			

Primary Care – 28/29

			Final March submission - 28/29 metrics			Final March submission - 28/29 metrics			
Metric	Metric ID	28-29 Target	NHS STW ICB	SaTH	RJAH	NHS SSOT ICB	UHNM	UHDB	RWT
Primary Care Same Day (%)	E.D.27	Not required in this submission	Not required in this submission			Not required in this submission			
Urgent Dental Appointments	E.D.28	37,428 appointments	Not required in this submission			Not required in this submission			
Count of Pharmacy First Consultations	E.D.26	No target set	67,123			195,489			

Mental Health – 26/27

			Final March submission - 26/27 metrics			Final March submission - 26/27 metrics			
Metric	Metric ID	26-27 Target	NHS STW ICB	SaTH	RJAH	NHS SSOT ICB	UHNM	UHDB	RWT
MHST (%)	E.C.1	77% coverage of operational MHSTs and teams in training	69% at Q1 26/27, achieving 77% by end of Q4 26/27.			77.00%			
MH OOA (number)	E.A.5	Reducing the number of inappropriate OAPs by end of March 2027	Using local figures, agreed with provider as more accurate. Reducing to 11 (from current 12) by March 27			16 by Mar-27			
Mental Health Support Team coverage of total schools/colleges	E.C.2	MHST coverage of total schools/colleges to increase by end of 2029; no specific target before then but expected to show improvement.	Aim for Q4 of 2026/27 is for 128 out of 266 schools/colleges (48%).			54.16%			
Reliable recovery rate for those completing a course of treatment and meeting caseness (monthly metric)	E.A.4a	51% Reliable recovery rate	Achieve 50% by Q4; 51.1% by March.			51.00%			
Reliable improvement rate for those completing a course of treatment (monthly metric)	E.A.4b	69% Reliable improvement rate	Maintain above 68% throughout the year, achieving 69.1% in March.			69.00%			
No. completed courses of treatment (monthly metric)	E.A.4b denominator	Increase	Aiming for 7000 completed treatments in year 2026/27			14,770			
Number of patients accessing Individual Placement Support services (12-month rolling metric)	E.H.34	Increase	600 throughout 2026/27 (was approx. 580 in Nov-25).			1,118			

Mental Health – 26/27 cont.

			Final March submission - 26/27 metrics			Final March submission - 26/27 metrics			
Metric	Metric ID	26-27 Target	NHS STW ICB	SaTH	RJAH	NHS SSOT ICB	UHNM	UHDB	RWT
Number of Children and Young People with mental health waits over 104 weeks (help-based clock stop) at the end of the reporting period	E.A.7	Eliminate by end of year	100 by Feb; zero by March. Waits of at least 78 weeks will also be monitored for improvement.			Zero by Mar-27			
Number of Children And Young People (0-17) accessing (1+ contact) mental health services (12-month rolling metric)	E.H.9	Above September 2025 baseline of approx. 6675 (STW), 16,610 (SSOT)	8341 by Q4 of 2026/27			17,446			
Number of women accessing Specialist Community Perinatal Mental Health Services (12-month rolling metric)	E.H.15	Minimum of September level (approx. 935 STW) and 780 SSOT.	Data quality under review, but number not expected to dip below 935 in 2026/27.			1,281			
Number accessing Mental Health Support Teams for Children And Young People (age 0-17) (12-month rolling metric)	E.A.6	Greater than August 2025 baseline of approx. 1555 (STW) and 2,265 (SSOT)	1800 by end of Q1; 2400 by end of Q4, 2026/27			3,238 by Mar-27			
Average Length of Stay for Patients in Adult Acute and PICU Mental Health Beds (3 month rolling metric)	E.H.38	Below August 2025 baseline of approx. 48 days (STW) and 39.16 (SSOT)	Maintain ALoS below 47 days throughout second half of 2026/27			38.77 days			
Average Length of Stay for Patients in Older Adult Acute Mental Health Beds (3 month rolling metric)	E.H.39	Below August 2025 baseline of approx. 116 days (STW) and 74.28 (SSOT)	Reduce AloS to 112 by February 2027			73.54 days			
Reliance on mental health inpatient care for under 18s with a learning disability and autistic under 18s	E.K.1c	At least 30% below March-24 baseline	Reducing from 2 inpatients in Q1, to 1 by end of Q4, 2026/27			3 by Q4 2026/27			

Mental Health – 27/28

			Final March submission - 27/28 metrics			Final March submission - 27/28 metrics			
Metric	Metric ID	27-28 Target	NHS STW ICB	SaTH	RJAH	NHS SSOT ICB	UHNM	UHDB	RWT
MHST (%)	E.C.1	89% coverage by Mar-28, reaching 100% by end of 2029 (operational MHSTs and teams in training)	89.00%			90.41%			
MH OOA (number)	E.A.5	Reducing or maintaining at zero the number of inappropriate out of area placements	11 reducing to 9 in 27/28			8 by Q4 2027/28			
Mental Health Support Team coverage of total schools/colleges	E.C.2	MHST coverage of total schools/colleges to increase by end of 2029; no specific target before then but expected to show improvement.	Aim for Q4 of 2027/28 is for 170 out of 266 schools/colleges (64%).			69.4%			
Reliable recovery rate for those completing a course of treatment and meeting caseness (monthly metric)	E.A.4a	52% Reliable recovery rate	52.07% by Q4, 2027/28			52.00%			
Reliable improvement rate for those completing a course of treatment (monthly metric)	E.A.4b	70% reliable improvement	70.6% by Q4, 2027/28			70.00%			
No. completed courses of treatment (monthly metric)	E.A.4b denominator	Increase	Assume 6.2% above 2026/27 level, to 7434			15,504			
Number of patients accessing Individual Placement Support services (12-month rolling metric)	E.H.34	Increase	10% increase, reaching 660 by Q4.			1,233			

Mental Health – 27/28 cont.

			Final March submission - 27/28 metrics			Final March submission - 27/28 metrics			
Metric	Metric ID	27-28 Target	NHS STW ICB	SaTH	RJAH	NHS SSOT ICB	UHNM	UHDB	RWT
Number of Children and Young People with mental health waits over 104 weeks (help-based clock stop) at the end of the reporting period	E.A.7	Not required in this submission	Not required in this submission			Not required in this submission			
Number of Children And Young People (0-17) accessing (1+ contact) mental health services (12-month rolling metric)	E.H.9	Above September 2025 baseline of approx. 6675	At least 8341 in each quarter			17,620			
Number of women accessing Specialist Community Perinatal Mental Health Services (12-month rolling metric)	E.H.15	Not below 2025/26 level	Number not currently expected to dip below 935.			1,281			
Number accessing Mental Health Support Teams for Children And Young People (age 0-17) (12-month rolling metric)	E.A.6	Greater than August 2025 baseline of approx. 1555	2700 by end of Q4, 2027/28			3,609 by Q4, 2027/28			
Average Length of Stay for Patients in Adult Acute and PICU Mental Health Beds (3 month rolling metric)	E.H.38	Below August 2025 baseline of approx. 48 days	Below 46 days by Q4, 2027/28			38.38 days			
Average Length of Stay for Patients in Older Adult Acute Mental Health Beds (3 month rolling metric)	E.H.39	Below August 2025 baseline of approx. 116 days	Assuming 3% improvement each year; expected to be below 109 days by Q4, 2027/28			72.80 days			
Reliance on mental health inpatient care for under 18s with a learning disability and autistic under 18s	E.K.1c	Not required in this submission	Not required in this submission			Not required in this submission			

Mental Health – 28/29

			Final March submission - 28/29 metrics			Final March submission - 28/29 metrics			
Metric	Metric ID	28-29 Target	NHS STW ICB	SaTH	RJAH	NHS SSOT ICB	UHNM	UHDB	RWT
MHST (%)	E.C.1	94% coverage by Mar-29, reaching 100% by end of 2029 (operational MHSTs and teams in training)	94.00%			100%			
MH OOA (number)	E.A.5	Reducing or maintaining at zero the number of inappropriate out of area placements	9 reducing to 8 in 28/29			Zero by Q4 2028/29			
Mental Health Support Team coverage of total schools/colleges	E.C.2	MHST coverage of total schools/colleges to increase by end of 2029; no specific target before then but expected to show improvement.	Aim for Q4 of 2028/29 is for 230 out of 266 schools/colleges (86%).			85% by Q4 2028/29 Reaching 100% by Dec-29			
Reliable recovery rate for those completing a course of treatment and meeting caseness (monthly metric)	E.A.4a	53% Reliable recovery rate	53.1% by Q4, 2028/29			53.00%			
Reliable improvement rate for those completing a course of treatment (monthly metric)	E.A.4b	71% reliable improvement	71.2% by Q4, 2028/29			71.00%			
No. completed courses of treatment (monthly metric)	E.A.4b denominator	Increase	Assume 7% above 2027/28 level, to 7954			16,276			
Number of patients accessing Individual Placement Support services (12-month rolling metric)	E.H.34	Increase	5% increase, reaching 695 by Q4, 2028/29			1,294			

Mental Health – 28/29 cont.

			Final March submission - 28/29 metrics			Final March submission - 28/29 metrics			
Metric	Metric ID	28-29 Target	NHS STW ICB	SaTH	RJAH	NHS SSOT ICB	UHNM	UHDB	RWT
Number of Children and Young People with mental health waits over 104 weeks (help-based clock stop) at the end of the reporting period	E.A.7	Not required in this submission	Not required in this submission			Not required in this submission			
Number of Children And Young People (0-17) accessing (1+ contact) mental health services (12-month rolling metric)	E.H.9	Above September 2025 baseline of approx. 6675	At least 8341 in each quarter			17,796			
Number of women accessing Specialist Community Perinatal Mental Health Services (12-month rolling metric)	E.H.15	Not below 2025/26 level	Number not currently expected to dip below 935.			1,281			
Number accessing Mental Health Support Teams for Children And Young People (age 0-17) (12-month rolling metric)	E.A.6	Greater than August 2025 baseline of approx. 1555	3000 by end of Q4, 2028/29			3,901 by Q4 2028/29			
Average Length of Stay for Patients in Adult Acute and PICU Mental Health Beds (3 month rolling metric)	E.H.38	Below August 2025 baseline of approx. 48 days	Below 45 days by Q4, 2028/29			37.99 days			
Average Length of Stay for Patients in Older Adult Acute Mental Health Beds (3 month rolling metric)	E.H.39	Below August 2025 baseline of approx. 116 days	105.3 days by Q4, 2028/29			72.08 days			
Reliance on mental health inpatient care for under 18s with a learning disability and autistic under 18s	E.K.1c	Not required in this submission	Not required in this submission			Not required in this submission			

Learning Disabilities & Autism – 26/27

			Final March submission - 26/27 metrics			Final March submission - 26/27 metrics			
Metric	Metric ID	26-27 Target	NHS STW ICB	SaTH	RJAH	NHS SSOT ICB	UHNM	UHDB	RWT
LD Inpatient (%)	E.H.32 (adult)	Deliver a minimum 10% reduction year-on-year unless already met 29 per million rate across 2 metrics combined	8 in Q1 26/27 reducing to 6 in Q4 26/27			15 by Q4 2026/27			
	E.H.33 (autistic)		10 in Q1 26/27 reducing to 8 in Q4 26/27.			9 by Q4 2026/27			
People with a learning disability and autistic people in mental health hospital with the longest lengths of stay	E.K.4	Reduce	December submission was thought to be over-ambitious and front-loaded. Revised to achieve 36.84% (7 patients) in Q4, 2026/27			17 by Q4 2026/27			
Percentage of people aged 14+ on the QOF Learning Disability Register with an annual health check and health action plan	E.K.6	Year-on-year improvement	In line with previous performance, at least half of the AHCs will take place in the second half of the year. Total across the 4 quarters will be 81%.			79% across the 4 quarters			
12-month admission rate for adults with a learning disability and autistic adults	E.K.5a	Reduce	Down to 48.2 per million in Q1 and 43.4 per million by end of Q4, 2026/27			7.64 by Q4 2026/27			
12-month admission rate for under 18s with a learning disability and autistic under 18s	E.K.5b	Reduce	Below 29.7 per million in Q1 and 19.8 per million by end of Q4, 2026/27			30.44 by Q4 2026/27			

Learning Disabilities & Autism – 27/28

			Final March submission - 27/28 metrics			Final March submission - 27/28 metrics			
Metric	Metric ID	27-28 Target	NHS STW ICB	SaTH	RJAH	NHS SSOT ICB	UHNM	UHDB	RWT
LD Inpatient (%)	E.H.32 (adult)	N/A	Not required in this submission			Not required in this submission			
	E.H.33 (autistic)		Not required in this submission			Not required in this submission			
People with a learning disability and autistic people in mental health hospital with the longest lengths of stay	E.K.4	Below 2026/27 level	Denominator unavailable in submission template, but assume no more than 6 patients (around 43%) by Q4, 2027/28			15 by Q4 2027/28			
Percentage of people aged 14+ on the QOF Learning Disability Register with an annual health check and health action plan	E.K.6	Year-on-year improvement	In line with previous performance, at least half of the AHCs will take place in the second half of the year. Total across the 4 quarters will be 81.5%.			80.5% across the 4 quarters			
12-month admission rate for adults with a learning disability and autistic adults	E.K.5a	Reduce	Down to 38.6 by end of Q4, 2027/28			Maintaining the rate of 7.64			
12-month admission rate for under 18s with a learning disability and autistic under 18s	E.K.5b	Reduce	Maintain below 20 per million for every quarter.			26.09 by Q4 2027/28			

Learning Disabilities & Autism – 28/29

			Final March submission - 28/29 metrics			Final March submission - 28/29 metrics			
Metric	Metric ID	28-29 Target	NHS STW ICB	SaTH	RJAH	NHS SSOT ICB	UHNM	UHDB	RWT
LD Inpatient (%)	E.H.32 (adult)	N/A	Not required in this submission			Not required in this submission			
	E.H.33 (autistic)		Not required in this submission			Not required in this submission			
People with a learning disability and autistic people in mental health hospital with the longest lengths of stay	E.K.4	Below 2026/27 level	Denominator unavailable in submission template, but assume no more than 6 patients (around 46%) by Q4, 2027/28			14 by Q4 2028/29			
Percentage of people aged 14+ on the QOF Learning Disability Register with an annual health check and health action plan	E.K.6	Year-on-year improvement	In line with previous performance, at least half of the AHCs will take place in the second half of the year. Total across the 4 quarters will be 82%.			82% across the 4 quarters			
12-month admission rate for adults with a learning disability and autistic adults	E.K.5a	Reduce	38.6 in final 2 quarters of 2028/29			6.55 by Q4 2028/29			
12-month admission rate for under 18s with a learning disability and autistic under 18s	E.K.5b	Reduce	Below 10 per million in final 2 quarters of 2028/29			21.74 by Q4 2028/29			

NHS Shropshire, Telford and Wrekin
NHS Staffordshire and Stoke-on-Trent

Workforce summary

Non-NHS Mental Health workforce by pathway - STW

Staff group	March 25	March 26	March 27	March 28	March 29
Children and young people	0.00	6.80	6.80	6.80	6.80
Mental Health Support Teams (new code)	0.00	0.00	0.00	0.00	0.00
Perinatal mental health	0.00	0.00	0.00	0.00	0.00
NHS Talking therapies	7.30	11.90	11.90	11.90	11.90
Individual Placement & Support (new code)	0.00	14.90	14.90	14.90	14.90
A&E and Ward Liaison	0.00	0.00	0.00	0.00	0.00
Adult community crisis	23.98	22.88	22.88	22.88	22.88
Community Mental Health	44.70	42.70	42.70	42.70	42.70
Acute inpatient	0.00	0.00	0.00	0.00	0.00
Other mental health workforce	57.30	14.37	14.37	14.37	14.37
Total workforce	133.28	113.55 (-14.8% or 19.73 WTE of which 11.55 are Designs in Mind or Trident)	113.55	113.55	113.55

- ICB submission **includes** Non-NHS MH only this year i.e. **excludes** MH Providers and Non-MH Providers to avoid double counting
- New codes/pathways introduced e.g. MH Support Teams
- Providers not able to forecast future years with confidence in absence of contract renewal – assumption that WTE will remain static if contracts renewed
- One provider contract will terminate at end March 26
- One provider ceased operations during 25/26

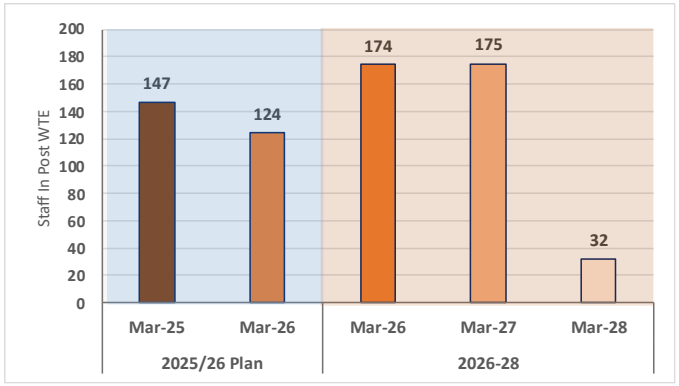
Primary care staff in post by staff group - STW

Staff group	March 25	March 26	March 27	March 28	March 29	Overall Growth 25-29
GPs	307.00	303.00	310.00	309.00	309.00	+ 0.65%
Nurses	174.00	173.00	181.00	184.00	184.00	+ 5.75%
ARRS Funded roles	280.00	285.70	292.10	291.10	290.10	+ 3.61%
Direct patient care roles	167.71	166.00	174.38	180.35	184.27	+ 9.87%
Administrative and Non-clinical	705.43	716.00	729.00	730.00	732.00	+ 3.77%
Total workforce	**1634.14**	**1643.70**	**1686.48**	**1694.45**	**1699.37**	**+ 3.99%**

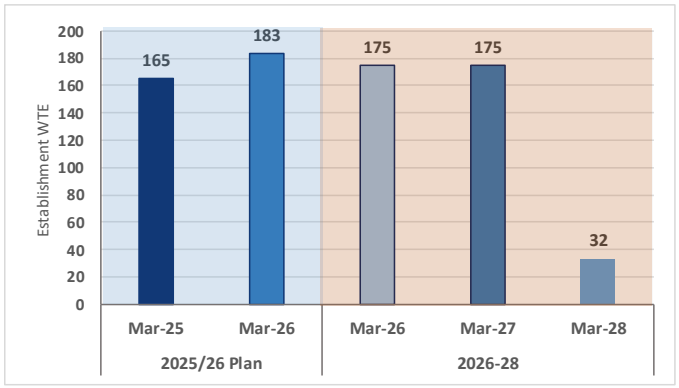
- Primary Care forecast is based on a combination of NHSE regional forecasting tool and results of a survey of GP practices and PCNs undertaken during December 25 – January 26.
- Suggested overall growth of 3.99% between March 25 and March 29 with highest growth in Direct Patient Care roles at 9.87%.
- New planning arrangements will require a separate ‘independent ask’ for Primary Care plans (further detail pending)

Non-NHS Mental Health workforce - SSOT

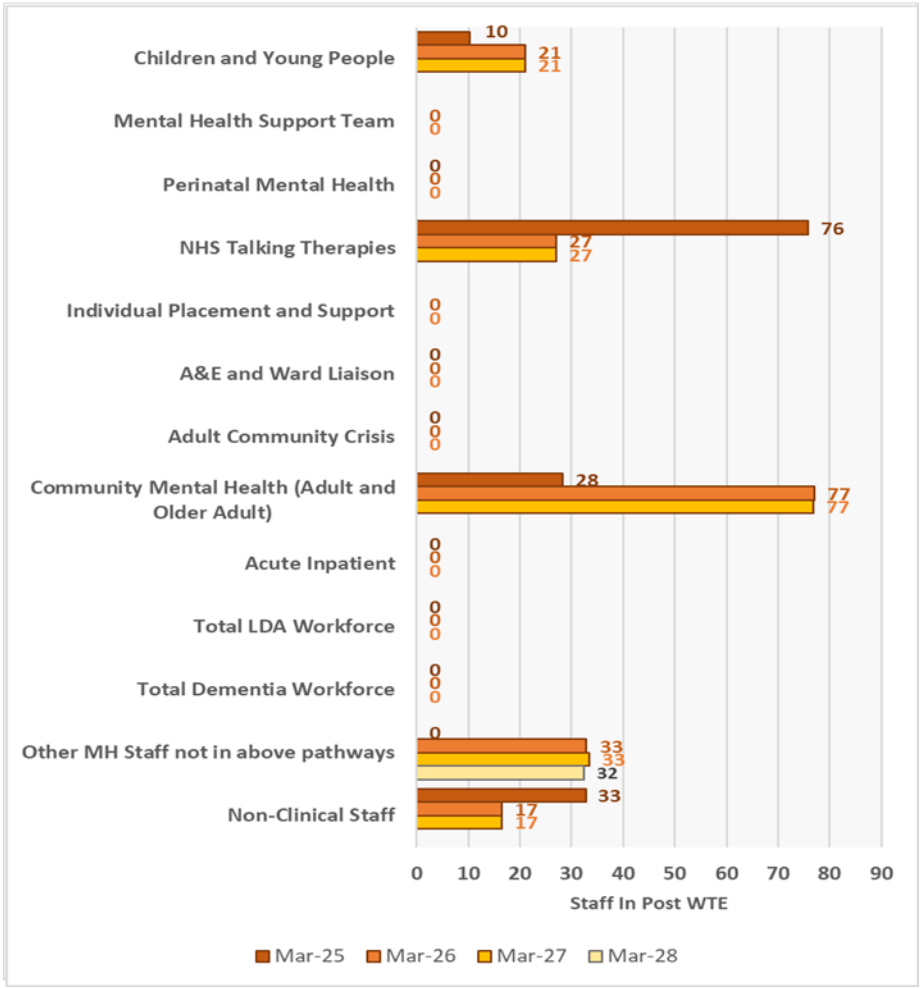
STAFF IN POST WTE



ESTABLISHMENT WTE



Staff In Post



Non-NHS Organisations covered:

- Burton & District Mind
- Changes Wellbeing
- Everyone Health
- Mental Health Matters
- Mid Mercian Citizen's Advice
- South West Staffordshire Citizen's Advice
- Turning Point

Primary care workforce - SSOT

The 2026 - 2029 Workforce Plan for Primary Care reflects the following

Total Workforce. Across the complete 3 years of the Medium Term Plan (MTP), the Primary Care workforce is predicted to increase by **+55 WTE (1.5%).** Plans for 2026/27 show a Mar-26 starting position **aligned** with that anticipated in the 205/26 plan. During 2026/27, the Total workforce is predicted to **grow by +27 WTE (+0.7%)** across the year. By Mar-28 a further **+18 WTE increase** is planned with an additional **+11 WTE being** added by Mar-19.

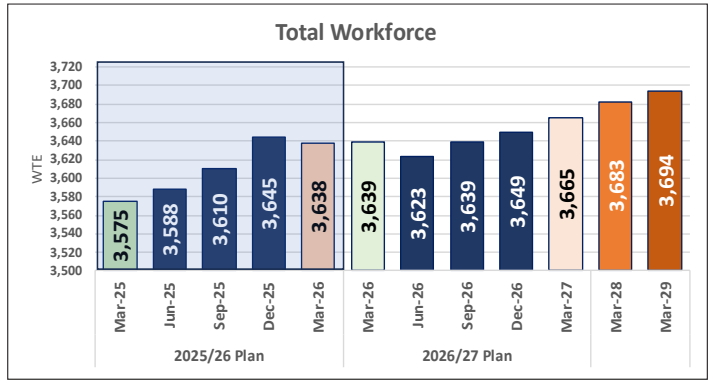
GPs: No change to the GPs Workforce. Each year is planned to start and conclude with 746 WTE.

Nurses: Nursing workforce in Primary care is planned to increase by +**12 WTE (+3%)** during 2026/27. This is followed by an additional **+10 WTE by 2029.**

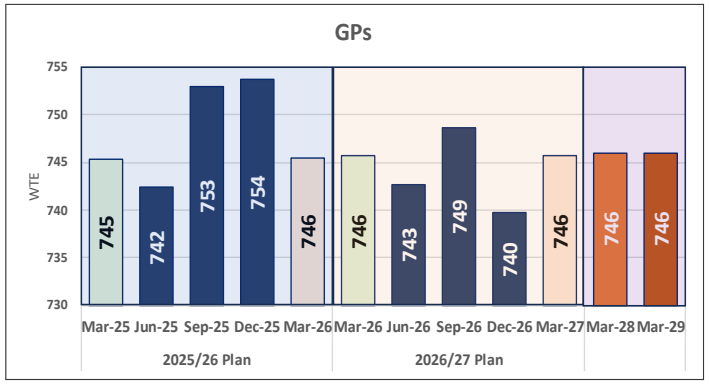
Admin & Non-clinical: Admin & Non-Clinical Workforce is anticipated to **increase** by +4 WTE (0.3%) by Mar-27. Between Mar-27 and Mar-29 a further **+3 WTE** is planned.

Direct Patient Care: DPC roles are planned to increase by a further **+12 WTE (1.2%)** across 2026/27 followed by an additional +3 WTE by Mar-29. On average, it is planned that 72% of the DPC roles will be funded via ARRS.

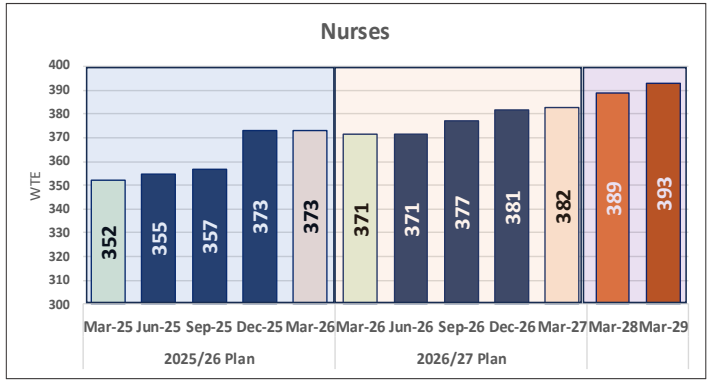
Overall Workforce



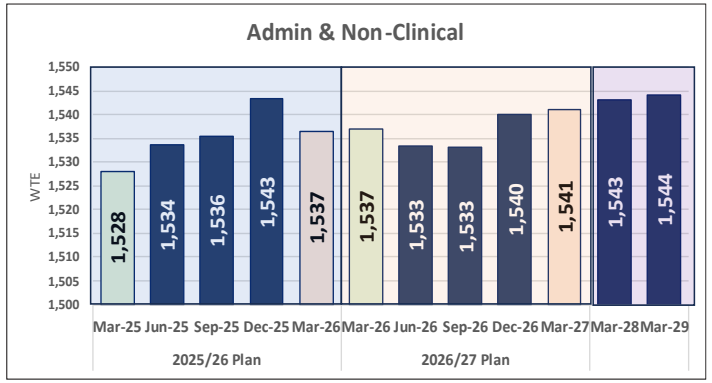
General Practitioners



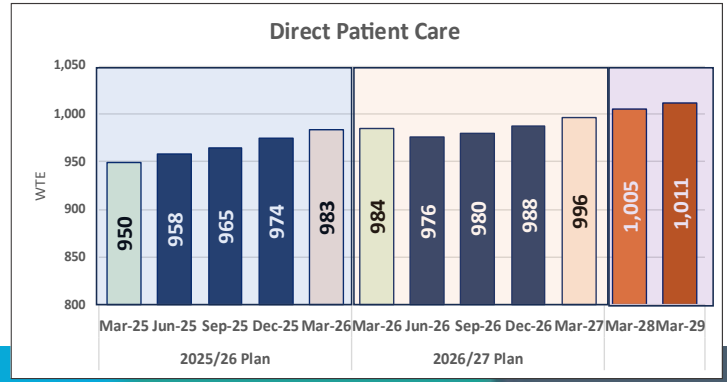
Nursing Staff



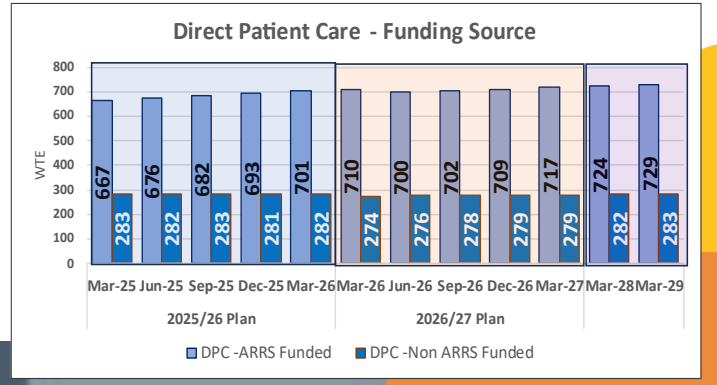
Admin/Non-Clinical Staff



Direct Patient Care



DPC Funding



Integrated Care System
Shropshire, Telford and Wrekin

Staffordshire and Stoke-on-Trent Integrated Care System

NHS
NHS Shropshire, Telford and Wrekin
NHS Staffordshire and Stoke-on-Trent

Enclosure No: 06

Report to:	Integrated Care Board
Date:	30th April 2026
Title:	NHS STW & NHS SSOT Cluster Operating Model
Presenting Officer:	Dr Lorna Clarson, Chief Officer Strategy and Improving Outcomes
Author(s):	Kirsten Owen, Associate Director of Special Projects, Dr Lorna Clarson, Chief Officer: Strategy and Improving Outcomes

Document Type:				**Action Required (select):**			
Report	☐	**Business Plan**	☐	**Information (I)**	☒	**Discussion (D)**	☒
Strategy	☐	**Policy**	☐	**Assurance (S)**	☒	**Approval (A)**	☐
Other	☒	*(please describe)*		**Ratification (R)**	☐	*(check as necessary)*	

Is the decision within SOFD powers & limits	**Yes**	☐	**No**	☒
Any potential / actual Conflict of Interest?	**Yes**	☒	**No**	☒
If Y, the mitigation recommendations:	*E.g. Staff have Financial + Non-Financial Professional Interests which can be managed by recording those in minutes and allowing presence in discussions with recusals from formal decisions*			
Any financial impacts: ICB or ICS?	**Yes**	☐	**No**	☒
If Y, are those signed off by and date:	*E.g. Chief Finance Office, dd-mmm-yyyy*			
Any impacts on ICB Undertakings?	**Yes**	☐	**No**	☒
If Y, are those signed off by and date:	*E.g. Chief Finance Office, dd-mmm-yyyy*			
Appendices:	STW and SSOT Cluster Operating Model			

(1) Purpose of the Paper:

This paper presents the Operating Model for the Shropshire, Telford & Wrekin (STW) and Staffordshire & Stoke-on-Trent (SSOT) ICB cluster and provides an overview of progress to date.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	Date
Virtual Transition Committee	30th March 2026

(3) Implications:	
Legal / Regulatory	The Operating Model describes the delivery of the ICB Statutory Duties, and adherence to NHSE Statutory Guidance
CQC / Patient Safety	n/a
Financial (CFO-assured)	The Operating Model describes a key aim to create a financially sustainable system, through the development and delivery of the Cluster operating model
Sustainability	n/a
Workforce / Training	The Operating Model describes the cluster emerging role as a Strategic Commissioner.
Equality & Diversity	n/a
Due Regard: Inequalities	Operating Model describes how the cluster aims to reduce health inequalities.
Due Regard: wider effect	Operating Model describes how the cluster acknowledges the implications of developing our system and the wider impact this will have on these wider areas

(4) Statutory Dependencies & Impact Assessments:

	Completed?			If N - N/A, Rationale	If Y, Outcome / Date Reported & Signed off
DPIA	**Yes**	**No**	**N/A**	Click or tap here to enter text.	*Reported to IG Committee:* Click or tap to enter a date.
	☐	☐	☒		
EIA	**Yes**	**No**	**N/A**	Click or tap here to enter text.	*Outcome and date of completion:* Click or tap here to enter text.
	☐	☐	☒		
QIA	**Yes**	**No**	**N/A**	*E.g. per QIA Policy, that it doesn't impact quality of services* Click or tap here to enter text.	*SRO sign-off, outcome & date of completion:* Click or tap here to enter text.
	☐	☐	☒		

Has there been Public / Patient Involvement?	**Yes**	**No**	**N/A**	*Click or tap here to enter text.*
	☐	☐	☐	

(5) Integration with SBAF (for NHS SSOT) / Strategic Risks (SR, for NHS STW)

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

SR1	Strategic Collaboration & Partnership	☒	SR4	ICS Workforce (retention/wellbeing)	☒
SR2a	ICB & System Financial Balance	☒	SR5	Digital & Data Systems / Strategy	☒
SR2b	ICB & System RRL / CRL Plans	☐	SR6	ICS Strategic Response (e.g. EPRR)	☒
SR3	Reducing Health Inequalities	☒	SR7	ICS Socio-Economic Development	☒
			SR8	Patient & Public Involvement	☐

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

Background

Over the last four months, a programme of work has taken place to define the future operating model for the clustered ICBs. This work aligns with national expectations for ICBs to mature into strategic commissioners and is shaped by national policies including the NHS 10-Year Plan and the Fit for the Future vision.

Summary of the Draft Operating Model

The model positions STW and SSOT as a single, coherent strategic commissioner operating across two ICBs. It is built around four key components:

1. Understanding the local context,
2. Developing population health strategy,
3. Delivering intelligent payer functions, and
4. Evaluating impact.

The model also outlines governance, system architecture, and clinical and professional leadership requirements.

(7) Recommendations to Board:

☑ The Integrated Care Board is asked to receive and approve the Operating Model and acknowledge that the model will evolve over time as it matures into its role as the strategic commissioner.

NHS STW and NHS SSOT Cluster Operating Model

Purpose of the Paper

This paper presents the Operating Model for the Shropshire, Telford & Wrekin (STW) and Staffordshire & Stoke-on-Trent (SSOT) ICB cluster. It outlines the development process, the underpinning national direction, and the emerging design principles that have shaped the proposed strategic commissioning and operating arrangements. The Board is asked to receive the paper and note progress to date, recognising that this is a point in time and that the operating model will continue to evolve and iterate.

Background

Over the last four months, we have undertaken a programme of work to define the future operating model for the clustered ICBs. This has been driven by the national expectation that ICBs mature into strategic commissioners, with Place and Neighbourhood forming the primary delivery architecture of integrated care.

National policy—including the NHS 10-Year Plan, the Government's *Fit for the Future* vision, and the emphasis on prevention, community-based models, and digital transformation—has shaped our approach throughout. In parallel, the operating model has been designed in partnership with our executive colleagues through a series of structured development sessions, ensuring alignment with organisational values, statutory duties, and the emerging system vision.

The ICB needs to be clear on its role and its remit to ensure that it functions effectively in that space. this operating model helps to reposition the ICB as the strategic commissioner and sets out the areas that it will have responsibility for. This context is important as it requires partners and providers to evolve and and respond at the same time.

Summary of the Operating Model

The model positions STW and SSOT as a single, coherent strategic commissioner, operating across two ICBs but functioning as one cluster. Its central purpose is to improve population health outcomes, reduce inequalities, and ensure that resources are used to deliver the greatest value.

It establishes a clear framework grounded in four core components of the commissioning cycle:

1. **Understanding the local context** through a unified business insight and intelligence function that shapes priorities using population data, inequalities analysis, quality indicators and lived experience.
2. **Developing long-term population health strategy** that is clinically credible, co-produced with partners, financially sustainable, and aligned to the ambitions of Place and system partners.

3. **Delivering the strategy through intelligent payer functions and resource allocation**, including outcomes-based approaches, market shaping, and support for neighbourhood-based models of care.
4. **Evaluating impact** to ensure delivery is evidence-led, value-driven, and continually improved through system-wide learning.

Alongside these core components, the model sets out:

- A cluster-wide board and committee structure operating “in common” until a future merger is agreed.
- Executive team portfolios aligned to the commissioning cycle and strategic leadership requirements.
- A system architecture that positions Health & Wellbeing Boards as the holders of population outcomes, Place Boards as the engine rooms of local planning and oversight, providers as collaborators in delivery redesign, and Neighbourhoods as the front line of integrated, preventative and personalised care.
- A narrative for how clinical and professional leadership, quality, finance, digital, workforce, estates, and public involvement underpin the operating model.

Development Process

The model has evolved through:

- Executive workshops focusing on strategic intent, roles, and system architecture.
- Iterative modelling of functions, responsibilities, and governance.
- Engagement with clinical, professional, quality, finance, and insight leads.
- Alignment with emerging organisational structures across both ICBs.
- Review of national guidance, best practice from other systems, and the expectations of NHSE for mature strategic commissioning.
- Review and feedback from the Transition Committee and ICB colleagues.

Recommendation

The Integrated Care Board is asked to receive and approve the Operating Model and acknowledge that the model will evolve over time as matures into its role as the strategic commissioner.

NHS Shropshire, Telford and Wrekin
NHS Staffordshire and Stoke-on-Trent
Working together as a cluster of Integrated Care Boards

NHS Shropshire, Telford and Wrekin
&
NHS Staffordshire and Stoke-on-Trent
Operating Model

Version 014

Our Cluster Values

Trust and integrity

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

Courage, ambition and shared risk-taking

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

Openness, honesty and psychological safety

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

Respect, inclusion and compassion

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

Collaboration and system-first leadership

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

Consistency, accountability and shared stewardship

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

Leading by example

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

Forward focus, innovation and constructive challenge

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

Our Goal

As clustered ICBs is to lead and support delivery of the Integrated Care Systems (ICS) aims across the geographies of Shropshire, Telford & Wrekin, Staffordshire and Stoke-on-Trent:

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

The Government has set out in Fit for the Future: 10 Year Health Plan for England, three strategic shifts for the NHS:

- Treatment to prevention: through proactive community and public health initiatives, working closely with local authorities, communities and individuals.
- Hospital to community: moving care closer to home by building more joined-up, person-centred care in local neighbourhoods, reducing reliance on acute care.
- Analogue to digital: harnessing technology and data to transform care delivery and improve quality of care.

Our Purpose

As strategic commissioners, STW and SSOT ICBs will focus on providing system leadership to improve population health, setting evidence based and long-term population health strategy and working as healthcare payers to deliver this, maximising the value that can be created from available resources.

Cluster Priority: Build a shared, evidence-driven understanding of population need, inequalities, demand and service pressures across STW and SSOT.

Cluster Priority: Operate as a single intelligent payer that directs resources toward outcomes, prevention, neighbourhood models, and community-based care.

Cluster Priority: Establish a unified 5–10-year strategy that strengthens prevention and quality of services, shifts care upstream, reduces inequalities, and embeds neighbourhood health models.

Cluster Priority: Create a single evaluation and assurance framework that measures outcomes, inequalities reduction, access, quality, productivity and system shift delivery.

Strategic Commissioner

- Set clear strategy and commissioning intentions aligned to population need
- Use data, insight, and resources to drive high-value care and evaluate impact
- Design and manage commissioning frameworks that drive improved outcomes
- Shape and steward the provider landscape to ensure services are configured to meet population needs

System Stewardship

- Act in a system stewardship role, creating the environment that enables partners across the health and care system to collaborate and deliver improved outcomes for local populations.
- Provide leadership to the development of system architecture so the system is best configured for integrated, population-focused delivery.

System Partner

- Provide strategic leadership for system transformation and improvement.
- Align organisations around shared outcomes and long-term population health goals.
- Create the conditions for innovation, collaboration, and sustainable change.

Our Health and Care Landscape

Shropshire, Telford & Wrekin		Staffordshire and Stoke-on-Trent
Around 500,000 Population		1.1 Million Population
Shrewsbury and Telford Hospital Trust – Shropshire Community Health NHS Trust – Robert Jones and Agnes Orthopaedic Hospital Foundation Trust – Midlands Partnership University NHS Foundation Trust and West Midlands Ambulance Services University Foundation Trust		University Hospital of North Staffordshire – University Hospital of Derby and Burton – Midlands Partnership University NHS Foundation Trust – North Staffordshire Healthcare Trust and West Midlands Ambulance Service NHS Foundation Trust
51 General Practices working through 8 Primary Care Networks 81 Community pharmacies 63 Dental Practices 62 Community Opticians		141 General Practice working through 25 Primary Care Networks 237 Community Pharmacies, 230 Dental Practices 140 Community Opticians
Shropshire Council and Telford & Wrekin Council		Stoke-on-Trent City Council and Staffordshire County Council
Independent and VCSE sector		Independent and VCSE sector

As a Strategic Commissioner

1. Understanding the local context
Assessing population needs now and in the future, identifying underserved communities and assessing the quality, performance and productivity of existing provision

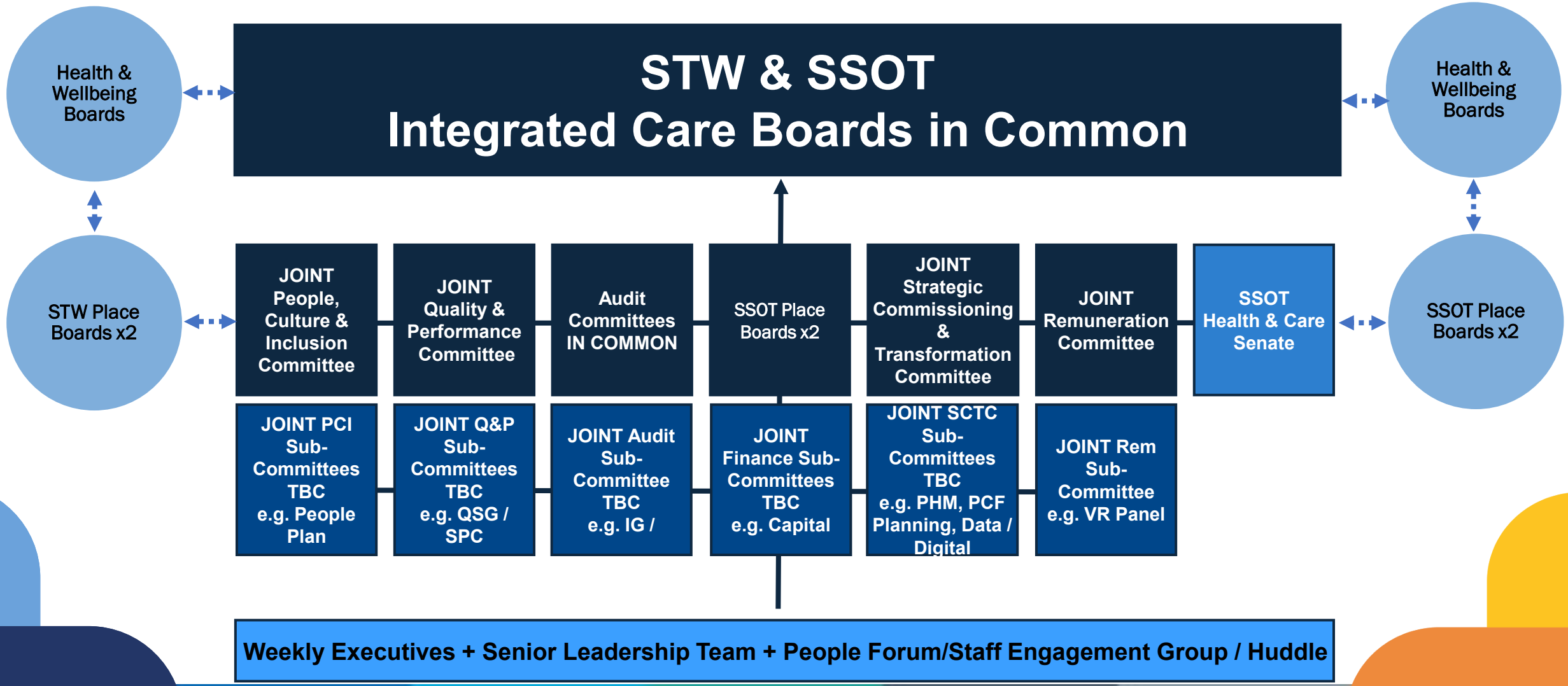
2. Developing long-term population health strategy
Long-term population health planning and strategy and care pathway redesign to maximise value based on evidence

3. Delivering the strategy through payer functions and resource allocation
Oversight and assurance of what is purchased and whether it delivers quality for residents and outcomes required.

4. Evaluating Impact
Day to day oversight of health care usage, user feedback and evaluation to ensure optimal, value-based resources use and improved outcomes.

Governance and Core Statutory Functions
Ensuring the ICB is compliant, accountable and safe. Establishing robust governance structures. Continue to fulfil statutory duties and monitoring equity of outcomes.

Board Structure



Pease see the Acronyms appendix

Statutory Duties

This table sets out key statutory duties, which relate to the establishment and core functions of ICBs. It is not exhaustive and is intended to capture the statutory duties that are most relevant to functional areas

	Chief of Staff & Chief Executive Office	Chief of Finance Officer	Chief Nursing Officer	Chief Medical Officer	Strategy and Improving Outcomes	System Development & Integration	The Board retains Accountability for all statutory duties with responsibility and oversight delegated to the following subcommittees
Duty to develop, publish and update Joint Forward Plan (JFP)	I	C	C	C	A	S	SCTC (C), QPC (I)
Duty to develop joint capital resource use plan	C	A	C	C	S	S	Audit (C)
Financial duty as to resource use limits	R	A	R	R	R	R	Audit (C)
Duty of co-operation (NHS bodies & LAs)	R	R	R	R	A	A	QPC (I)
Public involvement duty	A	S	R	R	R	R	QPC (C)
Duty of ICBs to commission health services	R	A	R	R	A	A	SCTC (C), QPC (I)
Duty to promote the NHS Constitution	R	R	R	R	R	R	QPC (I)
Duty as to effectiveness, efficiency & economy	A	A	A	A	A	A	Audit (C)
Duty to improve quality of services	I	S	A	A	R	R	QPC (C)
Duty to reduce inequalities in access/outcomes	R	S	R	R	A	A	QPC (C)
Duty as to patient choice	S	I	R	A	R	R	QPC (I)
Duty to obtain appropriate advice	A	S	A	A	R	R	QPC (I)
Duty to promote innovation	S	S	R	S	A	R	SCTC (C)
Duty in respect of research	S	S	R	S	A	R	SCTC (I)
Duty to promote education and training	R	C	R	A	S	R	PI Committee (C)
Duty to promote integration	S	S	R	R	R	A	SCTC (C)
Duty to have regard to wider effect (Triple Aim)	A	A	A	A	A	A	QPC (I)
Duties as to climate change	R	R	R	R	A	R	Audit (C)
Duty to establish an Integrated Care Partnership (ICP)	S	S	S	S	A	R	Board
Duty to have regard to assessments & strategies (JSNAs)	S	S	R	R	A	A	SCTC (I)
Public Sector Equality Duty (PSED)	A	S	R	R	R	R	PI (C), QPC (I)

R esponsible
A ccountable
S upport
C onsult
I nform

Executive Team responsibilities

Chief Executive

Chief of Staff

- Office of the Chair & CEO
- ICB Board Secretary
- Corporate Governance
- Inclusive Communications & Involvement
- Information Governance
- Equality, Diversity & Inclusion
- ICB People & Operational HR Function
- ICS People Transformation /Enabling
- Health & Safety
- Complaints, PALS & Compliments
- Corporate Administration Function
- Freedom to Speak Up (FTSU) Senior Officer
- Deputy Senior Information Risk Owner (SIRO)

Chief Finance Officer

- Strategic Financial Leadership
- Financial Accounts, Financial Management, Governance and Compliance
- Strategic and Operational Financial Planning
- Strategic Estates
- Contracting and Procurement
- Contracting and procurement management, governance and compliance (excl. primary care & AACC)
- Contract development, innovation and market management
- Planning
- Provider Performance Oversight
- Senior Information Risk Owner (SIRO)
- Board Lead for Counter Fraud

Chief Officer: Strategy & Improving Outcomes

- Strategic commissioning for outcomes
- Strategic commissioning for delegated specialist services & cross-border flows
- Specialised Commissioning
- Strategy and Strategic Planning
- Integrated Intelligence Hub
- Strategic analytics
- Population health management and forecasting
- Public health expertise
- Health inequalities
- Business intelligence
- Data science
- Strategic service change
- Digital transformation
- Sustainability
- Research and Innovation

Chief Officer: System Development & Integration

- Neighbourhood health delivery
- Place-based working
- Integrated working with Local Authorities and mobilisation of the Better Care Fund schemes
- Partnership development & system design
- Provider development & provider collaboratives
- System Convening
- Emergency Planning & Resilience Response (EPRR)
- Accountable Emergency Officer (AEO)
- Delivery of local response to demand and capacity pressures
- System mobilisation and delivery of the ICBs commissioning strategy

Chief Nursing Officer

- Clinical & Professional Strategic Leadership for Nurses, Midwives and Allied Health Professionals
- All Age Continuing Care & Individualised Commissioning
- Lead Executive for Safeguarding (Adults & Children) , Children in care and Child Death Processes
- Special Educational Needs & Disabilities (SEND)
- Prevent
- Mental Capacity and Liberty Protection Safeguards Lead
- Maternity & Neonatal
- Quality Assurance & Quality Improvement
- Acts as Director of Infection Prevention & Control (DIPC)

Chief Medical Officer

- Clinical Governance
- Clinical & Professional Strategic Leadership for Medical, Dental, Pharmacy, Ophthalmology professionals
- Primary Care Strategic Commissioning & Transformation (including Pharmacy, Dentistry and Optometry)
- Medicines Management/ Optimisation
- Caldicott Guardian

Understanding the local context

- Understanding the local context means having a clear and detailed picture of the needs of our population, now and in the future, and the quality and effectiveness of our services on which to base our strategy and decisions.
- The ICB will have a unified multi-disciplinary **Insight** function supported by **Business Intelligence, Data Science, Population Health Management,** as well as **Public Health and Health Economic expertise.** They will work with quantitative and qualitative data to give a richer picture of our population and will analyse needs, inequalities, demand and capacity, quality and safety, long waits, and service gaps. Data produced by this function will be triangulated with patient and clinical voice to ensure it becomes actionable insight which can drive long-term strategy and decision-making
- Engagement and insight from **Inclusive Communications & Involvement** will ensure community perspectives are embedded and that **the patient voice shapes our understanding.** Input from the **Quality team** bringing quality indicators and patient/service-user feedback will ensure **lived experience** is reflected and **Clinical and Professional Leadership** contributes real-world feasibility.
- This multi-disciplinary approach will allow us to create a comprehensive system-wide picture of need, our **Integrated Strategic Needs Assessment**, as the foundation of our strategic planning and Commissioning Intentions, aligning with national expectations for ICBs to steward population-level planning.
- Together, these teams will enable the ICB to identify priority inequalities, understand population variation, and build an evidence-based foundation for strategic commissioning.

Outcome: A unified understanding of the local context that drives prioritisation, informs commissioning intentions and supports strategic decision-making

Developing long-term population health strategy

- The long-term population health strategy will be shaped through **Strategy & Improving Outcomes**, supported by **Strategic Planning**, **Strategic Analytics**, **Health Inequalities**, **Public Health expertise**, **Clinical and Professional Leadership**, **Research & Innovation**, and **Digital Transformation**.
- These functions will translate insight into strategic priorities across prevention, pathways, workforce, quality, digital, estates, and service change, including contributions to the ICB Strategy (the 5-year Commissioning Plan) and Joint Forward Plan, with a supporting **Population Health Improvement Plan** against which we measure progress.
- The process will be informed by the **ISNA** and evidence from the **Insight** function and underpinned by long-term financial modelling from **Finance and Strategic Financial Planning functions**.
- Co-production will be ensured through **Inclusive Communications & Involvement**, **Clinical & Professional Leadership**, and **collaboration with Place-based teams and Local Authority partners**.
- **Workforce** strategy will be shaped ensuring future models of care are staffed safely and sustainably.
- These combined resources allow the ICB to set a long-term, system-aligned strategy that is credible, evidence-based, clinically endorsed, financially sustainable and co-produced with communities.

Outcome: A clear, system-owned long-term strategy setting out population health ambitions, inequality goals and the commissioning intentions required to achieve them

Delivering the strategy through payor functions and resource allocation

- Commissioning intentions will be driven by the 5-year Commissioning Plan, with **Commissioning** teams applying commissioning levers such as outcomes-based payments, procurement routes, and market-shaping, in collaboration with **Contracting & Procurement**, **Finance**, and **System Development & Integration**.
- **Place** and **provider collaborations** will lead local service design and implementation, supported by enabling functions (**Digital Transformation**, **Service Change**, **Provider Development**, **Neighbourhood Health Delivery**, and **System Development & Integration**) and informed by evidence-based interventions and local population data.
- Strategic workforce, estates, and sustainability impacts will be assessed through ICB **People Transformation**, **Strategic Estates**, and **Sustainability** functions to ensure alignment of workforce, infrastructure, and environmental considerations.
- The ICB will adopt an intelligent payor approach, led by **Contracting & Procurement** and supported by **Finance**, **Planning & Performance**, **Insight**, **Strategic Commissioning**, **Primary Care Strategic Commissioning**, and **Medicines Optimisation**.
- The intelligent payor function will use structured contract-management frameworks, integrating financial, activity, quality, and population-health data to monitor outcomes, ensure value for money, and drive system-wide efficiency.
- Resource allocation will be based on population need, inequality impact, and value for money, enabling consistent and aligned implementation across the system.

Outcome: Coherent, aligned delivery of the ICB strategy enabled by consistent use of commissioning levers and resource allocation decisions.

Evaluating the impact

- Evaluation of impact will be coordinated and led by the **Value-Intelligence and Evaluation** team, using health economics and cost benefit analysis supported by **Business Intelligence, Performance, Quality Assurance & Quality Improvement, and Clinical and Professional Leadership** teams, in partnership with **Place and provider collaboratives.**
- Monitoring delivery of outcomes, quality, safety, lived experience, and health inequalities, using data from the **Insight** function and from Inclusive **Communications & Involvement** to ensure patient experience shapes continuous improvement.
- This robust multi-disciplinary evaluation will drive decisions to scale, commission or decommission services according to their impact on the health of the population.
- This structured, system-wide approach supports a learning health system where impact drives future commissioning decisions, consistent with national expectations for accountability and stewardship

Outcome: A learning system where evidence of impact directly informs future commissioning decisions, enabling prioritisation, scaling of effective models and discontinuation of ineffective ones.

Cluster Strategic Commissioner Outcomes

1.Understanding the local context

A unified understanding of the local context that drives prioritisation, informs commissioning intentions and supports strategic decision-making

2.Developing long-term population health strategy

A clear, system-owned long-term strategy setting out population health ambitions, inequality goals and the commissioning intentions required to achieve them

3. Delivering the strategy through payer functions and resource allocation

Coherent, aligned delivery of the ICB strategy enabled by consistent use of commissioning levers and resource allocation decisions.

4.Evaluating Impact

A learning system where evidence of impact directly informs future commissioning decisions, enabling prioritisation, scaling of effective models and discontinuation of ineffective ones

Creating the environment for delivery

System Architecture

ICB

Local Authorities

VCSE

NHS Provider Sector

NHS Primary Sector

LA Care Sector

Health and Wellbeing Board

Place Based Partnership

Neighbourhood

Health & Wellbeing Boards - *Set the population outcomes and priorities. Population outcome focus and democratic accountability - (informed by JSNA)*

ICB as Strategic Commissioner - Sets system-wide commissioning intent for health, priorities and standards. *(what good looks like and what must be delivered from a health perspective)*

Place Based Partnerships - Place Boards at the heart of system governance, the engine room - translating Health & Wellbeing Board population priorities and ICB health strategy/commissioning intentions – leading local planning and oversight of delivery and providing assurance back to both. Health is a partner but not the lead.

NHS Providers – Collaborating to evolve joint, population-focussed delivery models, anchored in and wrapped around Place based delivery.

Neighbourhoods – The delivery mechanism for integrated, population-focused care—bringing together primary care, community services, social care and VCSE to improve outcomes, reduce inequalities and shift care closer to home.

ICB in a system stewardship role – Convening partners - enabling and aligning system activities to create the environment for delivery and quality expectations.

How we work at a population level

Place

Bring partners together to work jointly to plan, co-ordinate and deliver health and care services, in an integrated way, based on a shared view of the needs of the population, with the ultimate aim of improving health and wellbeing.

This approach aims to shifts resources and decision making closer to the people that they affect.

Neighbourhood

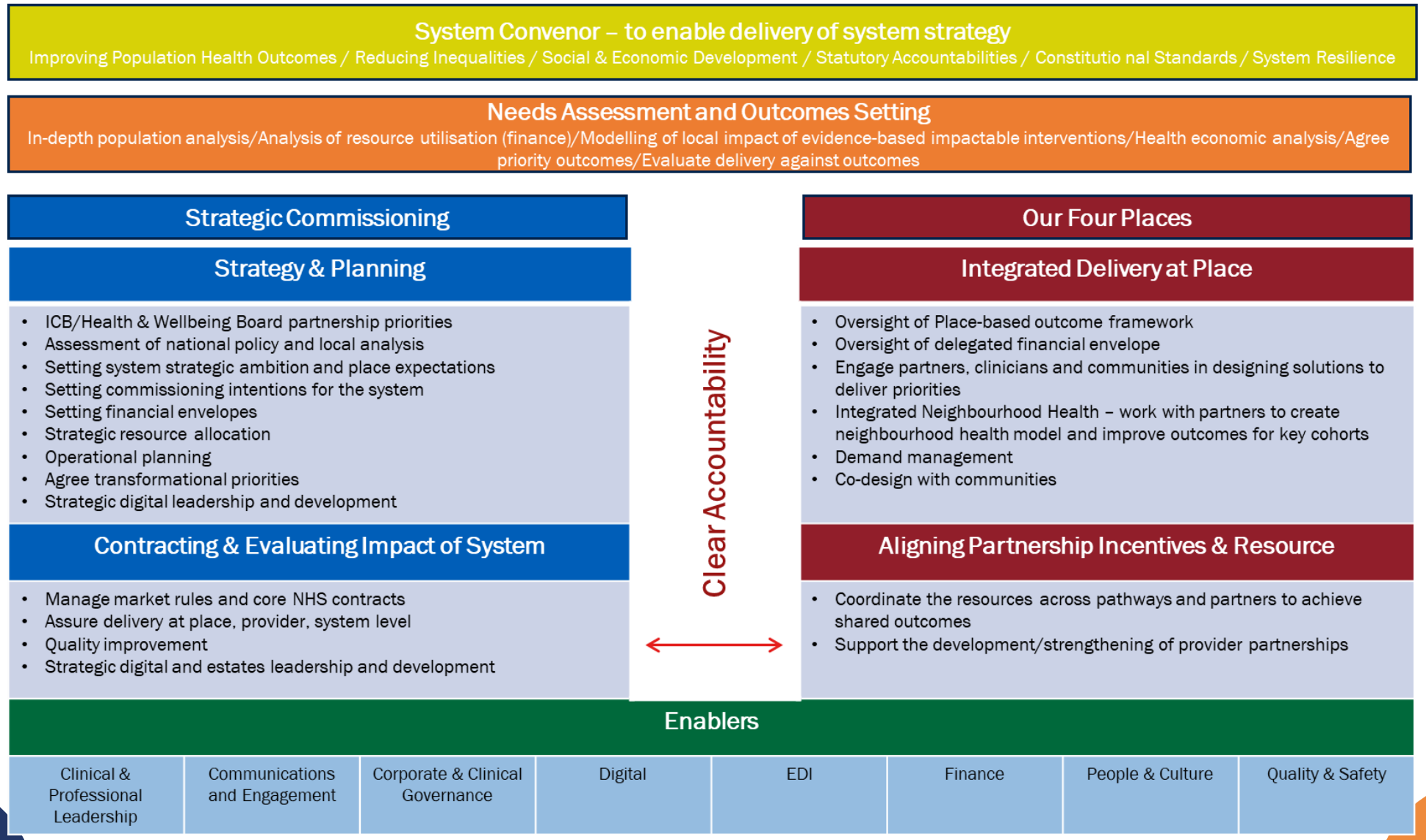
Neighbourhood health aims to focus on the needs of a local population to deliver - healthier communities, helping people of all ages live healthy, active and independent lives while improving their experience of care, and increasing their agency in managing their own care.

- **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

Neighbourhood Health Objectives

Bringing health services, wider resources and support closer to the communities	Delivering convenient care, at a time and place that fits around people's lives.
Replacing the status quo of 'hospital by default'	Promoting preventative health care, health education and tailored support
Empowering neighbourhoods and individuals to take charge of their own physical and mental health-	People can personalise their care to their own individual needs, choices and preferences.
Developing the broad framework required to provide health provision and services in local communities	Facilitating partnerships among health services and community groups
New models of care, not just moving services from one place to another	Designing services that work for patients, not demand they fit around the way providers have historically chosen to organise care

Integrated working between Strategic Commissioning and Place



Clinical & Professional Leadership

Clinical & Professional Leadership is a core function within the ICB operating model, working collaboratively with strategic commissioning, place-based partnerships and provider collaboratives to support the development and delivery of evidence-based, high-quality care.

- **Strategic contribution**
  Working with commissioning, population health and improvement teams to interpret data, clinical evidence and best practice, informing strategic priorities and commissioning intentions.
- **System contribution**
  Bringing multidisciplinary clinical and professional perspectives into system decision-making, helping to test feasibility, manage risk and support the development of sustainable models of care.
- **Convening and connection**
  Convening clinical and professional leaders across Place, neighbourhoods and provider collaboratives to support co-production of pathways and models that improve outcomes and reduce variation.
- **Quality, safety and stewardship**
  Supporting system-wide clinical governance, quality improvement and responsible resource use, ensuring assurance arrangements are robust and proportionate.

Through this role, Clinical & Professional Leadership supports the collective leadership of Place, providers and system partners in improving quality, outcomes and value for our populations.

Underpinning plans/strategies

1. 5-year Commissioning Plans
   i. STW Our Strategies - NHS Shropshire, Telford and Wrekin
   ii. SSOT Five Year Plan - Staffordshire and Stoke-on-Trent, Integrated Care Board
2. 3 Year Revenue, 4-year Capital and 3-year performance plans
3. Organisational Development plan
4. Clinical Strategy
5. Quality Strategy
6. Integrated Governance plan
7. Involvement and Communications Strategy

Financial Strategy

The cluster financial strategy aims to operate as one intelligent payer that reallocates resources toward prevention, neighbourhood-based care, and digital innovation, while adopting outcomes-based contracting, joint financial governance, and system-wide efficiency to achieve long-term financial sustainability by 2030/31.

Direction of travel

- ➔Move to a Single, Unified Cluster Financial Framework
- ➔Value-Based Commissioning & Outcomes-Driven Investment
- ➔Shifting Investment from Hospitals to Prevention & Community-Based Care
- ➔Shared Efficiency & Productivity Programme
- ➔Reform of Contracting Models
- ➔Alignment of Capital, Estates & Workforce Investment
- ➔Financial Sustainability by 2030/31

Clinical Strategy

- Our Clinical Strategy is to ensure that every person in our systems has the opportunity to live a **healthy, fulfilling life supported by safe, high-quality, and joined-up health and care**.
- We will use **clinical leadership, population health intelligence, and evidence-based practice** to design and commission services that **prevent illness, reduce inequalities, and empower people and communities** to stay well and live independently for longer.
- The Clinical Strategy is informed by detailed intelligence about **the needs of our local population** as well as **national priorities** in the 10-year Health Plan for England and our broader responsibilities working with **NHS Wales.** It sets out **clinical priorities** and **influences our Commissioning Intentions** and **5 year Commissioning Plan.**

Quality Strategy

- We will provide **system-wide assurance that care is safe, effective and high-quality**, delivering the ICB's statutory duty to improve quality of services link with improving population health and reducing inequalities.
- Quality information and assurance enables the ICBs to act as a strategic commissioner, ensuring **quality is central to how resources are allocated** and services are arranged.
- The National Quality Strategy will underpin our quality priorities and approach.
- Quality will be key to our statutory duty to provide **continuing healthcare**.
- We will drive system wide **quality improvement** to drive the ICB priorities and improved outcomes.
- Our **clinical governance** will support our work with providers, collaboratives, Place and the clinical and professional leadership to share intelligence and analytics to **identify risk**, variation, and system pressures.

Acronyms Appendix

Acronym	Meaning	Acronym	Meaning
AACC	All Age Continuing Care	IG	Information Governance
AEO	Accountable Emergency Officer	ISNA	Integrated Strategic Needs Assessment
BCF	Better Care Fund	JSNA	Joint Strategic Needs Assessment
BI	Business Intelligence	LA	Local Authority
CFO	Chief Finance Officer	PALS	Patient Advice and Liaison Service
CHC	Continuing Healthcare	PCN	Primary Care Network
CMO	Chief Medical Officer	PCI	People Culture and Inclusion
CNO	Chief Nursing Officer	PHM	Population Health Management
DIPC	Director of Infection Prevention and Control	Q&P	Quality and Performance
EDI	Equality, Diversity and Inclusion	QSG	Quality Surveillance Group
EPRR	Emergency Preparedness, Resilience and Response	SEND	Special Educational Needs and Disabilities
FTSU	Freedom to Speak Up	SIRO	Senior Information Risk Owner
GP	General Practice	SPC	System Performance Committee
HR	Human Resources	SSOT	Staffordshire and Stoke-on-Trent
ICB	Integrated Care Board	STW	Shropshire, Telford and Wrekin
ICS	Integrated Care System	VCSE	Voluntary, Community and Social Enterprise

Integrated Care System
Shropshire, Telford and Wrekin

Staffordshire and Stoke-on-Trent Integrated Care System

NHS
NHS Shropshire, Telford and Wrekin
NHS Staffordshire and Stoke-on-Trent

Enclosure No: 07

Report to:	ICB Boards in Common
Date:	30th April 2026
Title:	**Creating the System Architecture to Accelerate Delivery of Neighbourhood Models of Care**
Presenting Officer:	Phil Smith Chief Officer System Development and Integration
Author(s):	Claire Parker, Emma Pyrah and Nicola Harkness

Document Type:				Action Required (select):			
Report	☐	**Business Plan**	☐	**Information (I)**	☒	**Discussion (D)**	☒
Strategy	☒	**Policy**	☐	**Assurance (S)**	☐	**Approval (A)**	☐
Other	☐	*(please describe)*		**Ratification (R)**	☐	*(check as necessary)*	

Is the decision within SOFD powers & limits	**Yes**	☒	**No**	☐
Any potential / actual Conflict of Interest?	**Yes**	☐	**No**	☒
Not applicable				
Any financial impacts: ICB or ICS?	**Yes**	☐	**No**	☒
There are no specific financial impact in relation to this paper but there will be a need to deliver the model through medium term financial planning, 'left shift' funding, capital and digital funding.				
Any impacts on ICB Undertakings?	**Yes**	☐	**No**	☒
If Y, are those signed off by and date:	*E.g. Chief Finance Office, dd-mmm-yyyy*			
Appendices:	None			

(1) Purpose of the Paper:

To seek Board endorsement of the development of a single, integrated system vision and delivery approach for neighbourhood health. This is the next step in setting out the delivery environment to support the 5-year Strategic Commissioning Plan agreed at the March ICB Boards in Common and will form part of the response to NHS England's requirement for a system-wide strategic commissioning narrative by 15 May 2026.

The paper sets out:

- A high-level operating model for roles and functions of Place and Neighbourhoods
- Strengthened governance and system leadership
- A proposal for a phased approach to delegation (2026–2029)
- Priority actions for the next 12 months

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	Date
Presented for Board discussion on 30th April – recognising component elements on neighbourhood models of care have been presented at the Boards at various times.	
Expand as necessary if the report went to multiple meetings	

(3) Implications:	
Legal / Regulatory	*Set out in the NHS 10 Year Plan for Health*
CQC / Patient Safety	*None identified specifically within this paper*
Financial (CFO-assured)	*None identified specifically within this paper*
Sustainability	*n/a*
Workforce / Training	*Neighbourhood health is about working together differently to make optimal use of shared available resources. This will need to be defined in a workforce model and plan that articulates the future activity shift from hospital and community that fully takes account of population health needs and requirements, joint training and staff rotation across services and productive integrated working with a supply training and education plan to support delivery*
Equality & Diversity	*n/a*
Due Regard: Inequalities	*This model of care is designed to address inequalities including health and wider determinants of health where applicable and based on population health data.*
Due Regard: wider effect	*This model of care is designed to improve health and wider determinants to increase employment, access to education and improve wider socio-economic benefits.*

(4) Statutory Dependencies & Impact Assessments:

	Completed?			If N - N/A, Rationale	If Y, Outcome / Date Reported & Signed off
DPIA	**Yes**	**No**	**N/A**	Click or tap here to enter text.	*Reported to IG Committee:* Click or tap to enter a date.
	☐	☐	☒		
EIA	**Yes**	**No**	**N/A**	Click or tap here to enter text.	*Outcome and date of completion:* Click or tap here to enter text.
	☐	☐	☒		
QIA	**Yes**	**No**	**N/A**	*E.g. per QIA Policy, that it doesn't impact quality of services* Click or tap here to enter text.	*SRO sign-off, outcome & date of completion:* Click or tap here to enter text.
	☐	☐	☒		

Has there been Public / Patient Involvement?	Yes	No	N/A	Click or tap here to enter text.
	☐	☐	☒	

(5) Integration with SBAF (for NHS SSOT) / Strategic Risks (SR, for NHS STW)					
SBAF1	Responsive Patient Care - Elective	☒	SBAF5	High Quality, Safe Outcomes	☒
SBAF2	Responsive Patient Care - UEC	☒	SBAF6	Sustainable Finances	☒
SBAF3	Transforming Community Services	☒	SBAF7	Improving Productivity	☒
SBAF4	Reducing Health Inequalities	☒	SBAF8	Sustainable Workforce	☒
SR1	Strategic Collaboration & Partnership	☒	SR4	ICS Workforce (retention/wellbeing)	☒
SR2a	ICB & System Financial Balance	☐	SR5	Digital & Data Systems / Strategy	☒
SR2b	ICB & System RRL / CRL Plans	☐	SR6	ICS Strategic Response (e.g. EPRR)	☐
SR3	Reducing Health Inequalities	☒	SR7	ICS Socio-Economic Development	☒
			SR8	Patient & Public Involvement	☒

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

To seek both Boards endorsement of the development of a single, integrated system vision and delivery approach for neighbourhood health, as the next step in delivering the ICB's approved 5-year strategic commissioning plan and responding to NHS England's requirement for a system-wide strategic commissioning narrative by 15 May 2026.

Whilst we recognise the considerable progress that has been made to date, including involvement in the National Neighbourhood Implementation Programme (Shropshire), there is a need to have a clearly defined strategy and vision which is aligned across the geography of the Cluster ICB.

This model of delivery should focus on true integration, working together differently, and sustainability for our providers so we can plan for delivery of improved outcomes for our populations. population will only be delivered through sustainable, integrated partnerships between NHS, Local Authority and Voluntary, Community, and Social Enterprise (VCSE) sectors.

This paper sets out:

- Roles and functions of Place and Neighbourhoods
- Strengthened governance and system leadership
- A proposal for a phased approach to delegation (2026–2029)
- Priority actions for the next 12 months

(7) Recommendations to Board:

The Board are asked to:

Endorse the next steps:

Strategy

- Executive creation of a single system vision-mapping (May 2026)
- Establishment of Place Boards in SSoT – first meetings to take place (May 2026)
- System engagement (May–June 2026)
- Agree priority focus areas for year 1 (May 2026)
- Governance and footprint agreement (June 2026)
- Roadmap development (July 2026)
- Support the prompt development of a process to enable 'left shift' funding allocations and phased delegation to Place.
- System CEO development programme for strategic leadership (Sept 26 – Sept 27)

Leadership and sponsorship

- Provide visible leadership and sponsorship to the agenda
- Support the programme team to act to convene partners

Commitment to delivery

- Commit to delivery of identified actions and priorities
- Engage with processes to ensure alignment the development of new proposals and major investment decisions until alignment is achieved, such as estates and digital infrastructure.

Creating the System Architecture to Accelerate Delivery of Neighbourhood Models of Care

2.1 Introduction and Purpose

The purpose of this paper is to advise the Boards on all the strands of neighbourhood health at a national and local level. It then seeks both Boards endorsement of the development of a single, integrated system vision and delivery approach for neighbourhood health, as the next step in delivering the ICB's approved 5-year Strategic Commissioning Plan. The paper also sets out the ICB response to the recently published Neighbourhood Health Framework, including NHS England's requirement for a system-wide strategic commissioning narrative by 15th May 2026.

This paper sets out:

- A high-level delivery operating model for Place and Neighbourhoods
- Strengthened governance and system leadership
- A proposal for a phased approach to delegation from the ICB of authority and responsibility (2026–2029)
- Strengthened governance and leadership at all levels
- Priority actions for the next 12 months

2.2 Background

The NHS 10 Year Plan establishes a clear direction of travel for health and care systems, signalling a shift away from hospital-centred models towards a Neighbourhood Health Service designed around individuals, families and communities. This vision requires the replacement of a 'hospital by default' approach with a preventative, community-anchored model where care is delivered digitally, where appropriate, provided at home, whenever possible, accessed through neighbourhood health centres, when needed, and delivered in hospital settings only when clinically necessary.

The National Neighbourhood Health Framework, published in March 2026, reinforces this ambition and provides a platform for neighbourhood health as the default organising principle for NHS care. National guidance is explicit that neighbourhood health is not a discrete programme but a whole-system transformation. It requires systems to rewire commissioning, governance and delivery arrangements so that neighbourhoods are empowered to plan and deliver integrated, population-focused care. This includes a strong emphasis on prevention and early intervention, integrated neighbourhood teams, aligned governance structures and measurable population health and wellbeing improvement.

Integrated Care Boards are expected to set strategic intent, outcomes and enabling architecture, while devolving increasing responsibility and autonomy for delivery solutions to Place and Neighbourhoods.

Following both Boards approval of the 5-Year Strategic Commissioning Plan in March 2026, NHS England has requested each system to submit a single, aligned narrative by 15 May 2026 describing how partners will:

- Develop strategic commissioning capability
- Deliver neighbourhood health models
- Align financial flows and incentives
- Work collectively to remove barriers to delivery

A series of national publications were issued in March 2026, notably The Neighbourhood Health Framework and Population Health Delivery Models which set out clear expectations to organise services around defined populations, delivering proactive, preventative and integrated care.

Locally, whilst progress is being made and we are not starting this work from a zero base:

- There is no single, shared system vision or roadmap for neighbourhoods across the cluster
- Leadership and accountability for delivery is not clearly defined
- There is the potential for duplication and inconsistency due to delivery decisions often being made before strategy is finalised
- There is a risk of fragmented use of the ICB 2026/27 left shift neighbourhood funding aligned to local interpretation of need

This paper sets out to translates national policy, the ICB's 5-year Strategic Commissioning strategy, and the NHS England planning requirement into a single, coherent system delivery model which aligns to the ICB Operating Model. There is also an opportunity to agree the process to utilise the 'left shift' funding to maximise the opportunities for 26/27 and beyond, to deliver outcomes and impacts recurrently, that support the population and neighbourhoods across our cluster and are aligned to a single view of population need.

2.3.1 Our ambition

Within this national context, the Cluster ICBs as Strategic Commissioners are transitioning to a population-based, outcomes-driven commissioning model. This represents a significant shift in role, from managing individual services and contracts towards allocating resources based on population need, value and measurable impact. To deliver this effectively, Place and Neighbourhoods must be equipped not only with the authority to act, but also with the governance, leadership capacity and system support required to design, plan and implement optimal local models of care. Neighbourhood Health within our system must, therefore, be understood as a system-wide transformation rather than a single programme.

This is not a one-way delegation or passing of responsibility though from the ICB. It will require LA partners to bring their budgets into this space and to work differently to help flatten the demand curve and it will require providers to operate more collaboratively and to take a leadership role in the new models of care.

A wide range of existing community focussed developments already contribute to the Neighbourhood Health agenda: including the hospital transformation programme; the National Neighbourhood Health Improvement Programme (NNHIP) in Shropshire; our developing integrated neighbourhood teams; long-term condition transformation programmes; urgent and emergency care improvement; cancer and elective reform; women's health; access to primary

care and local authority-led community and prevention initiatives and the enabling digital, estates and workforce programmes. The publication of the national framework provides the opportunity and imperative to bring this activity together within a single, coherent delivery architecture, reducing duplication, improving alignment and accelerating impact.

Our ambition therefore is to establish a Neighbourhood Health Service that:

- Shifts care from hospital to community and home-based settings
- Embeds prevention and early intervention
- Is designed around populations and communities
- Improves outcomes and reduces inequalities

Neighbourhoods will become the default model for delivering care, consistent with national policy. It is important that we are accurate and precise in our use of language and that we do not conflate the place work and the neighbourhood work. We risk confusion if we use them interchangeably.

2.3.2 Alignment to National Policy and Delivery Models
In our systems, neighbourhoods will become the primary delivery units for integrated, population-focused care. Defined around natural communities and designed to bring together general practice, community pharmacy and dentistry, community health services, mental health services, acute providers, local authority social care and public health teams, and the voluntary, community, faith and social enterprise sector and where appropriate, urgent care, diagnostics and outpatients to collectively work together differently to achieve shared population outcome improvements.

While Primary Care Network boundaries are often a sensible starting point for neighbourhood geography, national guidance allows and expects local flexibility. In parts of our cluster, this will mean reviewing neighbourhood footprints to ensure they align with natural communities, local governance arrangements and operational viability.

Primary Care Networks have been pivotal in developing the Integrated Neighbourhood Team model which are at different levels of maturity and which in the main have been delivered using existing resources and contractual arrangements. There is a recognition that General Practice, Primary Care Networks and wider primary care services such as community pharmacy, optometry and dental services have a fundamental role within neighbourhood service delivery and will be critical to the further design of services based on population need.

Neighbourhoods are expected to improve routine access to care, provide proactive and anticipatory support for people with complex needs, strengthen prevention and early intervention, and offer safe and effective alternatives to hospital admission.

Whilst individual neighbourhoods are the primary focus, there will also be a need, in some circumstances, particularly where specialist input or larger scale models would make optimal use of the available resources, to develop delivery models that will operate across multiple neighbourhoods or localities. This pragmatic approach will ensure that neighbourhood health improves outcomes and sustainability of services and providers and return on investment.

This proposed approach aligns with national policy and guidance by:

- Establishing neighbourhoods as the primary delivery model, delivered through integrated neighbourhood teams
- Strengthening Place-based infrastructure, governance and planning and Health & Wellbeing Board leadership
- Delivering the three core priorities of neighbourhood health:
    - Improved access to routine care
    - Proactive care for populations with complex needs
    - Alternatives to hospital care
- Supporting the development of population health delivery models, with providers working collaboratively across neighbourhood and Place footprints
- Learning from existing models supported by primary care including PCN's and further testing and escalating where impacts are beneficial.
- Enabling the evolution of provider roles, including multi-neighbourhood and integrated delivery models using different neighbourhood contractual models
- Implementing a phased approach to the delegation of authority and responsibility to Place and neighbourhoods (2026–2029) aligned to national expectations

2.3.3 Proposed operating model, Governance and System Leadership (Definition of Roles)
The ICB acts as the strategic commissioner and system steward, setting system-wide priorities and outcomes, designing commissioning, contractual and financial architecture, removing barriers to integration and ensuring delivery of national requirements whilst laying the foundations for more fundamental reform.

At the same time, the ICB has a stewardship role in convening partners, aligning activity and creating the conditions in which neighbourhoods can succeed.

Health and Wellbeing Boards provide democratic accountability, setting population outcomes informed by Joint Strategic Needs Assessments and through collective leadership the development of Neighbourhood Health Plans.

Place-based Partnerships, operating as sub-committees of the ICB, currently in Shropshire, Telford and Wrekin, translate system strategy and Health and Wellbeing Board priorities into local delivery, provide oversight and assurance, and manage delegated resources. In Staffordshire and Stoke on Trent, some of this work is currently managed through the Joint Commissioning Boards but not specifically in relation to neighbourhood models of care.
We will continue to establish and build on Neighbourhood leadership and infrastructure arrangements, within a clear system architecture:

- **ICB (Strategic Commissioner)-**Sets strategy, outcomes and financial framework for health, including future delegation of budgets; retains statutory accountability.

- **Health & Wellbeing Boards-**Sets population outcomes and priorities, approves the Neighbourhood Health Plan for 2027/28.

- **Place-Based Partnerships,** operate as formal delegated subcommittees of the ICB Boards, with defined authority for local health and wellbeing planning, prioritisation, funding allocation and oversight of delivery. Over time delegated budgets from both the ICB and LA's will need to be brought into this space to be used as levers to drive a fundamentally different approach of delivery.

- **Providers (NHS and partners)-** Play a central role in collectively designing and delivering neighbourhood health, working collaboratively across organisational boundaries to deliver integrated, population-focused care.
  This includes evolving towards new population health delivery models, where providers:
  - Organise services around defined populations and neighbourhood footprints
  - Work as part of integrated neighbourhood teams
  - Take increasing responsibility for outcomes, quality and resource use
  - Collaborate across organisations to deliver care at scale, where necessary
  - Learn from primary care, community care, social care and VCSE services where neighbourhood services already exit or are being tested.

- **Neighbourhoods-** Act as the primary delivery mechanism, bringing together services to design and deliver integrated care for their populations.

Place-based Partnerships, operating as sub-committees of the ICB, currently mobilised in Shropshire, Telford and Wrekin, translate system strategy and Health and Wellbeing Board priorities into local delivery, provide oversight and assurance, and manage delegated resources. In Staffordshire and Stoke on Trent, some of this work is currently managed through the Joint Commissioning Boards but not specifically in relation to neighbourhood models of care, therefore an early priority is to establish Place Boards. There will be a need to revisit the two place Boards in STW to ensure that they are fit for purpose and established to deliver this shift in emphasis and approach.

Providers, both NHS and non-NHS, are expected to collaborate across organisational boundaries in the interests of local populations. Neighbourhood leadership teams will act as the delivery engine, coordinating planning, decision-making and the integrated delivery on the ground.

- Single system governance and accountability
- Place Boards as delegated subcommittees of the ICB

The ICB will retain statutory accountability, with Place responsible for delivery within a clearly defined scheme of delegation.

2.3.5. Phased delegation (2026–2029)

It is proposed that delegation of responsibility and resources to Place is recommended to progress through three phases, subject to further development, between 2026 and 2029. This will require LA commitment and agreement as much as it will require ICB agreement and commitment.

Phase 1 focuses on mobilisation and foundation setting, enabling neighbourhoods to have a key role in determining the use of designated ICB 'left-shift' funding while the ICB retains allocation decisions and assurance.

Phase 2 introduces shadow delegation arrangements and early outcomes-based contracting that will have clear LA budgets identified alongside NHS budgets, Phase 3 moves towards delegation for both Health and LA and accountability for agreed outcomes.

This staged approach reflects national guidance and recognises variation in neighbourhood and place maturity. It provides the ICB Board with assurance that autonomy will increase in a controlled and transparent manner, aligned to capability, governance and delivery readiness, while maintaining system integrity and collective accountability.

A **phased approach** will manage risk and build capability:

- **Phase 1 (2026/27): Mobilise**
  Foundation setting; Limited delegation; ICB retains funding decisions
- **Phase 2 (2027/28): Develop**
  Shadow delegation to Place of both LA and ICB budgets
- **Phase 3 (2028/29): Embed**
  Full delegation aligned to outcomes

Progression will be based on clear readiness criteria that will need to be developed and agreed in line with the phasing and informed by national guidance/neighbourhood maturity criteria.

2.3.6 Delivering this change

To respond to national requirements and enable successful delivery, we will develop and implement:

- A single system vision for neighbourhood health, collectively developed and agreed by all partners
- A single delivery roadmap, aligned to the national neighbourhood framework
- Strengthened infrastructure with clear governance and accountability across all partners

Supported by a targeted OD programme to build leadership, alignment and delivery capability.

2.3.7 Priorities for the next 12 months (2026/27)

The next 12 months represent a critical transition from neighbourhood development to neighbourhood delivery.

During this period, the system will focus on agreeing and refreshing neighbourhood footprints, where required, establishing the required infrastructure with consistent governance arrangements at Place and Neighbourhood level, and equally importantly aligning existing neighbourhood and community transformation programmes into a single delivery roadmap, this includes aligning to our clinical priorities and those priorities identified through the Health and Wellbeing Board Strategies and the Integrated Care Strategies. This will provide greater clarity of priorities and accountability.

The phased approach to delegation could commence in 2026/27, with the partial devolvement of decision-making and removal of duplication.

The focus for 2026/27 is to continue to establish the foundations for neighbourhood health while delivering tangible improvements in system performance, particularly in urgent and emergency care.

Summary priorities for 2026/27:

- Agree and embed a system-wide neighbourhood vision and roadmap
- Align existing neighbourhood and community development programmes into a single portfolio and integrated road map of work, driven by a shared view of population need
- Establish and strengthen Place and Neighbourhood governance arrangements
- Confirm neighbourhood footprints aligned to natural communities
- Develop approach to delegation
- Launch a process for allocation of the 26/27 neighbourhood left shift funding and the development of Neighbourhood Health and Wellbeing Improvement Plans
- Strengthen provider collaboration and population health delivery models
- Ensure learning from existing test and pilot projects is evaluated and rolled out at scale where there are beneficial impacts and outcomes.

Supporting infrastructure and investment

- **OD/Shared Strategic Vision:** Neighbourhood health will only work as a joint endeavour between the NHS and local authorities, alongside wider partners. This requires a truly collaborative effort between all partners and different ways of working together outside of organisational boundaries. Learning from national exemplars show that systems need to invest deliberately in relationships and trust building before expecting integrated delivery, including co-design and whole system shift.

- **Neighbourhood Health and Wellbeing Improvement Plans:** The ICB has ring fenced neighbourhood left shift funding for 2026/27. This is the first additional uncommitted investment available for investment in neighbourhood developments and is intended as a catalyst for future movement of resources in the system to deliver the 10 Year Plan. It is proposed that this opportunity is used to take the next step in the phased approach to delegation this year. All systems are required to have a Population Health Improvement Plan, this funding provides the opportunity to channel the investment at a more granular level through local collectively developed Neighbourhood Health and Wellbeing Improvement Plans. This would involve identification of priorities for funding at neighbourhood level, whilst the ICB specifies the priority outcomes and retains decision making on the allocation/approval of that funding. This change would move away from historic fair share/equal share allocation of funding towards needs and impact-based solutions giving greater local influence and accountability for how care is designed and delivered. The opportunity also exists to utilise other partner monies in this manner.

- **Estates/Capital:** Develop and submit neighbourhood capital estate proposals, working with partners to support neighbourhood health infrastructure and integrated care delivery, in particular plans for Neighbourhood Health Centres (in line with national policy)
- **Digital:** There is an urgent requirement that the system is able to describe the plan and roadmap to deliver the supporting neighbourhood digital model as this is currently a limiting factor to progress.

- **Workforce:** Neighbourhood workforce strategy and delivery plan covering distributed leadership capability across neighbourhood teams, ensuring skills and tools are in place for staff to safely work across organisational boundaries, multi-professional working with clearly defined roles and shared accountability, a shared vision across workforce leaders to inform future expansion plans

- **Community Engagement:** Building on what is already in place, community engagement needs to become continuous not episodic. Proactive listening to and working with patients, people and communities so that neighbourhood developments are informed by what is right for the local population and informed by what frontline staff say needs to change

- **VCSFE:** needs to be enabled to be an equal sustainable system partner with the necessary associated infrastructure, not just a delivery arm.

These priorities reflect the foundational requirements of the Neighbourhood Health Framework for 2026/27 and will form the basis of the NHSE submission in May 2026.

Population priorities for 2026/27:

Whilst the focus for 2026/27 is to establish the foundations for neighbourhood health, it is important that we are delivering tangible improvements for our population.

Priority areas will guide planning, investment and delivery. This will include targeted local activities linked to a shared view of target cohorts, centred around:

- Frail older people
- Long term condition management (focus on Cardiovascular, renal and metabolic conditions including diabetes)
- Children and young people
- Mental Health

With the intention of:

- Developing proactive care models for high-risk cohorts to reduce avoidable admissions and positively impact the UEC pathway
- Strengthening community-based alternatives to hospital care
- Improving discharge pathways and system flow
- Supporting overall delivery of the UEC Improvement Plan

2.3.8 Key risks and mitigations

Risk: Delegating funding too quickly

Mitigated through phased delegation, retained ICB control in Year 1, and clear readiness criteria

Risk: Lack of clarity in provider roles

Mitigated through defined expectations, provider collaboration and aligned incentives.

Risk: Local Government Reform in the Staffordshire and Stoke-on-Trent area resulting in stasis

Mitigated through commitment from the 2 LA's to this agenda and adopting an approach that enables the work to iterate and evolve once the outcome is better understood re the future of the LA footprints.

2.4 Conclusion

Neighbourhood health represents a long-term, system re-architecture of how health and care services are planned, commissioned and delivered. While significant progress has already been made, the next 12 months are pivotal in establishing the governance, delegation and system alignment required to realise this ambition at scale.

This paper provides the Board with clarity on direction of travel and seeks discussion and support for the proposed operating model, phased delegation framework and implementation approach to ensure that financial flows, estates and digital expenditure align to the vision for the system architecture and the delivery of the Strategic Commissioning 5-year plan.

What is also clear is that we need to learn and develop this work by doing. There is a need for clarity and an overarching strategic framework as set out in this paper. However, this is as much urgency for us to mobilise this work now at pace and shift beyond the planning phase. We have an opportunity over the next 3 months to generate some traction and early delivery on this before we get into the winter pressures period. Partners are asked for their commitment to this and for their leadership in driving this agenda forwards.

Next steps:

- Executive vision-mapping (May 2026)
- Establishment of Place Boards in SSoT – first meetings to take place (May 2026)
- System leadership engagement (May–June 2026)
- Place and Neighbourhood governance and footprint agreement (June 2026)
- Roadmap development and alignment (July 2026)
- Process for allocation of the ICB neighbourhood left shift funding (May 2026)
- NHSE submission (15th May 2026)
- System CEO development programme for strategic leadership (Sept 26 – Sept 27)

Phil Smith
Chief Officer: System Development and Integration
April 2026

ICB Cluster Risk Management Strategy

(1) Introduction and Common Definitions

(a) Background to this Document

"The focus of good Risk Management is the identification and treatment of risk [to] add maximum value to all activities of the organisation. It [looks at] the potential upside and downside of all those factors which can affect an organisation. It increases the probability of success and reduces the probability of failure [in] achieving the organisation's overall objectives" (Institute for Risk Management, 2002]

In all areas of business, there is always the potential for risk. It is either an opportunity for benefit (the upside); or it threatens successful delivery of strategic objectives (the downside).

The Cluster Risk Management Strategy & Policy merges the NHS Staffordshire & Stoke-on-Trent ICB Risk Management Strategy, June 2024; and the NHS Shropshire, Telford & Wrekin ICB Risk Management Policy, Sept 2023. It sets a Cluster-wide framework for identification, escalation, management (treatment) and assurance of risk. It includes a new, joint 'Risk Appetite Statement' to underpin our combined risk assessment processes. This will ensure a joined up, continuous and developing process that covers all parts of Cluster ICB business.

Whilst this document outlines Risk Management arrangements for the statutory ICBs operating as a 'Cluster' prior to formal merger of the two into one; it is important to note that these arrangements are also envisaged as guiding how the ICBs work in partnership with other key parts of their wider ICS Partner Family, so that the policy approach is equally applied to those System Risks relating directly to the ICBs' Strategic Commissioning functions undertaken in the commissioned service delivery parts of the ICSs, on behalf of the ICBs' populations.

The management of risk across organisational boundaries is complex. Meaning that our Governance Model should allow sovereign ICS Partners to manage their own risks independently, whilst enabling a robust partnership approach to joined up Risk Management that supports the delivery of System Strategic Objectives per the "Quadruple Aim".

As such, it is important that there are clear inter-relationships not just between the Cluster ICBs, but all ICS Partners, regarding the collaborative management and ownership of risks between these different organisations across the systems, potentially meaning that non-ICB partners may be responsible for implementing the Controls and providing the Assurances for aspects of strategic System rather than uniquely ICB Risk.

Together, we will view Risk Management as an essential business activity that underpins the achievement of our joint objectives and those specific to individual Statutory Organisations. A proactive and robust approach to risk management can:-

- Reduce our risk exposure by developing a 'lessons learnt' environment to more effectively target of resources, instead of just overloading our System or ICB Risk Registers with static risks;
- Support informed decision-making that allows innovation under a keener Risk Appetite (resulting in much stronger gatekeeping of risk, and not just accepting risk for risk's sake);
- Enhance compliance with applicable laws, regulations and national guidance;
- Increase Stakeholder confidence in Corporate Governance and the ICBs' ability to deliver.

(2) Policy & Strategy Definitions

Why it is important to differentiate between an ISSUE and a RISK:-

An Issue	*ISSUES* are events or challenges that have already happened and need to be managed well as part of day-to-day BAU. The language used to define or describe an Issue is always in the Present Tense: e.g. this problem has arisen, how should we deal with it? Issues result as a consequence from failure to mitigate Risk sufficiently. Issues are not recorded in a Risk Register, though may be recorded on Issues Logs that use a similar format / layout as a Register, to ensure consistency of approach.
A Risk	*RISKS* are defined as the combination of the Likelihood (probability) of an event and its Consequences. Risk is the "effect of uncertainty on objectives". A Risk is an event that has not happened yet but may. The language used to define or describe Risk is always set in the Future Tense: e.g. if this happens, this will be impacted.
(Strategic or System) Board Assurance Framework: SBAF	A tool used by ICB Boards & Committees to identify the level of risk they are willing to take in the pursuit of delivery of our statutory duties / healthcare improvement. Used by ICB Teams to demonstrate to Board / Committees their sources of Assurance and Control for minimising the likelihood or effect of those risks materialising, and where they do arise, how they are mitigating the risks to delivery of agreed Strategic Objectives through the active use of Controls and Assurances.
A Control	Any process, policy, device, practice, or action designed to modify, mitigate, or manage risks. These work by reducing Likelihood of risks occurring or minimising Consequences (impact) if they do. They are proactive measures to ensure Strategic Objectives are met, and act as the "first line of defence" against threats to objectives.
An Assurance	An Assurance is the process of Risk Owners or Strategic Objective Owners providing confidence to ICB Boards & Committees that Risks are being effectively identified, managed and mitigated by existing controls. They act as a system of checks and balances, verifying that Risk Controls are actively working as intended to deliver organisational objectives, rather than just identifying threats to delivery. These underpin our "Three Lines of Defence Model" (see later section): e.g. internal management or System Partner reviews, as the *First Line*; specialised monitoring or compliance checks through ICB Committees, as the *Second Line*; and independent internal / external audits or regulator assessments as the *Third Line*.
Risk Appetite	The level of risk we are prepared to accept in relation to any event or situation, after balancing the potential opportunities and threats it presents. If we do not know what our collective appetite for Risk is, or the reasons for it, this may lead to erratic or inopportune risk-taking, exposing the organisation to a risk it cannot tolerate. Or conversely, an overly cautious approach, which may stifle innovation, growth and development. The stronger our Appetite, the more we accept risk as being inherent to health & care; or the more we accept that uncertainty or change requires innovation that brings more risk. It is not practical to aim for a risk-free or risk-averse environment. We should sharpen our Risk Appetite to consider risks as a fact of life and only identify / manage those that are genuinely threats to delivery. Without it, we may become too risk averse. The tone from the top avoids taking risks or leads to behaviours that are inappropriate; failing to change the status quo and leading to poorer decision-making.

(3) Purpose

This document aims to re-establish, then embed Risk Management across two Cluster ICBs, ensuring informed decision-making, transparency, compliance with statutory duties, and alignment to ISO31000 / Institute of Risk Management / Good Governance core principles.

Getting it right will provide the appropriate Internal Control mechanisms, checks and balances for providing assurances and confidence to the ICB Boards & Committees. As well as to patients, partners and stakeholders that we're acting with probity and less likely to be derailed by unexpected risk as a Cluster than separately. Creating an effective Cluster Risk Culture will assure all that we are operating in accordance with the law and our statutory duties.

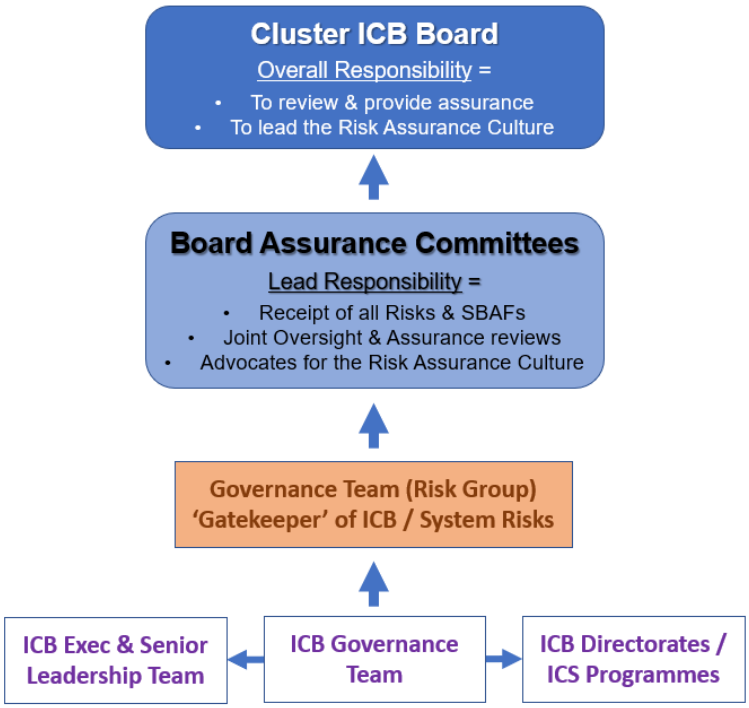
The document sets out our Cluster Risk Architecture (e.g. roles, responsibilities, communication and reporting arrangements); and describes how Cluster Risk Management is integrated into our shared governance arrangements, key business activities and cultures. Our new ICB approach as Strategic Commissioners will avoid being overly bureaucratic but will nonetheless be robust and proportionate to the levels of risk facing our two systems.

Our solutions will be systematic but will not look to waste time, resources or effort on non-value adding processes. In response, nor will we support ICB personnel overloading the Cluster Risk Register with any Issues or non-Strategic Risks only indirectly linked to delivery of our Strategic Objectives. A much stronger Cluster Risk Appetite of the Boards / Committees, joint management and ICB personnel will be crucial to achieving this.

(4) Strategic Scope and Roles & Responsibilities

This new strategy document and its core policy principles apply equally to all Cluster ICB staff, ICS partners contributing to Cluster Governance and delivery, Partnership / Programme Boards, and Place-Based Partnerships / joint teams discharging ICB statutory duties. Roles and Responsibilities will apply differently depending on the context, for example:-

Strategic Risks	The most important risks directly overseen by Board as part of assuring delivery via the Strategic Board Assurance Framework: SBAF. These are the potentially significant risks that need proactive identification or else they will threaten the achievement / delivery of ICB Strategic Objectives.
Operational (Corporate) Risks	The by-products of day-to-day delivery, whether arising from circumstances that have the potential to impact negatively on the ICB / its objectives. They are either ICB (Corporate) Risks – those directly relating to ICB Strategic Commissioner duties; or System Risks – those affecting ICS delivery of commissioned services or collaborative strategic objectives. They are recorded in the Organisational / Corporate Risk Register – as the tool for recording identified 'live' risks and monitoring actions against them. And as aligned to the relevant Lead ICB Committees responsible for providing assurance to Boards.
Operational (Corporate) Issues	These are events that have happened or are happening and need daily management by ICB Directorates & Teams responsible for providing BAU assurances to Committees that day-to-day activities are being managed effectively. Issues are recorded by ICB Teams on locally maintained Issues Logs; and only reported to Committees if they convert into risks.



- **The Unitary Cluster Boards of NHS SSOT & NHS STW:**

Hold overall responsibility for the effectiveness of the ICB's Risk Management system and processes; and must ensure they seek independent assurances from its Audit Committee, via Internal Audit, that systems and processes are robust and effective. The Boards determine overall Risk Appetite & Risk Tolerance statements underpinning the ICB Risk Culture.

- **Audit Committees in Common:**

Hold lead responsibility for oversight on 'Systems of Internal Control', including providing Boards with assurances on the effectiveness and the robustness of Risk Management. The Committee's role is not to manage risk, but to ensure our risk approach is effective.

- **Board Assurance Committees (in Common or Joint):**

Have delegated authority to manage risk per their Terms of Reference. In particular, assuring Boards that controls are working as they should from the updates they receive, and challenge when they are not working. They also ensure their non-risk agenda items calibrate to mitigating risk in the delivery of Strategic Objectives. At the end of each meeting, members will be asked if further risks have been identified, and how well their meeting has mitigated risk.

- **ICB Governance Team / Chief of Staff (COS):**

Acts as the bridge between Board, Committees and Staff in managing day-to-day process, by providing dedicated support and advice, including training & development where required. The COS has Exec responsibility for co-ordinating Corporate Registers. The Team also "gatekeep" first-line triage of SBAF + Risk Registers (updates or requests to add to registers).

- **ICB Chief Executive:**

Has overall accountability for Risk Management; in signing off informed Annual Governance Statements within Annual Reports, to provide public assurance that risks impacting on the achievement of objectives are effectively managed and the ICBs manage risk appropriately.

- **ICB Executives & Non-Executive Members (NEMs):**

Execs are responsible for ensuring that their Teams update risks regularly - at least quarterly - on Corporate Risks & SBAF matters assigned to their Directorate. Updating System Risks collaboratively with System Partners where beneficial. Non-Execs receive updates at Lead Committees (see above) to satisfy themselves that ICB systems are robust and defensible.

- **All ICB Risk Owners (Staff):**

Each is individually responsible for ensuring robust mitigating actions are identified and implemented for their risks; and for complying with the arrangements set out in this strategy. They are also expected to routinely consider risks when performing BAU.

(5) Risk Appetite, Risk Tolerance and Risk Culture

(a) Risk Appetite

Good Risk Management is not being risk averse. It recognises the potential in events that may result in improvements as well as unfavourable aspects. Maintaining a balanced risk approach will ensure we neither take on too much nor too little risk. A *Risk Aware* ICB, with a strong Risk Appetite actively encourages innovation to achieve objectives, knowing that risks are identified and controlled. It accepts that not everything we do needs to be logged on the Risk Register.

The question each prospective or current Risk Owner and each Lead Committee must ask themselves is this – what types of risks are we willing to accept to get us where we want to be, given we operate in a challenging environment with ever-present risk?

A Risk Appetite Statement is our declaration of the amount or types of risk we're willing to accept to achieve our Strategic Goals. It must be simple, understood and useful; so as to help Risk Owners better categorise risk and navigate the differential "appetites" in our business – e.g. we have AVOID cyber or compliance threats, while being OPEN to and SEEK innovation.

A Strategic Commissioner per the NHS 10 Year Plan will carry High Risk across the board. From improving health & wellbeing outcomes or the quality of commissioned services; to reducing inequalities; to meeting statutory & regulatory duties; or maintaining our reputation, to ensuring workforce resilience and financial sustainability. Maintaining the status quo is high-risk in itself. To achieve all we need to do, we must maintain a stronger, sharper Risk Appetite.

The following Risk Appetite Statements by ICB Function have been adapted from Good Governance Institute recommended dimensions and focus areas, referencing a predecessor previously agreed for NHS STW ICB, and operate in the following categories:-

Avoid	Minimal	Cautious	Open	Seek	Mature
Avoidance of risk is the key objective	Preference for very safe delivery options that have low inherent risk / limited reward potential	Preference for safe delivery options that have low inherent risk / limited reward potential	Willing to consider all potential delivery options while also providing an acceptable level of reward	Eager to innovate & to choose options offering higher rewards, despite greater inherent risk	Confident in setting high levels of appetite because controls & systems are robust

Integrated Care System
Shropshire, Telford and Wrekin

Staffordshire and Stoke-on-Trent Integrated Care System

NHS
NHS Shropshire, Telford and Wrekin
NHS Staffordshire and Stoke-on-Trent

Cluster Risk Appetite Statements (RAS) by Principal ICB Function

	Background & Context	Proposed RAS for the ICB Cluster Function (blue text)
Finance & VFM Risks	ICBs carry high financial risks with issues around medium-term financial sustainability:- *(1) Demand exceeding Supply;* *(2) Management attention focused on Statutory / Regulatory compliance;* *(3) Aspects of the ICB Operating (Business) model do not always support Financial Sustainability.* Decision-making usually reflects a low appetite for financial risk: i.e. willing to consider delivery options that provide acceptable rewards. To comply with regulatory requirements and enjoy financial flexibility, we need to show year-on-year improvement in financial sustainability, so are unlikely to be able to invest in initiatives whose benefits are realised long-term (>5yrs).	**We have an open appetite for financial risk** – e.g. we should be prepared to... ✓ Invest in new, transformative, preventative models of care, even if they carry short-term financial uncertainty ✓ Take informed risks where there's a strong case for long-term value, or better outcomes, mutual benefit (joint working, improved use of resources / risk-shares) ✓ Address difficult conversations about finances openly & directly, looking for joined-up financial management that takes account of Partners' differing financial requirements / constraints ***These kinds of risks might not need adding onto our Risk Register if our appetite is strong.*** What will be added are any Risks that may lead to uncontrolled over-spending, loss of accountability or financial instability. We will seek to minimise these by operating robust financial controls. All financial risks must be actively, transparently mitigated to target scores ASAP. ***Risk Scores should ideally be 10–20 / Close at Financial Year end***
Quality & Safety Risks	The ICBs & System carry high risks to patient safety & quality. Resources are constrained. Although we need to recognise that doing nothing is high-risk in itself – it may be less risky to take decisions that to try to affect change. We currently focus on in-year management of Issues, not Risks – we should move towards a forward-looking, strategic view of risk. Some things are under our direct control as a Strategic "Host Commissioner" contract holder. Associate Commissioner control is more indirect, though still fall within our sphere of influence – we need to understand how we can best exert our influence with those who have greater degree of controls or assurances. For areas where we have no influence, we will accept we often need to react.	**We have no appetite for safety risk exposure** – unmanaged or unmitigated safety risks that result in harm / injury or poorer outcomes to patients, public, workforce. **We have a cautious to open appetite in selected areas** – e.g. to enable us to achieve our strategic objectives. We are willing to test new ways of care delivery, even if there is short-term risk, as long as safety is monitored / managed throughout. Risk Stratification encourages greater innovation in targeted areas. **We have an open risk appetite** – e.g. for short-term variations that achieve longer-term objectives, or in moving from the 'here & now' to the future, including prevention, early intervention, 'left shift' etc. **While all such risks will generally be accepted onto Registers**, due to QIA Monitoring, they must be actively controlled and mitigated by Shared Culture & Risk Appetite across the System (via SQGs), with greater understanding of each other's positions to lower risk scores closer to target much sooner; and once clear of the evidence from robust quality monitoring, clinical leadership + strong oversight. ***Risk Scores should ideally be 5–15 / Close at Financial Year end***

	Background & Context	Proposed RAS for the ICB Cluster Function (blue text)
People & PCI / EDI Risks	The ICBs & Systems are currently carrying high workforce risks driven by a large, growing gaps between current capacity & demand. Pressures associated with this gap is often driving low morale, high sickness rates and delivery / performance issues in trusts. National programmes to address these challenges are focused on productivity. In addition, there is a gap between current approaches and the future needs in the NHS. We demonstrate a lower appetite for innovation than we could: i.e. changes happen but not always at the transformative scale required: e.g. small-scale innovations, limited workforce reform, minor skill-mix adjustments, few transfers of functions / services from partner to partners or use of the VCSE.	**We have a cautious to open appetite** – e.g. in areas of workforce / digital transformation, shaping the workforce around new skillsets + reform. We are open to considering changing practices to support multi-disciplinary, cross-partner working. We are interested in initiatives which emphasize collaboration, particularly clinical leadership, community capacity building, networking & facilitation. Pace of change is critical: e.g. avoiding quick, large-scale changes that could disrupt multiple systems, or avoiding low-scale / low-impact innovations. **We have an open risk appetite** – e.g. for short-term variations to achieve longer-term objectives, for initiatives including prevention, early intervention, 'left shift' etc. **While all such risks will generally be accepted onto Registers**, due to threats to staff safety, wellbeing, or employer legal responsibilities, all Risks must be well-managed, co-designed with staff, and aligned with our long-term workforce strategy. And be directed by a clear, agreed vision; adequate planning & implementation, and with greater understanding of each Partner's positions to lower risk scores nearer to target score sooner; once clear of the evidence from robust monitoring, workforce leadership + strong oversight in minimising risk. ***Risk Scores should ideally be 10–20 / Close at Financial Year end***
Performance & Delivery Risks	We work in a complex environment with ongoing pressure on services like urgent care, elective recovery and mental health. While good progress has been made, performance still varies across the system. We have strong reporting in place, but long-standing challenges and limited resources can slow improvement. In the past, we've had a low tolerance for performance risks, which has sometimes limited flexibility & innovation. Our preferences range between a Cautious Approach – i.e. safe delivery options that have a low degree of residual risk and a limited reward potential (risk avoidance); to an Open Approach we're willing to consider all potential delivery options while also providing an acceptable level of reward.	**We have an open risk appetite** – e.g. we want to move away from orthodox ways of managing service provision towards outcome-based indicators of performance. We are willing to take measured risks to improve services / outcomes over time. E.g. we may accept short-term dips in performance while we try new ways of working, shift care into the community, or invest in prevention. We are committed to narrowing inequalities across our population. We are prepared to make decisions which target improvement in PHM population groups where outcomes are below average. **To mitigate performance risks added to the Register**, we should ensure that any innovative initiatives are well-planned, monitored and lead to the long-term benefits intended to be realised. We prefer Risks to be added only where we know we can establish robust methods for monitoring / measuring impact on outcomes. We expect there to be clear ICB-System plans + shared ownership for managing any System delivery risks added to the Risk Register. We have low tolerance for unmanaged or repeated underperformance, especially where it affects safety, equity, or key NHS standards. ***Risk Scores should ideally be 5–15 / Close at Financial Year end***

	Background & Context	Proposed RAS for the ICB Cluster Function (blue text)
Reputation & Compliance Risks	We work in a high-profile environment with strong public interest in health & care services. Maintaining trust with all stakeholders is central to our success. While we have a good reputation for collaboration & leadership, there can be tension between short-term reputational risks / long-term transformation goals. We also operate in a highly regulated environment, with statutory duties / frameworks, and other requirements: e.g. past Undertakings or formal interventions. While compliance is generally well managed, the complexity of system working & partnership arrangements can create uncertainty about roles, responsibilities, assurance pathways.	**We have an open appetite for risks impacting Relationships & Engagement –** e.g. we will take difficult decisions if benefits result, even if it risks extra scrutiny / attention. We expect bold decisions to be supported by robust evidence + completed impact assessments. We recognise that some will involve trade-offs. We will seek to manage risk through proactive comms and involving stakeholders in our decisions. **We have a cautious appetite for risks impacting Regulation & Compliance** – e.g. we aim to comply fully with all such requirements and will only accept a low level of risk in these areas. We may tolerate minor or short-term gaps where they are well understood, pose no immediate harm, and are actively addressed. ***These kinds of risks might not need adding onto our Risk Register if our appetite is strong.*** While we do not seek to avoid reputational risk, we should only add Risks that threaten the undermining of public trust, or misleading stakeholders / damaging key relationships or putting legal obligations at risk. We may not add Risks where there are justified, measured, transparent non-compliance options under "Comply or Explain" governance models. Any such decision must be conscious, documented & subject to oversight. ***Risk Scores should ideally be 10–20 / Close at Financial Year end***
Innovation Risks	We wish to innovate, even if it carries high risk, because we believe BAU may exacerbate things and "Do Nothing" is greater than the risk of innovations which fail, because we can learn from past failures in the future. We are interested in innovations shifting resources from treatment towards early intervention & prevention that enable us to target inequalities. When considering whether or not to adopt an approach we will always seek to understand the benefits that it can deliver against our priorities, e.g. accelerate timescales in which benefits can be delivered; benefits at greater scale / with wider scope of impact, benefiting more of our population or several areas of inequality.	**We have a cautious to open appetite** – e.g. we balance risk vs. benefits across all areas to ensure we innovate whilst operating within Regulatory & Statutory Frameworks. We accept that not every innovation will succeed. We still expect clear goals, good governance + strong engagement as we test new ways of working. **We will usually adopt a seek appetite** – e.g. to innovation addressing our Strategic Objectives & Risks. We prefer there to be some evidence of the risks & benefits before we adopt it; although are willing to be 'Early Adopters' where there is scant / emergent evidence if this is our best option to address our most challenging priorities. ***These kinds of risks should not generally be added to our Risk Register as our appetite is strong.*** As we require high levels of control when we innovate. However any Risks that are agreed to be added must have very tight controls & detailed mitigations, with regular updates for 'course correction' with additional mitigations & controls secure from those closest to the risk (who should feel empowered to take riskier decisions). Controls must effectively manage risk without stifling innovation; based on measures of impact & outcomes / early indicators of strategic risk. ***Risk Scores should ideally be 15-20 / Close at Project end***

	Background & Context	Proposed RAS for the ICB Cluster Function (blue text)
Planning & Capacity Risks	While we are willing to consider innovations which carry high risks across risk categories, although our constrained capacity may mean we will have to be more selective in which risks we add at each risk review and based on horizon scanning. We have a strong appetite for developing & delivering ambitious plans against accelerated timelines to achieve our strategic aims & objectives. We operate a control environment & programme management approach that enables innovation whilst ensuring we can act quickly to identify / address risks & issues and take corrective action where needed. Our planning approach will identify the outcome / output measures we will use to assess progress and demonstrate success. We will ensure these are used to shape any risks identified.	**We have a cautious to open appetite** – we should balance risk vs. benefits across all areas to ensure we can pool or transfer risk where possible (e.g. use of BCF/s.75, or outcomes-based contracts); closely working with Regulators & Stakeholders to share rationale / build support for difficult decisions. **We will usually adopt a seek appetite** – e.g. to proactively communicate & engage with stakeholders / our population to identify the issues we need to solve through commissioning; with staff at all levels building support for new ways of Strategic Commissioner operating models, which may involve some short to medium term increases in risks relating to implementation of the model. ***While all such risks will generally be accepted onto Registers***, due to threats to regulatory or statutory responsibilities, however all Risks must be well-managed, co-designed with staff, and aligned with our long-term strategy. And directed by a clear, agreed vision; adequate planning & implementation, and with greater understanding of each Partner's positions to lower risk scores nearer to target score sooner. ***Risk Scores should ideally be 10-20 / Close at Project end***

(b) How Risk Appetite sets the Risk Tolerance

Pending assessments of the impact of uncertainty on delivery of our Strategic Objectives, we will further our new Risk Appetite by seeking to treat risks in the following ways:-

Avoid (lowest level of Risk Appetite)	If avoidance of risk is our key objective – i.e. we normally see most things as being high risk, or we have a low appetite for any safety / compliance breaches – we will normally choose the least risky action and default add risks to the Corporate Register. If so, then receiving Committees & Boards should request the strongest possible controls from Risk Owners on how they will mitigate their risks , especially where the risk stays static and is not moving to target score set by the owner (or has been labelled as an "enduring risk"). Where controlling risk is not possible in this, we could alternatively reject its addition to the Register altogether and our Risk Appetite require us to accept the underlying risk and tolerate it by accepting as part of BAU.
Cautious (a moderate Risk Appetite)	If our preference is for the safer end of innovative options that have a medium degree of risk, or more limited reward potential, we may accept these onto our Risk Register. As while success is anticipated, we leave room for failure just in case. A cautious risk approach here should normally tend towards understanding these will be 50-50 probability matters as to whether risks get added onto the Corporate Register – or not. We may prefer to ask a prospective Risk Owner to instead describe their matter as an Issue not a Risk and emplace it only on locally developed 'Issues Logs'. Or if accepting it onto the Register, we ask for stronger mitigating actions as Risk Controls to limit the Residual Risk Score to much lower levels than hitherto set. We may accept risk as a BAU fact of life, leading to personnel taking some riskier actions, but only if they minimise chance and impacts of failure, and only if their risk mitigation actions have bigger upsides if they succeed than the downsides if they fail.
Open & Mature (the highest level of Risk Appetite)	We are willing to innovate and choose options offering higher rewards, as delivery options provide an acceptable level of reward, meaning we accept there is just high risk in our wider context / business activities, and accept risk as a fact of life (just doing BAU) and therefore DON'T accept any risks bar the most consequential risks onto our Corporate Risk Register / SBAF. We are confident in our high levels of Risk Appetite, because either we have established risk controls, forward planning and responsive mitigations that are robust / our risk exposure is tolerable & accepted. Or we have accepted only the most Strategic Objective threatening risks onto the Risk Register, to keep the volume on there to the absolute lowest levels possible

These Risk Appetite / Risk Tolerance judgements will help us in setting realistic goals; allowing us to be ambitious, but not if the path to achieving our objectives is so risky that those goals are unlikely to be achieved. They help us identify targets that can be reasonably achieved, while maintaining a comfortable level of risk.

Meaning we are taking informed, risk-based decisions, based on clear baseline (understanding) of what kinds of risk we are or aren't willing to take. They give The Board / Committees / Senior Management a set of consistent guidelines within which to steer our future direction while maintaining appropriate risk levels.

(6) The Risk Management and Risk Assurance Process

Risks to delivery of Strategic Objectives and ICB Strategic Commissioner priorities may be identified through formal assessments or audits, discussion of current performance in Committee meetings, through triangulating with formal complaints, and ICB officer horizon scanning.

However they may be identified – including at the initial "is it a Risk or an Issue" triage set out in section (1b) – all Corporate Risk Register approved entries will include these as a minimum:-

The RISK - title, description, scoring (initial / inherent, residual / treated and target risk scores), the planned Controls & Assurances to reduce the scores as quickly as possible pre-ultimate closure of the risk, initial and post-Committee challenged updated mitigating actions, target dates, Risk Owner + Exec lead and lead oversight committee.

(a) Our Proposed Assurance Model =

ALL Risks and Strategic Objectives should adapt our multi-dimensional, 'Three Lines of Defence' Model, establishing the corporate hierarchy and indicated responsibilities in addressing these:-

(i) The Cluster SBAF for Strategic Risks (to delivery of Cluster Strategic Objectives);
(ii) The Cluster Operational Risk Register for live operational risks;
(iii) Cluster Directorate local risk logs for teams and programmes risks.

AND...

(i) First Line: Operational Management

Roles: Frontline Staff, Managers + Operational Leaders of Delivery + Quality Improvement teams // **Responsibility:** Owning, identifying, assessing, and mitigating risks in daily operations - they implement the Internal Controls required to keep risk within set tolerances

(ii) Second Line: Risk Oversight & Compliance

Roles: Risk Management Team, (Cluster) Board Assurance Committees per Terms of Reference governance & compliance functions // **Responsibility:** Defining policies, setting frameworks, monitoring effectiveness of the First Line and assurances reporting on risk to Audit Committee and Board, ensuring the First Line acts within well-defined limits

(iii) Third Line: Independent Assurance (Internal Audit)

Roles: Internal Auditors, reporting directly to the Board via Audit Committee // **Responsibility:** Providing independent and objective assurance on the efficiency & effectiveness of both the First and Second Lines

(b) Risk Identification and Analysis

Risk identification should be undertaken methodically by Risk Owners and their teams by reviewing significant areas of activity relating to delivery of ICB statutory duties, strategic objectives and commissioned services. This may arise through business planning,

performance monitoring, programme management processes, internal or external audit findings, or intelligence shared by the ICS partners.

Risk Owners are responsible for ensuring that potential risks are articulated clearly and in sufficient detail to allow an appropriate evaluation of both likelihood and consequence.

(c) Risk Description

All risks must be documented using the Cluster standardised format described above, ensuring the "IF – THEN – RESULTING IN" methodology is applied. This ensures clarity in distinguishing between the cause of the risk, the event which may occur, and the potential consequences for delivery of organisational objectives.

Each approved Risk Register entry must clearly set out the scope and nature of the risk, the relevant strategic objectives potentially affected (linking to the SBAF), and the relevant governance structure responsible for their oversight.

Internal Reporting and Risk Escalation Thresholds =

≥15 = Board; ***≥9*** = Board Assurance Committee; ***<8*** = Local Registers & Logs

Risk Score	Risk Level	Internal Reporting & Risk Escalation Threshold
0-8	Low Risk	Local Logs
9-14	Medium Risk	Committees
15-25	High Risk	ICB Board

(d) Risk Estimation / Risk Scoring

All identified risks will be assessed using the Cluster's agreed risk scoring approach, combining an assessment of Likelihood vs. Consequence to produce a numerical risk score between 0 and 25. However, the Cluster Governance Team proposes that we shift emphasis to using a new, hybrid approach developed by the Institute of Risk Management (IRM). With a 0-25 individual numerical scoring scale, rather than just the traditional Australia & New Zealand / NHS Likelihood versus Consequence[1] approach 5×5 scoring matrix alone.

Risk Owners will still use the traditional 5x5 Risk Scoring basis as the start-point: e.g. they can still score their risk a 4 for Likelihood (Likely) versus a Consequence of 5 (Almost Certain / Frequent) and obtain a High Risk Score of 20. But they would now instead have more flexibility to locally decide, per their new Risk Appetite, that 20 is just too high on the Risk Appetite dynamic, and so can opt to set their Inherent Risk Score at 19 instead. And then their proposed Risk Mitigations as Controls see a Residual Risk Score lower than this, and so on.

This approach allows risks to move incrementally up or down by single points as mitigation actions take effect, while still allowing risks to be categorised more broadly as High, Medium or Low segmentation (where High Risk is the crux rather than fixating on 16 versus 20 discussions that add little inherent value to the wider Cluster risk assurance discussion).

[1] The Likelihood Scale (1-5) = 1 - Rare/Very Unlikely: Almost inconceivable that the event will occur; 2 - Unlikely: Very unlikely to occur; 3 - Possible/Remote: Unlikely, but possible; 4 - Likely/Occasional: Likely to occur sometimes; 5 - Almost Certain / Frequent: Likely to occur many times. The Consequence Scale (1-5) = 1 - Insignificant: No or low financial impact; 2 - Minor: Minor impacts; 3 - Moderate: moderate impacts; 4 - Major: extensive impact; 5 – Catastrophic, like fatalities, massive damage.

As High Risks cannot ever score between 16 and 20, which can make it difficult to demonstrate gradual improvement or deterioration, and Risk Owners keeping their risk static at 16 or 20. The IRM scale allows a risk to reduce (or increase) progressively – e.g. from an initial 5x5 derived score of 20, then down to 19, 18, 17 then 16 – rather than remaining static on the Risk Register until a larger scoring change is justified.

The traditional 5×5 matrix generally ends up with inertia, Risk Management assurances becoming more restrictive; and seeing ultimately risks staying static and on registers for far too long for our new Risk Appetite.

This new scoring approach provides greater flexibility than traditional models by allowing incremental movement as mitigation actions are implemented or circumstances change. Risk Owners will therefore be able to demonstrate progressive movement of risks as mitigating actions take effect, rather than requiring large step-changes between scoring bands.

Each risk entry will still be expected to include:-

- ***Inherent Risk Score*** – the level at point of identification, prior to application of controls;
- ***Residual Risk Score*** – the level remaining after controls & mitigations are applied;
- ***Target Risk Score*** – the level felt acceptable in line with Cluster Risk Appetite Statements

Risk Owners must ensure that scoring decisions are proportionate, evidence-based and reviewed regularly as part of routine governance processes.

For more information and guidance on the new Risk Scoring Scale application see Appendix 1.

(e) Risk Evaluation

This enables the ICBs to determine whether a risk is acceptable within the Cluster's agreed Risk Appetite Statements; or whether additional mitigating action is required. Lead Committees will review risks within their Terms of Reference remit and determine whether risks should be:-

- Accepted within tolerance levels;
- Subject to challenge – further mitigation activity is required to be more assured;
- Escalated to a higher level of oversight (e.g. Board, Audit Committee or Internal Audit).

Where a risk poses a significant threat to delivery of agreed Strategic Objectives, escalation to the Board via the SBAF may be required.

(f) Risk Treatment

Where risks exceed the Cluster's agreed tolerance levels, Risk Owners must identify and implement appropriate mitigating actions. These should aim to reduce either the likelihood of the risk occurring or the severity of its potential impact. Typical treatment options may include:-

- Avoiding the activity giving rise to the risk – adding it to the register;
- Reducing or Managing the risk through improved controls or processes;
- Accepting the risk as BAU where it falls within the Cluster's defined Risk Appetite (either onto the register or not onto the register, as the case may be).

All mitigating actions must be recorded within the relevant Risk Register entry, with clear ownership and realistic target completion dates.

(g) Risk Monitoring and Review

Risks must be reviewed regularly by the assigned Risk Owner and Lead Committee to ensure that scoring, controls and mitigating actions remain current and reflective of the operational environment. Monitoring will include:-

- Regular review of Risk Registers by ICB Directorate Teams;
- Periodic review by Board Assurance Committees;
- Oversight by Audit Committees re. effectiveness of systems of internal control;
- Escalation to Boards where risks meet the agreed escalation thresholds.

Where risks reduce to acceptable levels and all mitigating actions have been completed, the relevant Committee may approve closure of the risk entry, with appropriate documentation retained for audit and assurance purposes.

(7) Training & Communication

The Governance Team will proactively raise awareness of this strategy across both ICBs and provide ongoing support to committees / individuals to enable them to discharge their responsibilities and reinforce risk culture. Members of the team can be contacted for formal training at team meetings (or other forums) by email: xxxx

Any individual who has queries regarding the content of the strategy, or has difficulty understanding how this relates to their role, should contact the Governance Team on: xxxx

The strategy will be published on Intranets. The document will be highlighted to new staff as part of the local induction process and made available to all staff through internal communication procedures (internet / intranet sites).

(8) Monitoring & Review

The Audit Committee will review the effectiveness of this strategy, and its implementation, via bi-annual targeted risk assurance update reporting. With the ICB Boards review the Cluster Risk Appetite on an annual basis.

Internal Audit will report on the implementation of this strategy as part of their annual Head of Internal Audit Opinion and audits conducted per the Audit Committees approved work programme. The Strategy itself will be reviewed every 3 years or earlier if required.

Appendix 1 – Guidance for Risk Owners on Applying the 0–25 Risk Scoring Scale

When recording risks on the Cluster Risk Register, Risk Owners must assign a numerical score between 0 and 25 to reflect the overall severity of the risk. This score should represent a combined judgement of both:-

- ✓ **Likelihood – how probable is it that the risk will occur (see below)**
- ✓ **Consequence (Impact) – how serious the outcome would be if it did (see below)**

Although the Cluster only uses the traditional 5×5 matrix as the starting-point assessment, Risk Owners should still use the same underlying considerations of Likelihood & Consequence when determining an appropriate Inherent Risk Score.

Assessing Likelihood (Probability / Frequence)

Likelihood refers to the probability or frequency with which the risk may occur. Risk Owners should consider historical trends, available evidence and professional judgement when assessing likelihood. Typical indicators include:-

- **Rare -** not expected to occur for several years; only in exceptional circumstances (<1% probability)
- **Unlikely -** could occur occasionally but not expected to happen frequently (approx. 1-5% probability)
- **Possible -** reasonable chance of occurring under certain conditions (approx. 6-20% probability)
- **Highly Likely -** expected to occur regularly if conditions remain unchanged (approx. 21-50% probability)
- **Almost Certain -** expected to occur frequently or more likely than not to happen (>50% probability)

These descriptors should guide judgement when determining where a risk sits on the overall 0-25 scale.

Assessing Consequence (Impact / Level of severity)

Consequence refers to the severity of the impact if the risk materialises. When assessing this, Risk Owners should consider the potential effect across relevant risk domains (e.g. patient safety, operational delivery, financial impact, reputation or regulatory compliance). Typical impact levels may include:-

- **Insignificant -** minimal disruption, negligible impact on delivery, very limited loss or damage
- **Minor -** short-term or locally manageable impact, small financial or operational consequence
- **Moderate -** more sustained impact requiring formal management action or intervention
- **Major -** serious impact with significant operational, financial or reputational consequences
- **Catastrophic -** severe impact affecting delivery of core services, at system or national level

Determining the Overall Risk Score

Risk Owners should use the above Likelihood & Consequence considerations to determine an overall score between 0 and 25, reflecting the combined severity of the risk.

The Cluster scoring bands are:

0–8: Low Risk (normally managed locally)

9–14: Medium Risk (normally overseen by Committees)

15–25: High Risk (normally escalated to Board level)

The individual scoring scale allows risks to move incrementally up or down by single points as mitigating actions take effect. This provides a more accurate reflection of gradual improvement or deterioration in risk exposure compared to the traditional matrix approach.

Risk Owners should ensure that scoring decisions are reasonable, evidence-based and proportionate, and should review scores regularly in consultation with the relevant Lead Committee.

Enclosure No: 09

Report to:	Integrated Care Board Meeting
Date:	30th April 2026
Title:	Equality Diversity and Inclusion Update to the Shropshire Telford and Wrekin Programme.
Presenting Officer:	Vanessa Whatley, Chief Nursing Officer Shropshire Telford and Wrekin
Author(s):	Vanessa Whatley, Chief Nursing Officer, Shropshire Telford and Wrekin

Document Type:				**Action Required (select):**			
Report	☒	**Business Plan**	☐	**Information (I)**	☐	**Discussion (D)**	☒
Strategy	☐	**Policy**	☐	**Assurance (S)**	☒	**Approval (A)**	☐
Other	☐	*(please describe)*		**Ratification (R)**	☐	*(check as necessary)*	

Is the decision within SOFD powers & limits	**Yes**	☐	**No**	☒
Any potential / actual Conflict of Interest?	**Yes**	☐	**No**	☒
If Y, the mitigation recommendations:	*E.g. Staff have Financial + Non-Financial Professional Interests which can be managed by recording those in minutes and allowing presence in discussions with recusals from formal decisions*			
Any financial impacts: ICB or ICS?	**Yes**	☐	**No**	☒
If Y, are those signed off by and date:	*E.g. Chief Finance Office, dd-mmm-yyyy*			
Any impacts on ICB Undertakings?	**Yes**	☐	**No**	☒
If Y, are those signed off by and date:	*E.g. Chief Finance Office, dd-mmm-yyyy*			
Appendices:	None			

(1) Purpose of the Paper:

This paper provides the ICB Board with assurance on collective Equality, Diversity and Inclusion (EDI) activity across the Shropshire, Telford and Wrekin Integrated Care System. It provides a summary of ongoing population focussed system work to progress on anti-racism commitments as directed by the Board, and to seeks alignment of this work within the wider system EDI framework.

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

(3) Implications:	
Legal / Regulatory	*ICB Statutory Duties*
CQC / Patient Safety	*Addressing equality, diversity and inclusion improves the quality of health and care provided to the population by supporting a more engaged, representative and inclusive workforce, strengthening organisational culture, and ensuring services are accessible, responsive and equitable for all communities.*
Financial (CFO-assured)	*n/a*
Sustainability	*n/a*
Workforce / Training	*Addressing equality, diversity and inclusion impacts the workforce by strengthening engagement and morale, improving retention and development opportunities, and creating a more inclusive and supportive working environment*
Equality & Diversity	*EDI should be reported regularly to the ICB Board to enable effective oversight, accountability and assurance on progress and impact.*
Due Regard: Inequalities	*ICBs must have regard to reducing inequalities in all of its activities*
Due Regard: wider effect	*ICBs must have regard to the wider impact in all of their decisions*

(4) Statutory Dependencies & Impact Assessments:

	Completed?			If N - N/A, Rationale	If Y, Outcome / Date Reported & Signed off
DPIA	**Yes**	**No**	**N/A**	Click or tap here to enter text.	*Reported to IG Committee:* Click or tap to enter a date.
	☐	☐	☒		
EIA	**Yes**	**No**	**N/A**	Click or tap here to enter text.	*Outcome and date of completion:* Click or tap here to enter text.
	☐	☐	☒		
QIA	**Yes**	**No**	**N/A**	*E.g. per QIA Policy, that it doesn't impact quality of services* Click or tap here to enter text.	*SRO sign-off, outcome & date of completion:* Click or tap here to enter text.
	☐	☐	☒		

Has there been Public / Patient Involvement?	**Yes**	**No**	**N/A**	*Click or tap here to enter text.*
	☐	☐	☒	

(5) Integration with SBAF (for NHS SSOT) / Strategic Risks (SR, for NHS STW)			
SBAF1 Responsive Patient Care - Elective	☐	**SBAF5** High Quality, Safe Outcomes	☒
SBAF2 Responsive Patient Care - UEC	☐	**SBAF6** Sustainable Finances	☒
SBAF3 Transforming Community Services	☐	**SBAF7** Improving Productivity	☒

SBAF4	Reducing Health Inequalities	☐	SBAF8	Sustainable Workforce	☒
SR1	Strategic Collaboration & Partnership	☐	SR4	ICS Workforce (retention/wellbeing)	☒
SR2a	ICB & System Financial Balance	☐	SR5	Digital & Data Systems / Strategy	☐
SR2b	ICB & System RRL / CRL Plans	☐	SR6	ICS Strategic Response (e.g. EPRR)	☐
SR3	Reducing Health Inequalities	☐	SR7	ICS Socio-Economic Development	☒
			SR8	Patient & Public Involvement	☐

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

This paper updates the ICB Board on collective Equality, Diversity and Inclusion (EDI) activity across the Shropshire, Telford and Wrekin Integrated Care System, undertaken in line with the Public Sector Equality Duty and the Board's commitment to tackling racial discrimination.

Following delivery of actions from the 2023 report on experiences of racism, system partners have continued collaborative work through the EDI Steering Group, including the Everyone Belongs Here campaign, participation in national research on racism in rural communities, and sharing best practice and lived experience.

This work supports consistent anti-racism action across the system alongside individual organisational responsibilities. It is now proposed that this activity is aligned within the wider system EDI framework to ensure sustainability and strategic coherence.

(7) Recommendations to Board:

- ☑ The Board is asked to note the report and take assurance on the progress being made in strengthening Equality, Diversity and Inclusion (EDI) in response to the report on the Perceptions and experience of racism in the workplace by health and social care staff in Shropshire Telford and Wrekin (2023).

- ☑ The Board is asked to endorse the strategic direction of travel, including the development of a cluster-based approach to EDI, and to support the integration of insights from this programme of work into a coherent, system-wide EDI framework that drives sustained improvement and impact.

1.0 Introduction

1.1 Public authorities are bound by the Public Sector Equality Duty to Eliminate unlawful discrimination harassment and victimisation, advance equality of opportunity and foster good relations.

1.2 The STW ICB Board had previously agreed to work collectively to support the activities to reduce discrimination with racial discrimination as a priority area in response to the report on the Perceptions and Experience of Racism in the Workplace by Health and Social Care Staff in Shropshire Telford and Wrekin (2023),the action for which was fully delivered following the report, however the Board supported jointly focussed work to continue on this important agenda

1.3 The Race Code sets out clarity and an accountability framework, that is designed to provide organisations across all sectors and sizes, with the opportunity to address a very specific challenge. This is shown by its 4-key Principles: Reporting, Actions, Composition and Education.

1.4 While individual organisations are bound by their own statutory requirements under section 149 of the Equality Act 2010 (the Public Sector Equality Duty), this paper provides an update on the collective action of the Integrated Care System (ICS) to address the EDI agenda as a collective action and progress against the strategic objectives agreed by the ICB Board.

2.0 Background

2.1 The ICB Board agreed strategic objectives for this work, as a below, and resourced board development on the legal basis of Equality, Diversity and Inclusion in November 2024. Specific collective action has featured on Objective 6: *Build an ICS that celebrates diversity, empowers change and recognises the impact of our health and care teams*, as previously reported.

1. Foster the development of rewarding careers across our ICS, ensuring they are free from discrimination and offer fair opportunities for all.
2. Lead collaboratively and take individual action to champion and continually elevate the EDI agenda.
3. Foster an inclusive and welcoming work culture where colleagues are supported and empowered to openly discuss EDI.
4. Ensure quality, equitable care for all by empowering people, improving access, enhancing outcomes and embracing diversity.
5. Celebrate our people and their contributions, while consistently and publicly reaffirming our commitment to EDI ambitions as a system.
6. Build an ICS that celebrates diversity, empowers change and recognises the impact of our health and care team

2.2 An STW System EDI Steering Group collaborates on actions to address this Objective whilst individual organisations have their own priorities and statutory requirements to meet organisational objectives.

2.3 This included raising the profile of EDI in the consistent actions of anti-racism at Board level and launching a system-wide communication campaign named Everyone Belongs Here. The remainder paper provides an update to the system actions.

3.0 Current direction

3.1 The System EDI Steering Group met in November 2025 and January 2026 with good system representation. The Group has an important role in information sharing and key outputs for the system as below:

3.2 Everyone Belongs Here

3.2.1 The Everyone Belongs Here campaign has been largely focussed on inclusion from a racial awareness perspective and has been widely used across the system. This is now being developed for Pride Month in June with a new set of materials and adapted design.

3.2.2 The EDI Steering Group is once again reaching out to colleagues across the system to support the campaign and take part in the development in communication products.

3.3 University of Leicester Research

3.3.1 As previously reported the University of Leicester has carried out an in-depth research project on racism in rural communities, with outputs including a film, associated poetry and creative works, and summaries of their findings regarding experiences of hostility and expressions of hostility.

3.3.2 Cornwall Integrated Care System, Leicestershire ICS and Shropshire, Telford and Wrekin ICS, with leadership from Shropshire Council has already participated in some of the actions from the output of the study and is now engaged in the next phases of the research study.

3.3.3 The University of Leicester submitted a funding bid to further progress the actions, including the co-development of an anti-racist policy/statement of intent for rural organisations. This contains evidence-based guidance on strategically addressing racism in rural spaces with other supportive systems with large rural area. NHS STW and Shropshire Council have engaged with this, and a successful funding bid is now in process of being actioned.

3.3.4 The objectives are

- ***To co-develop an anti-racism policy statement of intent for rural organisations, using the evidence base plus updates***
- ***To produce a national anti-racism policy briefing paper including key partners case studies***
- ***To develop a national policy webinar with open access online, to take place in September***

3.4 Sharing best practices

3.4.1 Two notable leaders in EDI have shared their experiences with the Group. Promise Monday, author of Cultural Fluency Without Compromise and paediatrician at SATH and Sherilyn Ndhlovu, EDI Midwife shared her work with those who birth and their families leading to her award as BAME midwife of the Year from the BAME Healthcare Awards, also from SaTH. The experience from these key people is discussed as how we influence conversations, engagement and co-production as a system.

4.0 Next steps

4.1 The EDI Steering Group remains committed to continuing and sharing good practice across the system as an informal network. However, following discussions with ICB executives, and in line with the ICB's strategic objectives, this work should now be considered for alignment and integration within the wider EDI agenda amalgamating it with workforce focus to address other priorities and system objectives across the clustered ICB.

5.0 Recommendations

5.1 The Board is asked to note the report and take assurance on the progress being made in strengthening Equality, Diversity and Inclusion (EDI) in response to the report on the Perceptions and experience of racism in the workplace by health and social care staff in Shropshire Telford and Wrekin (2023).

5.2 The Board is asked to endorse the strategic direction of travel, including the development of a cluster-based approach to EDI, and to support the integration of insights from this programme of work into a coherent, system-wide EDI framework that drives sustained improvement and impact.

Enclosure No: 10

Report to:	NHS Shropshire, Telford and Wrekin and NHSE Stoke and Staffordshire ICB Board in Common
Date:	30.04.2026
Title:	Public Sector Equality Duty (PSED) Workforce Reports 2025/26
Presenting Officer:	Mish Irvine, Chief of Staff
Author(s):	Sara Hayes, Head of People, OD & Inclusion SSOT, Granville Thelwell, EDI Business Partner, SSOT

Document Type:				**Action Required (select):**			
Report	☒	**Business Plan**	☐	**Information (I)**	☒	**Discussion (D)**	☐
Strategy	☐	**Policy**	☐	**Assurance (S)**	☒	**Approval (A)**	☐
Other	☐	*(please describe)*		**Ratification (R)**	☐	*(check as necessary)*	

Is the decision within SOFD powers & limits	**Yes**	☒	**No**	☐
Any potential / actual Conflict of Interest?	**Yes**	☐	**No**	☒
If Y, the mitigation recommendations:	*E.g. Staff have Financial + Non-Financial Professional Interests which can be managed by recording those in minutes and allowing presence in discussions with recusals from formal decisions*			
Any financial impacts: ICB or ICS?	**Yes**	☐	**No**	☒
If Y, are those signed off by and date:	*E.g. Chief Finance Office, dd-mmm-yyyy*			
Any impacts on ICB Undertakings?	**Yes**	☐	**No**	☒
If Y, are those signed off by and date:	*E.g. Chief Finance Office, dd-mmm-yyyy*			
Appendices:	Appendix A – STW PSED Workforce Equality Report; Appendix B – STW Workforce Diversity Profile; Appendix C – SSOT PSED Workforce Equality Report; Appendix D – SSOT Workforce Diversity Profile			

(1) Purpose of the Paper:

This paper outlines the ICB's response and actions relating to the data in the Appendices outlined above.

Equality reporting under the Public Sector Equality Duty (PSED) enables the Board to understand how effectively the ICBs are delivering the three core aims of the PSED, having *due regard* to the need to:

1. **Eliminate unlawful discrimination, harassment and victimisation**

2. **Advance equality of opportunity** between people who share a protected characteristic and those who do not

3. **Foster good relations** between people who share a protected characteristic and those who do not

By examining patterns in recruitment, retention, progression, and staff experience across protected characteristics, this reporting provides essential insight into where inequalities persist and where targeted action is required. Considering the information in these reports ensures transparency, strengthens accountability, and supports evidence-based decision-making so that we can create a fair, inclusive, and high-performing organisation that reflects and serves our communities.

This paper focuses on **Workforce Diversity Reporting** in both ICBs, providing the Board with the information required for oversight and assurance, proposing a new and seeking permission to publish these reports and the cluster corporate workforce equality objective for 2026 – 2026 on our webpages.

The ICB's PSED reports in relation to our patients are in progress and will be shared by the end of June 2026.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	Date
Expand as necessary if the report went to multiple meetings	

(3) Implications:	
Legal / Regulatory	*Ensuring alignment to our Public Duty in relation to Equality Diversity and Inclusion.*
CQC / Patient Safety	*Assurance that our patients are not receiving inequitable care.*
Financial (CFO-assured)	*n/a*
Sustainability	*n/a*
Workforce / Training	*Ensuring alignment to our Public Duty in relation to Equality Diversity and Inclusion and supporting the continued development of a diverse engaged workforce.*
Equality & Diversity	*Meeting our Public Duty in relation to Equality and Diversity.*
Due Regard: Inequalities	*Ability to identify areas for continuous improvements and to drive data driven priorities and objective setting in relation to Equality and Diversity.*
Due Regard: wider effect	*Evidencing due regard in relation to Equality Impact on wider activity.*

(4) Statutory Dependencies & Impact Assessments:

	Completed?			If N - N/A, Rationale	If Y, Outcome / Date Reported & Signed off
DPIA	**Yes**	**No**	**N/A**	*Not required*	*Reported to IG Committee:* Click or tap to enter a date.
	☐	☐	☒		
EIA	**Yes**	**No**	**N/A**	*Not required*	*Outcome and date of completion:* Click or tap here to enter text.
	☐	☐	☒		
QIA	**Yes**	**No**	**N/A**	*E.g. per QIA Policy, that it doesn't impact quality of services Not required*	*SRO sign-off, outcome & date of completion:* Click or tap here to enter text.
	☐	☐	☒		
Has there been Public / Patient Involvement?	**Yes**	**No**	**N/A**	*Not required*	
	☐	☐	☒		

(5) Integration with SBAF (for NHS SSOT) / Strategic Risks (SR, for NHS STW)

SBAF1	Responsive Patient Care - Elective	☒	**SBAF5**	High Quality, Safe Outcomes	☒
SBAF2	Responsive Patient Care - UEC	☒	**SBAF6**	Sustainable Finances	☐
SBAF3	Transforming Community Services	☐	**SBAF7**	Improving Productivity	☐
SBAF4	Reducing Health Inequalities	☒	**SBAF8**	Sustainable Workforce	☒
SR1	Strategic Collaboration & Partnership	☐	**SR4**	ICS Workforce (retention/wellbeing)	☒
SR2a	ICB & System Financial Balance	☐	**SR5**	Digital & Data Systems / Strategy	☐
SR2b	ICB & System RRL / CRL Plans	☐	**SR6**	ICS Strategic Response (e.g. EPRR)	☐
SR3	Reducing Health Inequalities	☒	**SR7**	ICS Socio-Economic Development	☒
			SR8	Patient & Public Involvement	☐

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

Public Sector Equality Duty Reporting

This report provides a high level summary of key equality, diversity and inclusion metrics for each ICB. Enclosed with this report are two reports for each ICB which together form our PSED Workforce reports.

The **Workforce Profile reports** provide a breakdown of the ICB workforce and the population demographic as seen through the lens of each Protected Characteristic, so that we can consider how representative the workforce is of the populations we serve.

The **PSED - Workforce reports** provide the wider workforce equality, diversity & inclusion context, drawing evidence from the staff survey, the way the ICB approaches staff engagement, communication, training & development and staff networks, as well as delivering the specific statutory duties of Gender Pay reporting and the prevention of workplace sexual harassment.

Given the Cluster transitional landscape, and the fact that organisational design, team structures and workforce data remain fluid, each ICB has produced its own **separate PSED Workforce Report and Workforce Profile Report** for the 2025–26 cycle. This approach ensures clarity, accuracy and accountability against each organisation's statutory obligations under the Public Sector Equality Duty (PSED) at a time when structures are not yet fully aligned.

The information contained within the reports indicates that the clustered ICBs have some key opportunities in workforce EDI to ensure that colleagues from all underrepresented groups experience our recruitment and employment in a fair and equitable way.

Next Steps on Reporting

As the cluster arrangements mature and the new workforce model becomes fully embedded, it is anticipated that future reporting cycles will move towards **joint cluster workforce reporting**. This will allow for a more unified view of equality, diversity and inclusion across the cluster footprint, support consistent workforce planning, and promote shared learning and improvement across both ICBs.

As the Management of Change concludes, as the ICBs have appointed to the new roles, there will be the opportunity to reprofile and analyse the reshaped workforce, establish a refreshed and reliable baseline, and use this to accurately benchmark the cluster ICBs before setting future EDI objectives, risk mitigations, and targeted actions.

Corporate Workforce Equality Objective 2026-2028

It is important that we have a corporate strategic direction for our work that addresses evidenced structural workforce inequalities identified in the reports through proportionate and accountable action, and at the same time enables the ICBs to meet the requirement to have such an objective as part of the Public Sector Equality Duty (PSED). The proposed objective is:

To reduce structural inequalities in the cluster ICB workforce by improving representation, fairness in recruitment and progression, and the workplace experience of Disabled, Ethnic Minority and other underrepresented groups through accountable leadership, fair processes, and a safe, inclusive culture.

The objective is underpinned by an EDI Workforce Action Framework which focuses on leadership accountability, fair processes, workforce experience and culture, and is proportionate to the

inequalities evidenced within workforce data and staff experience. To support and enable delivery of this Framework the ICBs have taken the opportunity to build PSED responsibilities proportionate to the Band of the role into every new job description, so that it becomes a normal and expected part of everyone's role.

The proposed framework comprises five inter-related action areas:

1. Board-level, measurable EDI objectives and accountability
2. Fair and inclusive recruitment and talent management
3. Develop and implement plans to eliminate pay gaps
4. Address workforce health inequalities and experience gaps
5. Eliminate bullying, discrimination, harassment and violence

Through delivery of this framework, by 2027/28 the clustered ICBs aspire to demonstrate:

- A measurable and proportionate improvement in workforce representation.
- Increased transparency and fairness in recruitment and progression.
- Stronger organisational conditions that support psychological safety, inclusion and fair treatment.
- Greater confidence and trust in workforce equality monitoring processes.
- Clear, consistent and proportionate EDI leadership accountability across the cluster.

(7) Recommendations to Board:

The Board are asked to consider the report and its Appendices and consider:

i. Consider whether the information contained provides appropriate information from which to propose evidence-based objectives and actions; and
ii. Consider whether there is assurance of compliance with the statutory Public Sector Equality Duty in relation to Workforce; and
iii. Approve the cluster corporate PSED Workforce Objective for 2026 – 2028; and
iv. Approve publication of the reports and the cluster corporate PSED Workforce Objective for 2026 – 2028 on each ICB's respective external digital platform.

Public Sector Equality Duty (PSED) Workforce Reports 2025/26

2.1 Introduction

2.1.1 The purpose of this paper is to provide the Board with an overview of the evidence available to demonstrate compliance with the Public Sector Equality Duty in respect of its workforce.

2.2 Background

2.2.1 The ICBs operate within a clear and comprehensive statutory framework of Equality legislation that considers both workforce and the populations we serve.

2.2.2 This statutory framework includes duties under the Equality Act 2010, the Public Sector Equality Duty (PSED) and associated Specific Duties Regulations, all of which require the elimination of discrimination, the advancement of equality and the fostering of good relations, alongside annual publication of compliance information and the setting of four yearly Equality Objectives. Additional obligations apply through the Gender Pay Gap Regulations and recent amendments to the Equality Act introduced strengthened duties to prevent workplace sexual harassment.

2.2.3 Additionally, the Human Rights Act 1998 further mandates that all ICB functions uphold the FREDA principles of Fairness, Respect, Equality, Dignity and Autonomy. Equally, the Health and Care Act 2022, imposes the general inequality duty that the ICB must have explicit regard to reducing inequalities in access to services and health outcomes across its population.

2.2.4 By examining patterns in recruitment, retention, progression, and staff experience across protected characteristics, this reporting provides essential insight into where inequalities persist and where targeted action is required. Considering the information in these reports ensures transparency, strengthens accountability, and supports evidence-based decision-making so that we can create a fair, inclusive, and high-performing organisation that reflects and serves our communities.

2.2.5 Given this transitional landscape, and the fact that organisational design, team structures and workforce data remain fluid, each ICB has produced its own separate PSED Workforce Report and Workforce Profile Report for the 2025–26 cycle. This approach ensures clarity, accuracy and accountability against each organisation's statutory obligations under the Public Sector Equality Duty (PSED) at a time when structures and wider governance are not yet fully aligned.

2.3 Context and Headline Position for each ICB

2.3.1 The accompanying reports provide a detailed analysis of the equality, diversity and inclusion characteristics of each ICB's workforce. There are some variations due to the way in which each ICB has historically gathered information and reported on this important area.

2.3.2 A very high-level summary of the information shows:

SSOT	STW
Workforce Profile by Protected Characteristics	
• Workforce Age profile weighted to mid/late career; under 25s are most under-represented as a proportion of the population.	• Workforce Age profile weighted to mid/late career; under 25s are most under-represented as a proportion of the population.
• Disability declaration by staff has risen for the 4th consecutive year to 7.9%, but non-disclosure also increased.	• Disability declaration by staff is 8.9%.
• Ethnic diversity has increased for the 3rd consecutive year and 9.9% of the workforce are non-white.	• Ethnic diversity demonstrates 10.2% of the workforce are non-white.
• Workforce remains strongly female (81.6%) and male representation has decreased since 2024.	• Workforce is strongly female (79.6%)
• Directorate variation in profiles, demonstrating a need for tailored EDI action planning.	• No data at Directorate level

SSOT	STW
Recruitment Overview 2025	
• Diversity at application stage, which varies through the stages of appointment – for example:	• Diversity at application stage, which varies through the stages of appointment – for example:
○ Global majority applicants: 46% of applicants → 11.5% appointed.	○ Global majority applicants: 55.2% of applicants → 6.8% appointed.
○ Disabled applicants: 10.8% of applicants → 2.9% appointed.	○ Disabled applicants 8.3% applied → 8.5% appointed.
○ Under 25s: 3.8% of applicants → none were shortlisted.	○ Under 25s: 6.4% applied → 1.4% shortlisted → none were appointed.

SSOT	STW
Gender Pay Gap	
• GPG reduced but remains: 27.7% (average) and 19.5% (median).	• GPG: 26.93% (average) and 16.36% (median).

2.3.3 The information contained within the reports indicates that the clustered ICBs have some key opportunities in workforce EDI, such as:

- The development of shared EDI standards, harmonised governance, and consistent PSED delivery across both ICBs.
- Redesign of recruitment, reasonable adjustments, and EHIA processes in the context of the cluster to strengthen fairness and compliance.
- The potential to reset workforce culture and embed inclusive leadership through cluster wide development.
- Re-energising staff networks as embedded structures will strengthen lived experience insight and decision making.

2.3.4 During 2026–27, the ICB will focus on aligning policies, data practices, leadership responsibilities and cultural expectations across the cluster to create a coherent and collaborative EDI agenda. The intention is to build a shared framework that supports inclusive employment practices, improves workforce experience, and ensures that both ICBs continue to meet their statutory duties while adapting to the evolving reform landscape.

2.3.5 Finally, throughout this period of transformation, and the development of new shared leadership structures the ICB remains committed to fulfilling its PSED responsibilities. Equality considerations continue to be integral to decision-making, organisational design, and the support offered to our workforce during this complex period of change.

2.4 Corporate Workforce Equality Objective 2026–2028

2.4.1 To meet the requirements of the Public Sector Equality Duty (PSED), the clustered ICBs are required to set a corporate workforce equality objective that addresses evidenced structural workforce inequalities through proportionate and accountable action.

2.4.2 Using the evidence presented within this report and the accompanying Workforce Diversity Profile Reports, the clustered ICBs propose the following joint Corporate Workforce Equality Objective:

To reduce structural inequalities in the cluster ICB workforce by improving representation, fairness in recruitment and progression, and the workplace experience of Disabled, Ethnic Minority and other underrepresented groups through accountable leadership, fair processes, and a safe, inclusive culture.

2.4.3 Corporate equality objectives can be set for a period of up to four years. However, in recognition of the transitional nature of the cluster arrangements during 2026/27 and the intention to formally merge during 2027/28, it is proposed that this workforce equality objective is set for a two-year period. A new corporate workforce equality objective will be developed once organisational arrangements are fully embedded and a stable workforce baseline has been established.

2.5 Proposed EDI Workforce Action Framework 2026–2028

2.5.1 To support and enable delivery of the Corporate Workforce Equality Objective, the ICBs have developed a proposed EDI Workforce Action Framework for 2026–2028. This framework focuses on leadership accountability, fair processes, workforce experience and culture, and is proportionate to the inequalities evidenced within workforce data and staff experience. The development of actions, delivery and monitoring of outcomes will be the responsibility of the collective Board, however the newly created Cluster Chief of Staff role (which has a strong people focus) will be crucial in creating direction to take this forward collectively. The decision of the Chair and CEO to invest in, and appoint, a Chief of Staff that has significant experience in HR and the wider people agenda is an important step in supporting this work and demonstrating that it is a priority for the organisation.

2.5.2 The proposed framework comprises five inter-related action areas:

Action 1: Board-level, measurable EDI objectives and accountability

- Carrying out a Board- level Inclusion development programme which has been developed internally to ensure that Executives are able to meaningfully represent those with protected characteristics in our Commissioning plans.
- Board – level inclusion objectives which will be devolved to clear, measurable EDI objectives for senior leaders and directorates across both ICBs.
- Strengthen consistent expectations for inclusive behaviours and leadership practice through cluster-wide governance and leadership development.
- Improve training and knowledge regarding EDI which has already commenced via an Anti-Racist programme which has been developed and being delivered by System partners across the clustered ICBs.

- **Action 2**: Fair and inclusive recruitment and talent management – the clustered ICBs are particularly focused on improving the participation and career development of colleagues with protected characteristics within our workforce, so will continue to develop our work which embeds the 6 High Impact Recruitment Actions:

  - Further develop inclusive recruitment standards across both ICBs, including equality audits and training for recruitment panels – it is possible that positive action be taken to improve the participation of colleagues from ethnic minority backgrounds.
  - The ICBs will work, via the Ethnic Minority staff forum, to explore and better understand the feedback regarding career progression for this group and an action plan will be agreed and implemented.
  - Monitor and address disproportionality for Sex (Male/Female), Broad Race/Ethnicity and Disabled applicants, applying lawful positive action where appropriate. A particular focus will be taken on improvements in the area of Race/Ethnicity.
  - Expand early-career and targeted entry routes, including internships and apprenticeships, to increase representation of under-represented groups, particularly under-25s.

  Action 3: Develop and implement plans to eliminate pay gaps

  - Develop a cluster-wide approach to Gender, Race and Disability Pay Gap reporting, in preparation for forthcoming legislative requirements.
  - Publish targeted improvement actions annually once full reporting duties apply.

  Action 4: Address workforce health inequalities and experience gaps

  - Provide targeted support for staff by Disability, Broad Race/Ethnicity and “prefer not to say” groups, and for directorates with lower scores in career progression, psychological safety, or fairness.
  - Strengthen timely access to reasonable adjustments and improve consistency and quality of workforce equality data across both ICBs.

- Reduce non-disclosure across protected characteristics, particularly within senior and Non-AfC roles.

Action 5: Eliminate bullying, discrimination, harassment and violence

- Deliver directorate-specific culture and behaviour improvement plans to strengthen fairness, respect and psychological safety, informed by staff experience insights and targeting areas of persistent inequality.
- Reinforce a consistent cluster-wide approach to respectful behaviour, early resolution and anti-discrimination practice, supported by harmonised HR, OD, EDI and Reasonable Adjustment policies.

2.5.3 Through delivery of this framework, by 2027/28 the clustered ICBs aspire to demonstrate:

- A measurable and proportionate improvement in workforce representation.
- Increased transparency and fairness in recruitment and progression.
- Stronger organisational conditions that support psychological safety, inclusion and fair treatment.
- Greater confidence and trust in workforce equality monitoring processes.
- Clear, consistent and proportionate EDI leadership accountability across the cluster.

2.6 Conclusion

2.6.1 The report provides the context, legacy reporting position and current workforce reporting to enable the ICBs to propose evidence-based objectives and actions for coming years and demonstrate the ICBs have delivered their statutory Public Sector Equality Duty in relation to workforce matters for 2025-26.

2.6.2 Work to finalise the ICB's Public Sector Equality Duty reports in relation to patient matters for 2025-26 will be concluded and shared by June 2026.

2.6.3 Equality, diversity and inclusion is a key part of the success of the clustered ICBs as a strategic commissioner, whether in terms of strategic commissioning for the reduction of health inequalities, or reducing workforce inequalities.

2.7 Recommendation(s)

2.7.1 The Board are asked to consider the report and its Appendices and consider:

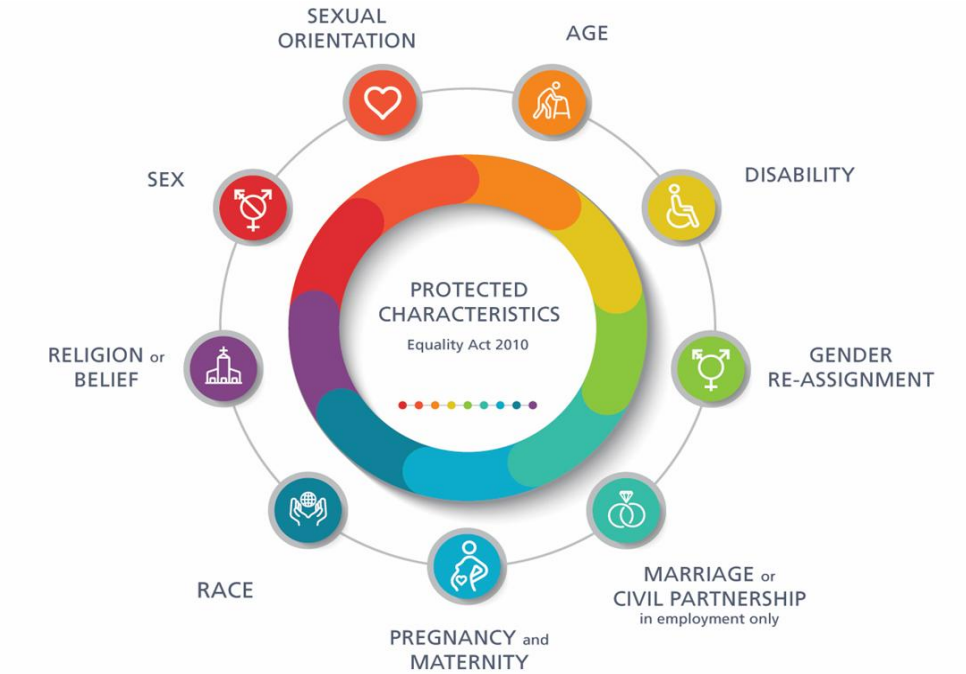
i. Consider whether the information contained provides appropriate information from which to propose evidence-based objectives and actions; and

ii. Consider whether there is assurance of compliance with the statutory Public Sector Equality Duty in relation to Workforce; and
iii. Approve the cluster corporate PSED Workforce Objective for 2026 – 2028; and
iv. Approve publication of the reports and the cluster corporate PSED Workforce Objective for 2026 – 2028 on each ICB's respective external digital platform.

Mish Irvine
Chief of Staff
April 2026

Shropshire, Telford and Wrekin Integrated Care Board Public Sector Equality Duty (PSED) Equality, Diversity, and Inclusion Annual Report 2025/2026

Workforce Equality



Documents or information from the Shropshire, Telford and Wrekin ICB website or key publications can be made available in alternative formats (such as audio, Clear Information, Easy Read, British Sign Language, interpreter services, large print, or Braille) on request.

Please contact the general reception number (01782 29800) and speak to any member of the administration team. Alternatively, deaf, and hard of hearing patients, carers and staff can use the Next Generation Text service.

Contents

Introduction

PSED Annual Report (Workforce)

Shropshire, Telford & Wrekin ICB

The 2025–26 reporting period has been a year of organisational transition for Shropshire, Telford and Wrekin Integrated Care Board (ICB). As the ICB continues to embed the ambitions of the ICB Blueprint and respond to the direction set within the NHS Long Term Plan, our operating environment has evolved considerably. In parallel, the development of the cluster arrangement with Staffordshire and Stoke-on-Trent ICB has created new opportunities for shared leadership, alignment of functions, and a more collaborative approach to workforce planning.

These developments have inevitably shaped the focus and pace of our Equality, Diversity and Inclusion (EDI) work. While our statutory responsibilities under the Public Sector Equality Duty (PSED) remain unchanged, the organisational restructuring required to support the Blueprint and cluster model has, at times, taken priority. As a result, some EDI workforce initiatives were paused or deferred to ensure safe transition of services, clarity of roles, and stability for our people during a period of significant operational change.

Despite these challenges, the ICB has continued to fully commit to and act on, its duty to eliminate discrimination, advance equality of opportunity, and foster good relations across its workforce. This report outlines the activity undertaken over the year to meet our PSED requirements, highlights areas of progress, and acknowledges where work will resume once structural changes are fully embedded. Importantly, it provides a transparent account of how system-level transformation has influenced our capacity, our priorities, and the shape of our future workforce EDI programmes.

Looking ahead, the alignment created through the cluster arrangement presents a renewed opportunity to build a stronger, more consistent approach to EDI across organisational boundaries. As our new structures settle, the ICB remains committed to strengthening its culture, embedding equality into decision making, and ensuring that our workforce reflects, represents, and is equipped to serve the diverse communities of Staffordshire and Stoke-on-Trent. making, and ensuring that our workforce reflects, represents, and is equipped to serve the diverse communities of Staffordshire and Stoke-on-Trent.

Population Profiles Shropshire, Telford and Wrekin.

Shropshire

Population

2024

332,455

people

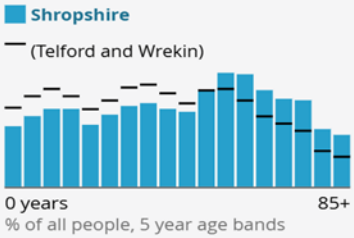
195,952 people in Telford and Wrekin

Source: ONS – Mid-year estimates

Small area: Output area

Age profile

2024



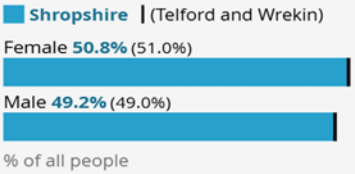
% of all people, 5 year age bands

Source: ONS – Mid-year estimates

Small area: Output area

Sex

2024



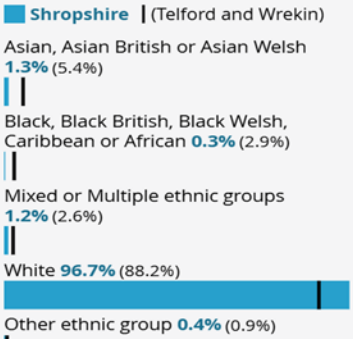
% of all people

Source: ONS – Mid-year estimates

Small area: Output area

Ethnic group

2021



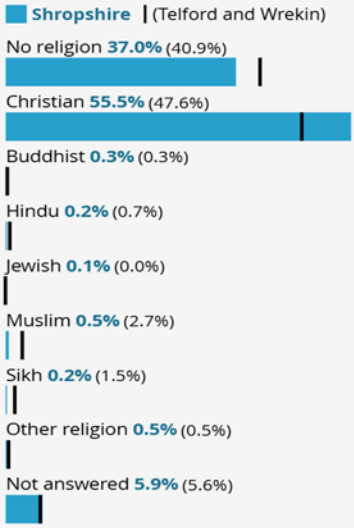
% of all people

Source: ONS - Census 2021

Small area: Output area

Religion

2021



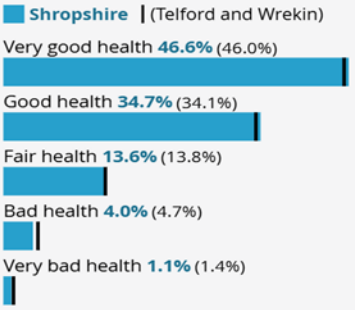
% of all people

Source: ONS - Census 2021

Small area: Output area

General health

2021



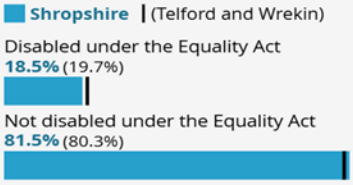
% of all people

Source: ONS - Census 2021

Small area: Output area

Disability

2021



% of all people

Source: ONS - Census 2021

Small area: Output area

Sexual Orientation – Shropshire (Census 2021 – ONS)

Shropshire Council and the ONS have published clear local-level data:

2.3% of Shropshire residents aged 16+ identified as **LGB+** (Gay/Lesbian, Bi, or "Other sexual orientation").

Telford & Wrekin (Census 2021 – ONS) The searches returned no published, specific LGB+ percentage for Telford & Wrekin as a whole.

Shropshire, Telford and Wrekin (STW) ICB serves a geographically mixed population, spanning large rural areas alongside smaller urban centres. Shropshire has one of the oldest populations in England, alongside younger, more ethnically diverse and deprived communities, particularly in Telford. Wrekin's more rural and semi-rural areas are generally less deprived and closer to national averages. The population experiences complex health and care needs, including higher prevalence of long-term conditions, mental health need, disability and frailty, compounded by rurality. Shropshire is one of the least densely populated areas in the West Midlands, impacting on service access and workforce stability pressures e.g. workforce supply and recruitment. Marked inequalities exist between affluent rural and suburban areas and pockets of deprivation, contributing to variation in life expectancy, healthy life years and health outcomes across STW

Equality legislation

Equality Act 2010 and its Public Sector Equality Duty (PSED)

The Public Sector Equality Duty came in to force in April 2011 (s.149 of the Equality Act 2010) and public authorities like the NHS are now required, in carrying out their functions, to have due regard to the need to achieve the objectives set out under s149 of the Equality Act 2010 to:

(a) eliminate discrimination, harassment, victimisation, and any other conduct that is prohibited by or under the Equality Act 2010.

(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.

(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The Equality Act 2010 (Specific Duties) Regulations 2011 require the ICB to:

- Publish information to show compliance with the PSED, at least once a year.
- Produce Equality Objectives at least every four years.

The Equality Act 2010 (Gender Pay Gap Information) Regulations 2017

- These Regulations impose obligations on employers with 250 or more employees to publish information relating to the gender pay gap in their organisation.

The Equality Act 2010 was amended in 2024 to include new duties aimed at preventing sexual harassment in the workplace. These changes came into force on October 26, 2024, under the Worker Protection (Amendment of Equality Act 2010) Act 2023.

Human Rights Act 1998

The Human Rights Act 1998 sets out universal standards to make sure that an individual's basic needs as a human being are recognised and met. Public authorities have a mandated duty to ensure they have arrangements in place to comply with the Act.

It is unlawful for a healthcare organisation to act in any way that is incompatible with the Act. In practice, this means we must treat individuals with Fairness, Respect, Equality, Dignity and Autonomy – known as the FREDA principles.

Click here to read more about the Human Rights Act (equalityhumanrights.com).

Associated legislation - Health and Social Care Act 2022

Statutory obligations on ICBs under the NHS Act 2006 (as amended by the Health and Care Act 2022)

Section 14Z35 of the 2006 Act (as added by section 25(2) of the 2022 Act) imposes the general inequality duty on an ICB that it: must, in the exercise of its functions, have regard to the need to:

1. reduce inequalities between persons with respect to their ability to access health services.

- reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services (including the outcomes described in section 14Z34(3).

ICB Equality Objectives 2025

Equality Objective 2025/26 – Workforce Equality
Foster the development of rewarding careers across our ICS, ensuring they are free from discrimination and offer fair opportunities for all.
Lead collaboratively and take individual action to champion and continually elevate the EDI agenda.
Foster an inclusive and welcoming work culture where colleagues are supported and empowered to openly discuss EDI.
Ensure quality, equitable care for all by empowering people, improving access, enhancing outcomes and embracing diversity.
Celebrate our people and their contributions, while consistently and publicly reaffirming our commitment to EDI ambitions as a system.

Build an ICS that celebrates diversity, empowers change and recognises the impact of our health and care teams

Workforce Equality

Improving the Diversity Profile

Shropshire, Telford and Wrekin Care Board (ICB) continues to move through a period of organisational transformation driven by the requirements of the national Government NHS reset, the response to the nationally published ICB Blueprint, the NHS Long Term Plan, and the development of the emerging cluster arrangement with Staffordshire and Stoke-on-Trent ICB. These changes are reshaping our leadership structures, workforce configuration and future operating model.

During 2025 - 26, a major milestone was achieved with the appointment of the cluster Executive Team, establishing shared strategic leadership across the two ICBs. Building on this, the organisation is now progressing through the next phase of the Management of Change (MoC) process, which focuses on redesigning the senior management team structures within the ICB. This work is essential to ensuring clear governance, aligned responsibilities and the right leadership capacity for the new cluster model. A final, wider restructure of the remaining ICB workforce will follow once senior structures are fully established.

Running in parallel to the MoC activity is an ongoing Voluntary Redundancy (VR) programme, which has been introduced to support workforce realignment, ensure organisational affordability, and provide staff with choice and stability during a period of structural change. The VR programme forms one of several mechanisms enabling the ICB to transition safely and responsibly into its future operating arrangements, while continuing to mitigate the impact on staff wherever possible.

Given this transitional landscape, and the fact that organisational design, team structures and workforce data remain fluid, each ICB has produced its own separate PSED Workforce Report and Workforce Profile Report for the 2025–26 cycle. This approach ensures clarity, accuracy and accountability against each organisation's statutory obligations under the Public Sector Equality Duty (PSED) at a time when structures are not yet fully aligned.

As the cluster arrangements mature and the new workforce model becomes fully embedded, it is anticipated that future reporting cycles will move towards joint cluster workforce reporting. This will allow for a more unified view of equality, diversity and

inclusion across the cluster footprint, support consistent workforce planning, and promote shared learning and improvement across both ICBs.

Throughout this period of transformation including MoC, VR activity, and the development of new shared leadership structures, the ICB remains committed to fulfilling its PSED responsibilities. Equality considerations continue to be integral to decision-making, organisational design, and the support offered to our workforce during this complex period of change.

Workforce Diversity Profile Report

Overview

This summary describes what the workforce of Shropshire, Telford and Wrekin Integrated Care Board looked like at the end of September 2025. At that point the ICB employed 323 people. The figures below represent percentages only, to protect anonymity.

STW ICB has a predominantly female, older, white workforce, with increasing but still limited representation of younger staff and disabled staff.

Some protected characteristic groups are broadly in line with, or above, local population averages (e.g., ethnicity), while others (notably disability and younger age groups) show lower representation. Diversity patterns vary across pay bands, with senior roles showing higher non-disclosure rates for several characteristics and stronger male representation.

Workforce Profile – Key Patterns

Age

- The ICB has a mainly older workforce, with fewer younger employees than the local population.
- Only 0.9% of staff are aged 16–25, compared with around 9–12% in the local area.
- Most staff are aged 35–64, especially within senior roles.
- This pattern is typical of organisations with a large number of specialist and senior non-clinical roles.

Disability

- 8.1% of staff have declared a disability.
- Around 7.1% of staff chose not to share this information.
- This declared rate is lower than the local working-age population, where disability prevalence is about 20%.
- Disability non-disclosure is highest among senior (Non-AfC) staff.

Marriage and Civil Partnership

- Most staff are married (58.2%).
- 22.6% are single, and 10.2% are divorced.
- A small proportion are in civil partnerships (1.24%).
- Some information is unknown, and this varies by pay group.

Ethnicity/Race

- 10.2% of staff are from ethnic minority backgrounds, which is slightly higher than the combined Shropshire, Telford and Wrekin population average of 8.7%.
- Asian staff are well represented across all pay bands.
- Black staff are represented in bands 1–4 and 8a–9.
- Staff from mixed backgrounds appear mainly in lower pay bands.
- Because the overall workforce is small, small changes in staff numbers can shift percentages.

Religion and Belief

- Christianity is the most declared religion.
- A high proportion (26.9%) chose not to give information about religion or belief.
- Non-disclosure is especially high for senior (Non-AfC) roles, where over 70% did not state a religion.

Sex (Female/Male)

- The workforce is 79.6% women and 20.4% men.
- This is similar to national NHS patterns, where women make up around three-quarters of the workforce.
- At senior (Non-AfC) levels, men are proportionally more represented.
- Men are under-represented in pay bands 1–7.

Sexual Orientation

- 3.1% of staff identify as lesbian, gay or bisexual.
- 73.9% identify as heterosexual.
- 22.6% chose not to declare their sexual orientation.
- Non-disclosure is highest among senior (Non-AfC) staff.

Other Characteristics

Religion and sexual orientation disclosures remain inconsistent, with particularly high nondisclosure in Non-AfC roles.

Full-Time and Part-Time Working

- 61.6% of staff work full-time and 38.4% part-time.
- Part-time working is more common in some pay bands than others.
- Senior (Non-AfC) roles lean more towards part-time and sessional patterns of working.

Recruitment Profile (Oct 2024–Sep 2025)

1228 people applied → 215 were shortlisted → of which 161 interviewed → with 59 applicants appointed.

Findings

- Younger and Black ethnic applicants are less represented in final appointments than at the application stage. Under 25yrs (6.4% of applicants; 0% appointed) Black (30.3 of applicants – 1.7% appointed)
- Nondisclosure rates are high at the appointment stage for several characteristics including Disability 33.9% and Religion and Belief 42.4%, making it harder to establish diversity profile.
- Disabled applicants show representation at shortlisting and interview, but this does not carry through to appointments.

Areas of focus

- Making it easier and reassuring for new starters to share their equality information (if they choose to).
- Looking closely at each stage, especially shortlisting and final decision-making, to understand why patterns differ for some groups.
- Continuing good practice that supports disabled applicants through each step of the process.

Overall Conclusion

As ICB reform and cluster arrangements with continue, establishing a consistent cluster ICB approach to workforce equality and PSED delivery will be crucial for accountability and improved outcomes.

The Workforce Diversity Profile Report also provides a workforce profile of the ICB at organisation-level and a profile of all the applicants who applied for posts within the ICB. This data shows how applicants by protected characteristics faired across the different recruitment stages.

Workforce Race Equality Standard (WRES) & Workforce Disability Equality Standard

NHS Integrated Care Boards (ICBs) are not mandated to produce Workforce Race Equality Standard (WRES) or Workforce Disability Equality Standard (WDES) reports. These requirements primarily apply to NHS Trusts and Foundation Trusts. However, we are encouraged to adopt the principles of these standards and apply

them as much as possible to our own workforce. This is reflected in this and our Workforce Diversity Profile report.

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

While ICBs are not mandated to produce standalone Workforce Race Equality Standard (WRES) or Workforce Disability Equality Standard (WDES) reports, they are encouraged to adopt and apply the principles of these standards within their workforce equality work. STW ICB has reflected these principles within its Public Sector Equality Duty (PSED) reporting for this cycle.

STW adopt WRES and WDES fully as a way of embedding equality considerations through its own longstanding workforce reporting practices. As governance, data processes and operating models across the cluster become more closely aligned, both ICBs aim to move toward a single, harmonised approach towards WRES and WDES. This unified model will strengthen diversity, transparency, comparability and shared learning, supporting improved equality outcomes across the cluster.

Gender Pay Gap (GPG) Report

Substantial changes are expected as the ICB Reform measures including new cluster structures and Management of Change processes are completed.

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

The ICB remains committed to transparency and to addressing gender-based inequalities and will continue to monitor developments closely throughout this period of transition.

Average & Median Hourly Rates 2025

Gender	Avg. Hourly Rate	Median Hourly Rate
Male	£35.36	£27.49
Female	£25.83	£22.99
Difference	£9.52	£4.50
Pay Gap %	26.93%	16.36%

Average Hourly Rate Pay Gap

The difference in the average hourly rate between Male and Female is £9.52 which equates to 26.93% in percentage terms.

Median Hourly Rate Pay Gap

The difference in the median hourly rate between Male and Female is £4.50 The pay gap in percentage terms being 16.36%

The reasons for variations in hourly pay rates between male and female staff may result from a range of factors, including:

- Women increasingly taking up roles historically occupied by men, such as digital, technical or IT functions.
- A higher proportion of women working part-time in Non-AfC pay structures, which may influence hourly rate comparisons and progression patterns.
- Women moving into specialist or sessional roles that were previously male-dominated, creating shifts in average pay calculations.
- Vacancy and turnover trends where male staff have left senior or specialist posts and replacements have not yet been appointed.
- Men remaining proportionately over-represented in the most senior roles within the workforce, as seen in the higher pay quartiles, which continues to influence the gender pay gap.

It is also worth noting that when working with small staff numbers any variation in these numbers can have, what may appear to be, disproportionate changes in percentages.

The ICB combined workforce by female or male as at 30/09/2025 was as follows:

- Female Staff 79.6%
- Male Staff 20.4%

The above figure can be used to give an approximation if the quartiles are representative of the ICB workforce profile by sex.

Proportion of Male and Female Staff by Quartile Pay Bands 2025

Quartile	Female	Male	Female %	Male %
1. Lower	69	7	90.79%	9.21%
2.	72	11	86.75%	13.25%
3.	55	20	73.33%	26.67%
4. Higher	60	29	67.42%	32.58%

Staff Survey

The NHS Staff Survey results are aimed at NHS organisations, to inform local improvements in staff experience and well-being. Several ICBs took the decision to not participate in the national Staff Survey in 2025 due to the scale of the national change programme. It is positive that both NHS STW and NHS SSoT took part and had strong levels of engagement.

The Staff Survey offers a snapshot in time of how people experience their working lives, gathered at the same time each year. The tables below are staff responses to a sample of questions disaggregated by protected characteristics.

This year's staff survey results must be viewed in the context of the organisational change taking place within the ICB. The ongoing restructure and the cluster development have all shaped how people are experiencing work during this period.

The relevant Staff Survey Questions are:

Q14b Not experienced harassment, bullying or abuse from managers.	Q14c Not experienced harassment, bullying or abuse from other colleagues.	Q15 Organisation acts fairly, career progression.
Q16b Not experienced discrimination from manager/team leader or other colleagues	Q17 Not experienced unwanted behaviour of a sexual nature from other colleagues.	Q21 Feel organisation respects individual differences

Key	Overall ICB staff survey response %.	Green – at least 3% above overall staff response	Red - at least 3% below overall staff response	Amber - within 3% of overall staff response	* Below reporting threshold of 10 staff

Protected Characteristic data for Gender Re-assignment, Maternity & Pregnancy, Marriage, and Civil Partnership are not collated or analysed

Analysis of the 2025 NHS Staff Survey responses, disaggregated by protected characteristics, provides important insight into how different groups experience their working environment.

Across most protected characteristics, results for harassment, bullying, discrimination, career progression and organisational respect remain broadly aligned with overall organisational averages. However, several groups show clear disparities that require focused PSED action.

In the tables below, the key is as follows:

* Indicates the total staff responses was less than ten.

STW Workforce by Age		Comparator (Organisation Overall)	16-20	21-30	31-40	41-50	51-65	66+
Q	Description	n = 229	n = 0	n = 16	n = 56	n = 62	n = 89	n = 2
q14b	Not experienced harassment, bullying or abuse from managers	93.4%	*	100.0%	94.5%	90.3%	94.3%	*
q14c	Not experienced harassment, bullying or abuse from other colleagues	92.1%	*	100.0%	94.6%	82.3%	95.5%	*
q15	Organisation acts fairly: career progression	54.4%	*	68.8%	50.0%	56.5%	52.8%	*
q16b	Not experienced discrimination from manager/team leader or other colleagues	96.5%	*	100.0%	98.2%	93.5%	96.6%	*
q17b	Not experienced unwanted behaviour of a sexual nature from other colleagues	99.1%	*	100.0%	100.0%	100.0%	98.9%	*
q21	Feel organisation respects individual differences	73.2%	*	75.0%	75.0%	75.8%	69.7%	*

Summary

Younger staff (21–30) reported highly positive experiences, including 100% not experiencing harassment or bullying from managers or colleagues. In contrast, staff aged 41–50 reported lower experiences of positive colleague behaviour (82.3% versus 92.1% overall). This may indicate a need to explore cultural or team-level issues affecting mid-career staff.

STW Workforce by Disability		Comparator (Organisation Overall)	Yes	No
Q	Description	n = 229	n = 56	n = 169
q14b	Not experienced harassment, bullying or abuse from managers	93.4%	96.4%	92.8%
q14c	Not experienced harassment, bullying or abuse from other colleagues	92.1%	92.9%	91.7%
q15	Organisation acts fairly: career progression	54.4%	55.4%	54.4%
q16b	Not experienced discrimination from manager/team leader or other colleagues	96.5%	91.1%	98.2%
q17b	Not experienced unwanted behaviour of a sexual nature from other colleagues	99.1%	100.0%	99.4%
q21	Feel organisation respects individual differences	73.2%	71.4%	74.6%

Summary

Disabled staff generally showed similar levels of positive experience to non-disabled colleagues across most indicators. However, a notable gap appears in discrimination (Q16b), with disabled staff reporting 91.1% versus 98.2% for non-disabled colleagues.

STW Workforce by Race/Broad Ethnicity Groups		Comparator (Organisation Overall)	White	Mixed/ Multiple ethnic groups, Asian/ Asian British, Black/ African/ Caribbean/ Black British, Other ethnic groups
Q	**Description**	**n = 229**	**n = 208**	**n = 16**
q14b	Not experienced harassment, bullying or abuse from managers	93.4%	94.2%	87.5%
q14c	Not experienced harassment, bullying or abuse from other colleagues	92.1%	92.3%	87.5%
q15	Organisation acts fairly: career progression	54.4%	56.3%	31.3%
q16b	Not experienced discrimination from manager/team leader or other colleagues	96.5%	98.1%	75.0%
q17b	Not experienced unwanted behaviour of a sexual nature from other colleagues	99.1%	99.5%	100.0%
q21	Feel organisation respects individual differences	73.2%	75.0%	56.3%

Summary

This remains the area of greatest inequality. Minority ethnic staff reported lower scores on harassment/ bullying from both managers and colleagues (87.5% vs comparators of 93.4% and 92.1%). The largest disparity is in career progression fairness (31.3% vs 56.3% for White staff). Similarly, only 75% reported not experiencing discrimination, compared with 98.1% for White staff

STW Workforce by Sex (Female/Male)		Comparator (Organisation Overall)	Female	Male	Non-binary	Prefer to self-describe:	Prefer not to say
Q	Description	n = 229	n = 173	n = 37	n = 0	n = 0	n = 17
q14b	Not experienced harassment, bullying or abuse from managers	93.4%	94.7%	91.9%	*	*	82.4%
q14c	Not experienced harassment, bullying or abuse from other colleagues	92.1%	93.0%	89.2%	*	*	88.2%
q15	Organisation acts fairly: career progression	54.4%	56.1%	51.4%	*	*	47.1%
q16b	Not experienced discrimination from manager/team leader or other colleagues	96.5%	96.5%	100.0%	*	*	87.5%
q17b	Not experienced unwanted behaviour of a sexual nature from other colleagues	99.1%	99.4%	100.0%	*	*	94.1%
q21	Feel organisation respects individual differences	73.2%	74.0%	81.1%	*	*	47.1%

Summary

Women and men reported broadly similar outcomes, with women slightly more positive on several indicators. The “prefer not to say” group scored lower, including 47.1% on career progression.

Workforce by Sexual Orientation		Comparator (Organisation Overall)	Heterosexual or straight	Gay or Lesbian	Bisexual	Other	I would prefer not to say
Q	Description	n = 229	n = 197	n = 2	n = 5	n = 2	n = 20
q14b	Not experienced harassment, bullying or abuse from managers	93.4%	95.4%	*	*	*	80.0%
q14c	Not experienced harassment, bullying or abuse from other colleagues	92.1%	92.3%	*	*	*	90.0%
q15	Organisation acts fairly: career progression	54.4%	57.4%	*	*	*	40.0%
q16b	Not experienced discrimination from manager/team leader or other colleagues	96.5%	98.0%	*	*	*	89.5%
q17b	Not experienced unwanted behaviour of a sexual nature from other colleagues	99.1%	99.5%	*	*	*	95.0%
q21	Feel organisation respects individual differences	73.2%	77.2%	*	*	*	45.0%

Summary

Heterosexual staff rated their experience close to or above the organisational average.
As in other categories, “prefer not to say” reported weaker outcomes (e.g., 40% for career progression fairness).

STW Workforce by Religion or Belief		Comparator (Organisation Overall)	No religion	Christian	Buddhist, Hindu, Muslim, Sikh	Any other religion (please specify)	I would prefer not to say
Q	Description	n = 229	n = 89	n = 104			n = 21
q14b	Not experienced harassment, bullying or abuse from managers	93.4%	92.1%	98.0%	*	*	81.0%
q14c	Not experienced harassment, bullying or abuse from other colleagues	92.1%	88.8%	95.1%	*	*	85.7%
q15	Organisation acts fairly: career progression	54.4%	52.8%	65.4%	*	*	28.6%
q16b	Not experienced discrimination from manager/team leader or other colleagues	96.5%	98.9%	98.1%	*	*	90.0%
q17b	Not experienced unwanted behaviour of a sexual nature from other colleagues	99.1%	100.0%	99.0%	*	*	95.2%
q21	Feel organisation respects individual differences	73.2%	78.7%	78.8%	*	*	42.9%

Summary

Christian, no-religion, and minority-faith groups reported experiences broadly aligned with or better than organisational averages. Minority-faith staff reported particularly strong scores on several indicators. However, the “prefer not to say” group again reported low levels of fair treatment (28.6% for career progression).

	STW Workforce by Directorate	Comparator (Organisation Overall)	Corporate & Communications	Delivery	Executives & Governing Body	Finance, Comm, Cont and Perf	Med, Prim Care, Dig & Pharm	Nursing & AACC	People & Training	Strategy and Develop
Q	Description	n = 229	n = 14	n = 30	n = 10	n = 44	n = 45	n = 66	n = 11	n = 9
q14b	Not experienced harassment, bullying or abuse from managers	93.4%	78.6%	100.0%	100.0%	88.6%	93.2%	93.8%	100.0%	*
q14c	Not experienced harassment, bullying or abuse from other colleagues	92.1%	85.7%	86.7%	90.0%	95.5%	95.5%	89.4%	100.0%	*
q15	Organisation acts fairly: career progression	54.4%	42.9%	53.3%	80.0%	72.7%	31.1%	54.5%	70.0%	*
q16b	Not experienced discrimination from manager/team leader or other colleagues	96.5%	100.0%	96.6%	100.0%	95.5%	95.6%	95.5%	100.0%	*
q17b	Not experienced unwanted behaviour of a sexual nature from other colleagues	99.1%	100.0%	100.0%	100.0%	97.7%	97.8%	100.0%	100.0%	*
q21	Feel organisation respects individual differences	73.2%	71.4%	76.7%	90.0%	81.8%	64.4%	68.2%	90.0%	*

Summary

Staff experience differs across directorates, indicating local leadership and culture are key determinants of staff wellbeing:

- Corporate & Communications reported lower results, particularly 78.6% for not experiencing harassment from managers.
- Finance, Commissioning, Contracting & Performance show strong results across most indicators, including multiple 100% scores.
- Med, Prim Care, Dig & Pharm showed weaker perceptions of career progression (Q15) 31.1 % and organisational respect, with Q21 at 64.4%.

- Executives & Governing Body along with People and Training report consistently strong experiences, albeit with small staff numbers.

Directorate variation highlights the need for localised cultural improvement plans rather than a single organisational approach.

Overall Summary

Overall, Staff Survey evidence demonstrates that the ICB maintains strong organisational level performance on key behavioural indicators. However, disaggregated results highlight inequalities most notably for minority ethnic staff, disabled staff (in relation to discrimination), and individuals who choose not to disclose protected characteristics. Directorate level variation further reinforces the need for targeted cultural and leadership interventions.

This evidence will inform the ICB's actions to eliminate discrimination, advance equality of opportunity, and foster good relations across its workforce in line with PSED requirements.

ICB corporate communications and involvement – Staff

We keep our workforce engaged and informed through a range of activities, including:

- Team Huddle – usually held via Microsoft Teams fortnightly on a Tue. If an urgent communication is needed, we will arrange a special Team Brief
- Regular Messaging –
    - for sharing key messages about process, policy and system updates
    - a message directly from the Chief Executive Officer, Simon Whitehouse. These are stored on the intranet – Shro & Tel.
    - monthly meetings with staff/partner representatives for the sharing of feedback and organisation updates.

ICB priorities for 2026/2027

As the ICB enters 2026–27, a key organisational priority will be progressing the next phase of the **ICB Reform Blueprint** and operationalising the newly formed cluster between **Shropshire, Telford & Wrekin (STW) ICB** and **Staffordshire & Stoke-on-Trent (SSoT) ICB**. This new cluster arrangement creates an opportunity to strengthen consistency, reduce duplication, and develop a shared approach to equality, diversity and inclusion (EDI) and the Public Sector Equality Duty (PSED). Establishing common standards, governance expectations and ways of working will be central to ensuring both ICBs operate with clarity, fairness and transparency in how workforce decisions are made.

During 2026–27, the ICB will focus on aligning policies, data practices, leadership responsibilities and cultural expectations across the cluster to create a coherent and collaborative EDI-PSED agenda. The intention is to build a shared framework that supports inclusive employment practices, improves workforce experience, and ensures that both ICBs continue to meet their statutory duties while adapting to the evolving reform landscape. This work will require sustained engagement, careful change management and a continued emphasis on staff wellbeing and communication throughout the transition.

Future Joint Reporting Intentions:

From 2026, STW and SSoT ICBs will move to a single cluster workforce profile and implementation of a joint equality objective and action plan following completion of the MoC.

Shropshire, Telford and Wrekin Integrated Care Board

Workforce Diversity Profile Report 2025

This report was produced by the ICB EDI/People Team December 2025

Introduction

This is Shropshire Telford and Wrekin (STW) Integrated Care Boards (ICB) workforce diversity profile report . Public authorities with over 150 employees must consider its employee profile and if it representative of the communities it serves, if staff are treated equitably and without discrimination. This information should be published considering protected characteristics.

This report will focus on two areas, the workforce profile of the ICB and the recruitment process. Other activities and outcomes in relation to workforce equality diversity and inclusion e.g. , training and development, staff engagement, staff experience and feedback, health and wellbeing will be captured in the ICB's 2025-26 Public Sector Equality Duty Annual report which will be published in March 2026.

The report provides a profile of ICB staff in post as of the 30.09.2025 which at that point totalled 323. To preserve anonymity staff numbers are replaced with percentages as to make it difficult to identify individual staff. It is worth considering that when working with relatively small figures, small changes in staff numbers can substantially alter the demographic profile of a workforce.

At a Shropshire Telford and Wrekin system level, the ICB continue to work with NHS providers and wider partners to make the local area a better place to work in a movement towards an 'One Workforce' approach where the greatest impact can be had by affecting change across the whole local workforce.

This year, STW ICB has produced a separate workforce profile rather than a joint report with Shropshire, Telford and Wrekin (STW) ICB. This reflects our current organisational differences, including how workforce data is structured, reported, and published. Each ICB operates under distinct governance and reporting frameworks, which makes a combined profile unfeasible at this time. However, we remain committed to ongoing alignment and will revisit this approach once formal clustering arrangements are in place and organisational changes, including any workforce transitions, have been completed

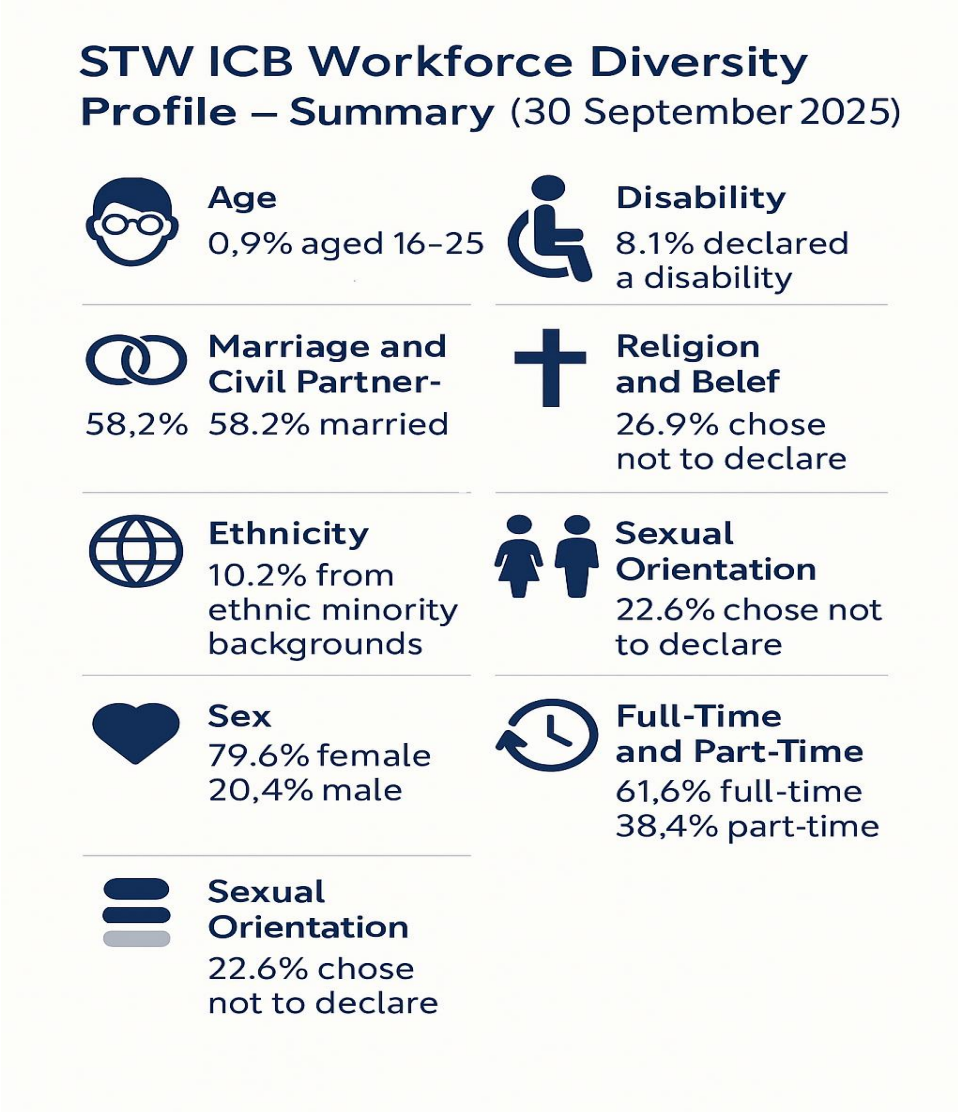
Note: Figures have been rounded up to one decimal place. Afc which is used within the tables is an abbreviation for Agenda for Change Pay Scales

Shropshire Telford and Wrekin Integrated Care Board.

ICB

Workforce Profile

Summary



STW ICB has a predominantly female, older, White workforce, with increasing but still limited representation of younger staff and disabled staff.

Diversity patterns vary across pay bands, with senior roles showing higher non-disclosure rates for several characteristics and stronger male representation.

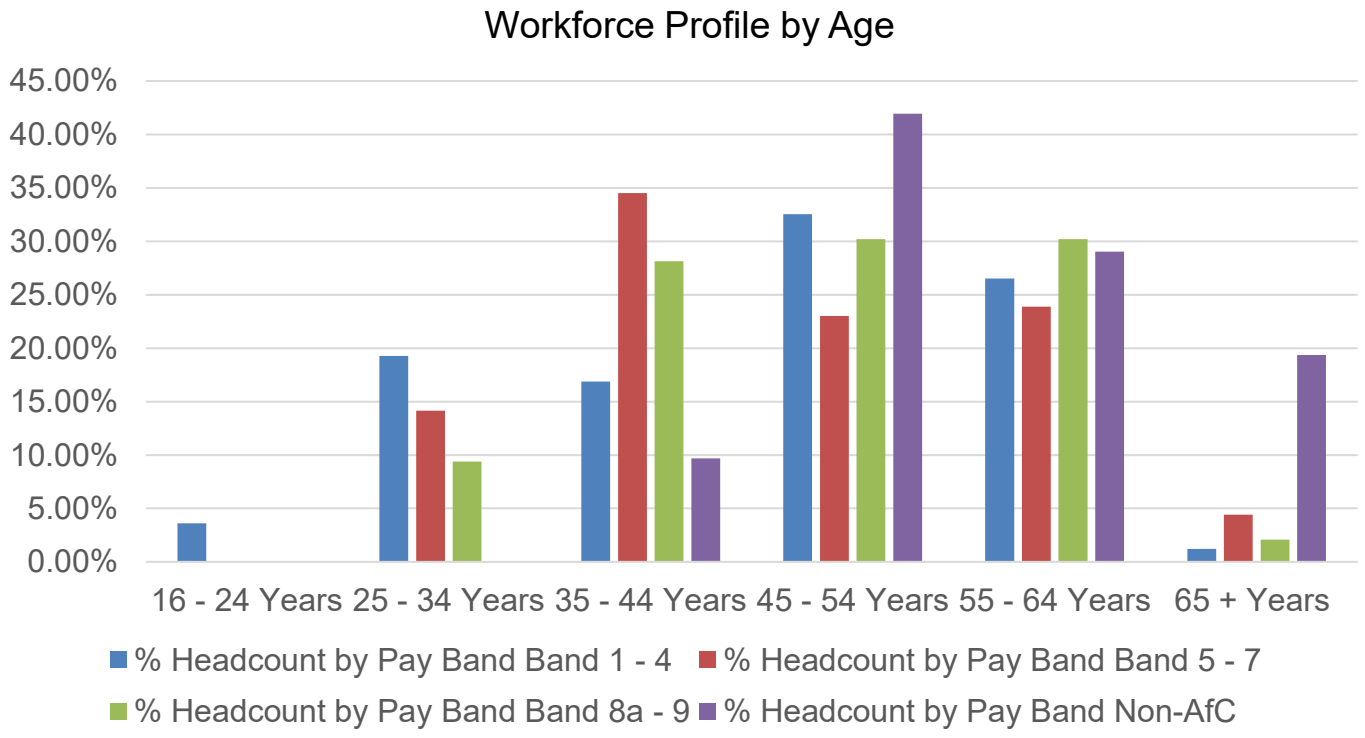
Some protected characteristic groups are broadly in line with, or above, local population averages (e.g., ethnicity), while others (notably disability and younger age groups) show lower representation.

Age

The overall Integrated Care Boards workforce profile by age varies across pay bands: (under 25yrs 0.9%), (25-34 yrs 12.7%), (35-44 yrs 25.7%), (45-54 yrs 29.4%), (55-64 yrs 29.6%), and (65yrs+ 4.3%)

Age: The ICB's weighted towards a more mature workforce with under 25-year-old staff underrepresented as a proportion of the population. For example, 16–24 age range represents 8.9% of the population for Shropshire. Telford and Wrekin 16-25 years is estimated at 12%. Estimated because the published public tables aggregate by decades; they don't report 16–25 directly

The workforce dynamics of an ICB differs when compared with NHS Provider Trusts. There are proportionately higher numbers of senior non-clinical positions. This may be one reason why there are lower numbers of staff in the under 25 age range. The Table below show ICB staff in post as of the 30th September by age ranges and pay bands.



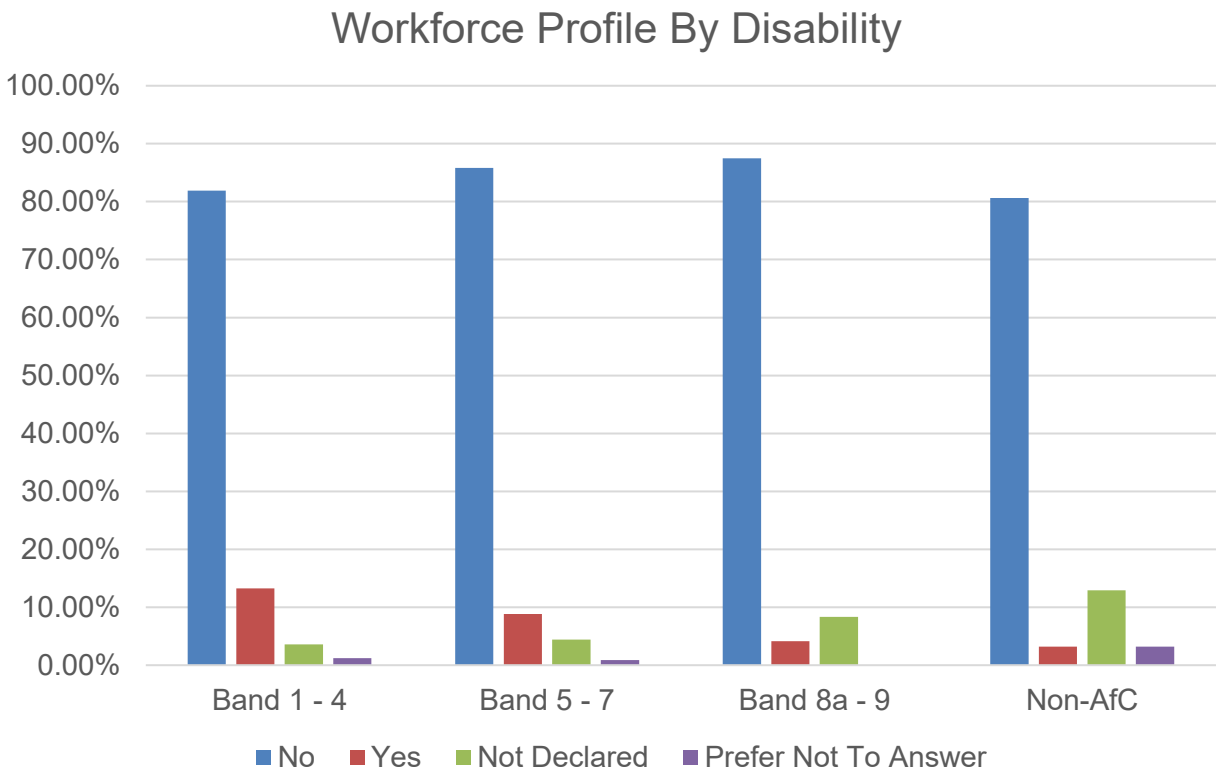
2025: 16 – 25 yrs olds as a percentage of the ICB workforce **0.9 %**

Disability

The proportion of the working age population with a declared disability is approximately 20% (NOMIS).

Declared disability rates: STW 8.9%. Local population prevalence approx. 20%. Even assuming staff who declared or preferred not to say having a disability did have a disability, this would only 15.2% which is below population levels.

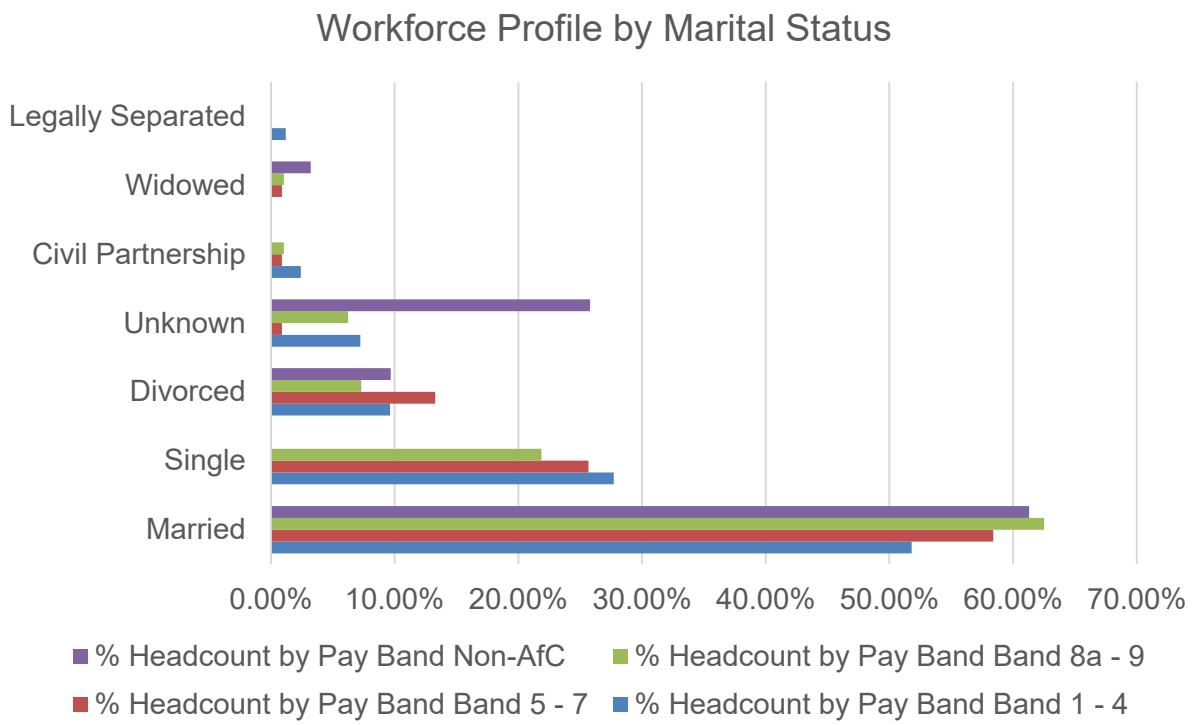
Though the number of Non Afc staff who did identify has having a disability has increased from 2.9% to 6.1%. The non-declaration rate for this pay group of 15.2 % is relatively high compared to other staff pay bands.



2025 all ICB Staff by Disability 8.1% . Not declared/preferred not to say 7.1%

Marriage and Civil Partnership

The percentage figure of ICB staff identifying has being in a civil relationship for this reporting period was 0.4% this is above the combined Shropshire Telford and Wrekin (STW) profile figure of 0.2%. 61.7% of the ICB workforce identified has being married which is higher than the (STW) profile figure of 50%. The highest pay band group who identify as married were bands 8a-9 with 62.5%. 6.5% of staff's marital status is unknown across the whole workforce though this figure varies across pay bands. The lowest being bands 5-7 with 0.9% not disclosing and Non-Afc band the highest nondisclosure rate of 25.8%

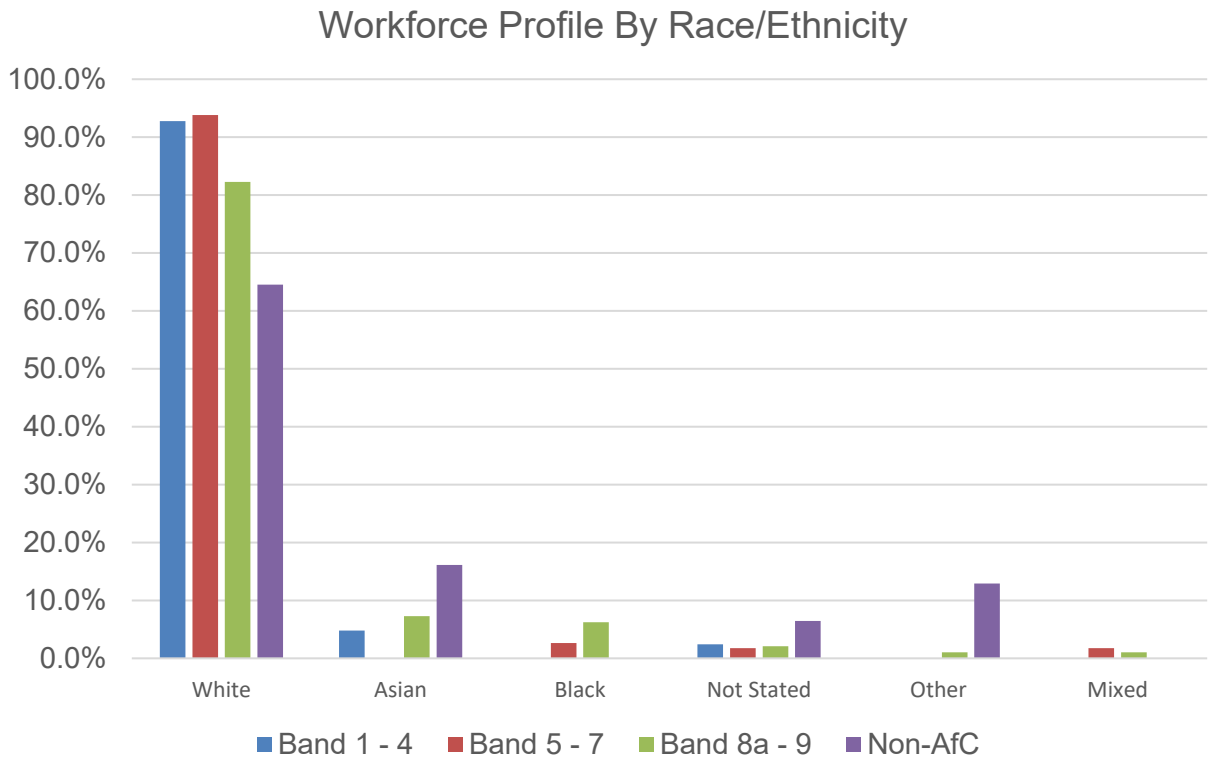


2025 all ICB Staff by Marital Status

Married	**58.20%**
Single	**22.60%**
Divorced	**10.22%**
Unknown	**6.50%**
Civil Partnership	**1.24%**
Widowed	**0.93%**
Legally Separated	**0.31%**

Race

The combined average percentage of the non-white population in Shropshire Telford and Wrekin is approximately 8.69%. The combined Asian population is approximately 4.8%, Mixed 2.2% Black 1.2% When using this average, the percentage of Asian staff are positively represented across all pay bands. Black staff are positively represented in bands 1-4 (2.4%) and 8a-9 (1.4%). Staff who identify as mixed heritage are positively represented at the lower bands. As mentioned at the top of this report consideration should be given when working with relatively small figures, as small changes in staff numbers can substantially alter the demographic profile of a workforce in percentage terms.



2025 all ICB Staff:
Non-White Staff 10.2% -
White Staff 87.3%
Not stated 2.5%

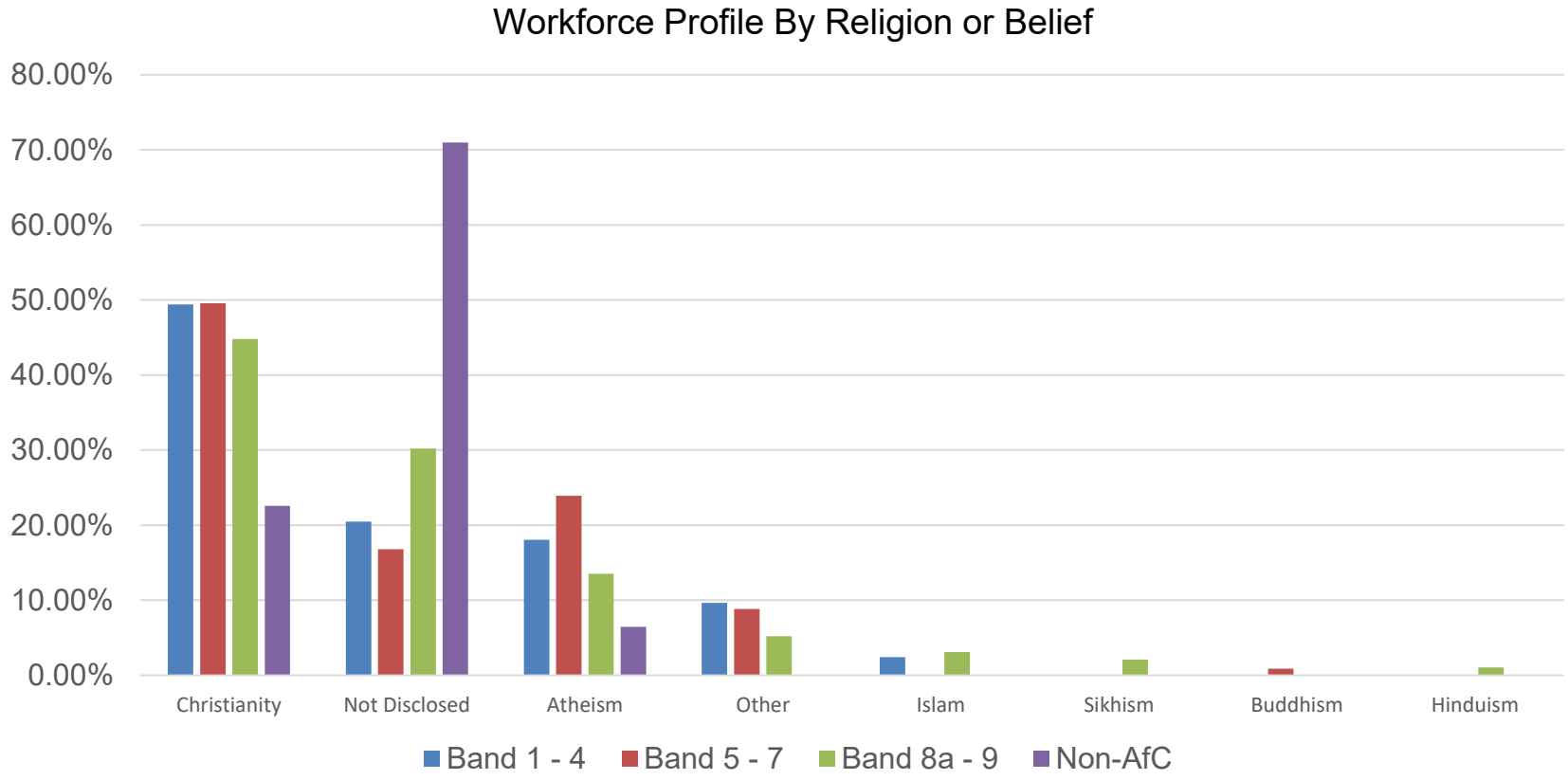
*The Census Bureau defines a person of the Asian race as “having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Religion and Belief

According to the 2021 Census: Shropshire is more traditionally Christian, older population profile, and lower religious Diversity. Telford & Wrekin: More diverse, younger population, and higher share of non-religious residents.

High non-disclosure: 26.9%. Christianity is the most declared faith. It is difficult to confirm representativeness across the ICB due to high non-disclosure.

A theme in relation to religion and belief is the percentage of all staff across all pay bands who did not wish to disclose this information with the highest levels in the Non Afc Pay Band 70.97 %



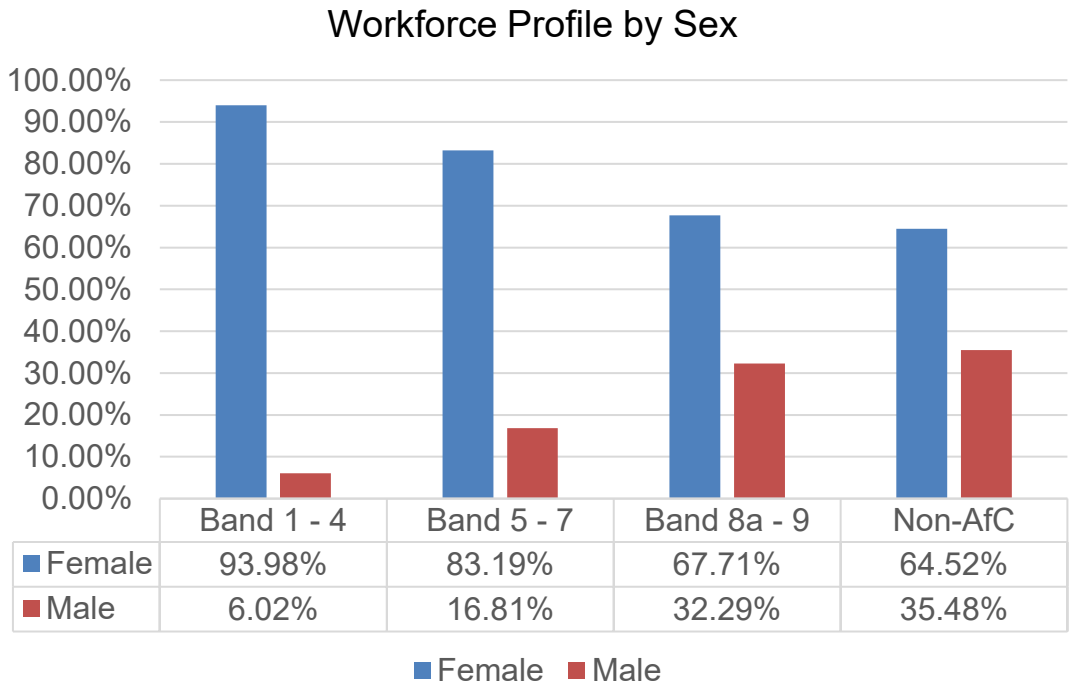
2025 all ICB Staff: Nondisclosure rate 26.9%

Sex
(Female Male)

Female and Males both make up 50% of the overall Shropshire Telford and Wrekin (STW) population.

Health and Social Care is one of the public sectors where women thrive in terms of representation. The NHS workforce totals 1.3 million staff, of which 76.7% are women (2021 NHS England) This figure of 76.7% is similar with the ICB workforce demographic of 79.6% of the workforce being women and 20.4% men. While the NHS has traditionally been a female dominated sector these figures are not represented at senior levels.

When looking at the more senior and (non-AfC) roles, male staff are overrepresented as a proportion of the ICB workforce. Males are underrepresented at both pay band groupings 1-4 (6%) and 5-7 (16.8%) respectively.

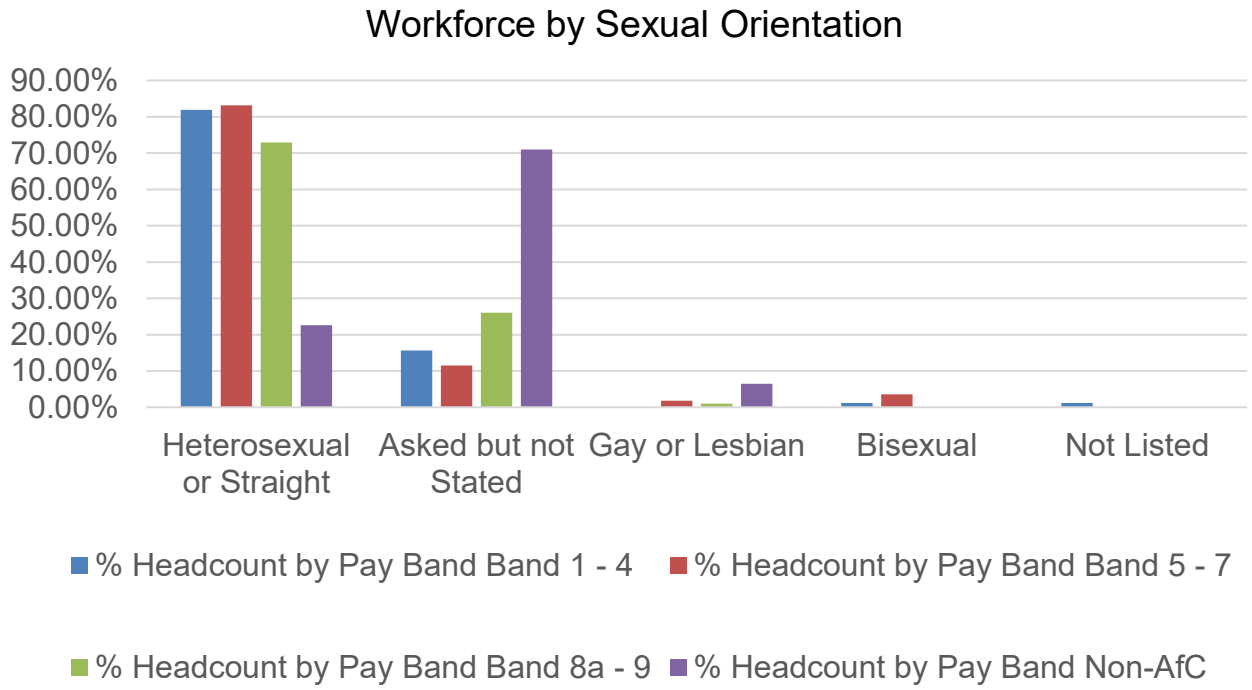


2025 All ICB Staff by Sex:
Female 79.6 %
Male 20.4 %

Sexual Orientation

Detailed data on the population by sexual orientation isn't readily available in a combined format. There is national data available on sexual orientation in the UK. According to the Office for National Statistics (ONS), in 2022, 93.4% of the UK population aged 16 years and over identified as heterosexual or straight. 3.3% identified as lesbian, gay, or bisexual (LGB), which is an increase from 2.1% in 2017

Staff who identified as LGB are represented across all pay band ranges. A total of 73.9 % of staff identified as Heterosexual or Straight. 22.6% were asked but declined to provide their sexual orientation status. 70.1% of Non-AfC pay band staff did not state or chose not to declare this information.



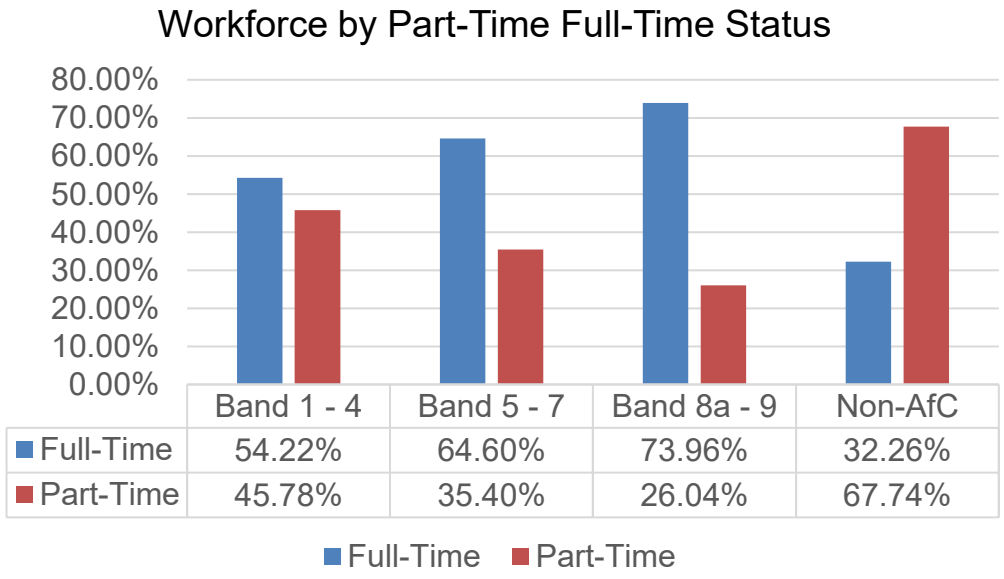
2025 All ICB Staff:
LGB 3.1%
Heterosexual /Straight 73.9%
Not stated 22.6%
Not listed 0.3%

Full Time and Part Time Participation

When analysing this data, it is important to consider the dynamics of full and part time working. Disaggregating this data for example by sex (female male) can provide a range of meaningful data around working habits that can be attributed to historical factors such as:

- The organisations operating structures
- preferred part time working arrangements for women with families or who have carer commitments..
- Though women have traditionally occupied Part-Time roles Non AfC for Change staff or highly specialised roles which are sessional are predominantly occupied by males
- It is important to consider the various types and roles available as well as other considerations within the organisation and the different gender profiles that occur within specific roles.

Age, Disability Religion and Belief may also be determining factors to consider in better understanding the dynamics of full and part time working arrangements and ensuring due regard to equality of opportunity between the protected characteristics.



2025 ICB Staff by Participation:

Full Time 61.6%
Part-Time 38.4%

Shropshire Telford and Wrekin Integrated Care Board - Recruitment.

Recruitment process data by Protected Characteristics 2024

Summary Recruitment Profile 2025

This section explains who applied for jobs at Shropshire, Telford and Wrekin ICB, and who went on to be shortlisted, interviewed, and finally appointed. The information is shown by different protected characteristics to help us understand whether people are having fair and equal experiences during recruitment. In total:

1,228 people applied for roles
215 were shortlisted
161 attended an interview
59 were appointed

In Summary

What this data suggests:

- Some groups move through the recruitment process differently than others.
- Younger applicants, and applicants from Asian and Black ethnic backgrounds, are less represented in final appointments than at the application stage.
- Nondisclosure rates are high at the appointment stage for several characteristics, making it harder to draw full conclusions.
- Disabled applicants show representation at shortlisting and interview, but this does not carry through to appointments.

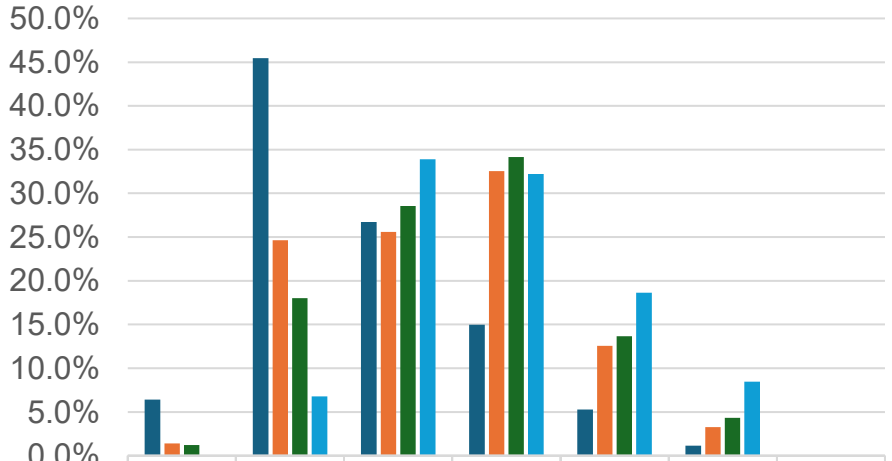
What could help improve fairness and understanding:

- Making it easier and more reassuring for new starters to share their equality information (if they choose to).
- Looking more closely at each stage, especially shortlisting and final decision-making, to understand why patterns differ for some groups.
- Continuing good practice that supports disabled applicants through each step of the process.

Age.

All the 1228 applicants provided this information and represented a broad range of age groups. Of the 215 applicants who were shortlisted, interviewed and appointed represented a wide spread of age groups except for the under 25-year age group. This group was the only one where no appointments were made.

Applicants by Age

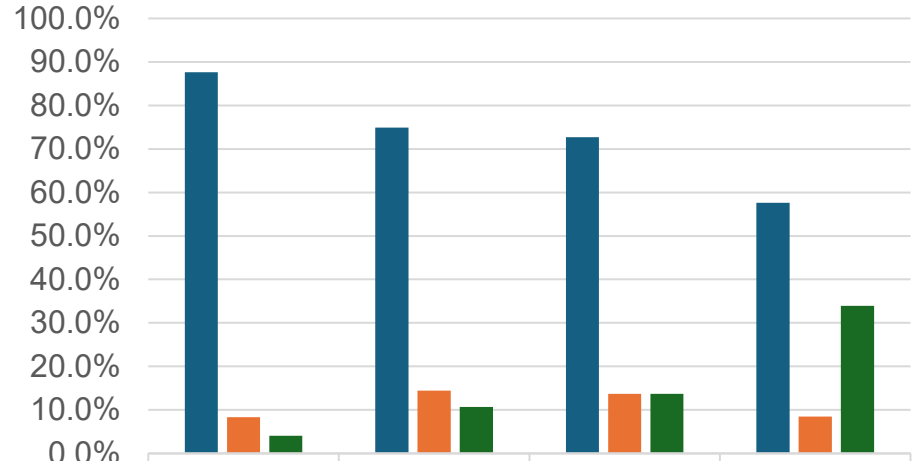


	Under 25	25-34	35-44	45-54	55-64	65+	Not stated
	Age						
Applied %	6.4%	45.4%	26.7%	15.0%	5.3%	1.1%	0.0%
Shortlisted %	1.4%	24.7%	25.6%	32.6%	12.6%	3.3%	0.0%
Interview attended %	1.2%	18.0%	28.6%	34.2%	13.7%	4.3%	0.0%
Appointed %	0.0%	6.8%	33.9%	32.2%	18.6%	8.5%	0.0%

Disability

Of the 1228 applicants 8.3% identified as having a disability. Of the 215 applicants who were shortlisted 14.4% were disabled. 161 applicants were interviewed 13.7% of which identified as having a disability. Of the 59 applicants who were appointed 8.5% were disabled . Applicants who either did not state or chose not to disclose their status totalled 4.1% of the 59 applicants who were appointed 33.9% came from this group.

Applicants by Disability

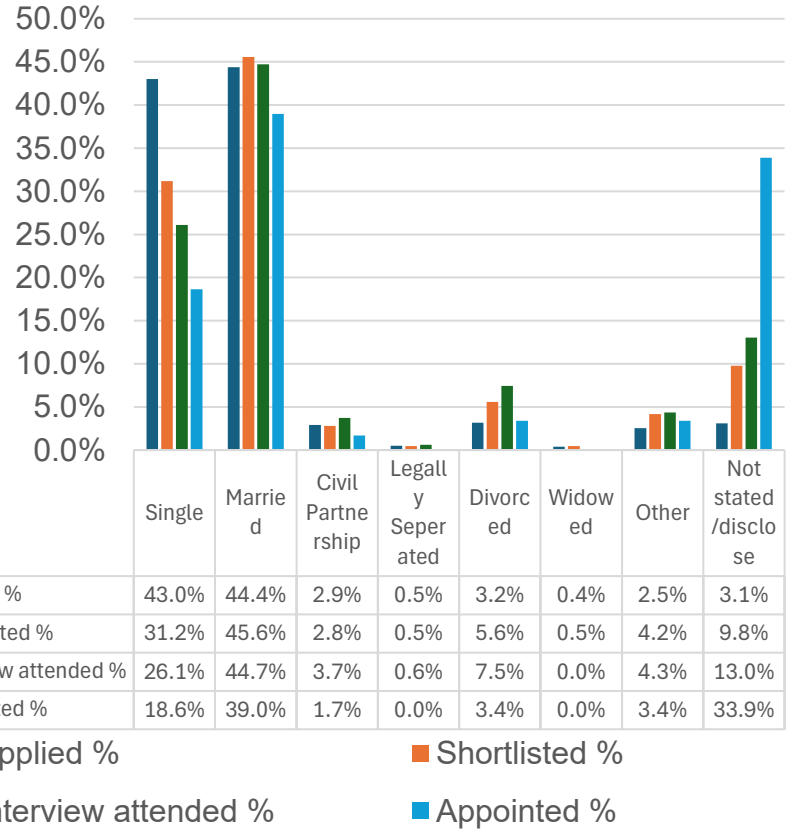


	Applied %	Shortlisted %	Interview attended %	Appointed %
No	87.6%	74.9%	72.7%	57.6%
Yes	8.3%	14.4%	13.7%	8.5%
Not stated or wished not to disclose	4.1%	10.7%	13.7%	33.9%

Marriage and Civil Partnership

Of the 1228 applicants 215 were shortlisted of which 45.6% identified as being married and 2.8% identified as being in a civil partnership. Of the 59 applicants who were appointed, 39.0% were married,1.7% civil partnership and 33.9% had not disclosed or provided their status.

Applicants by Marital Status

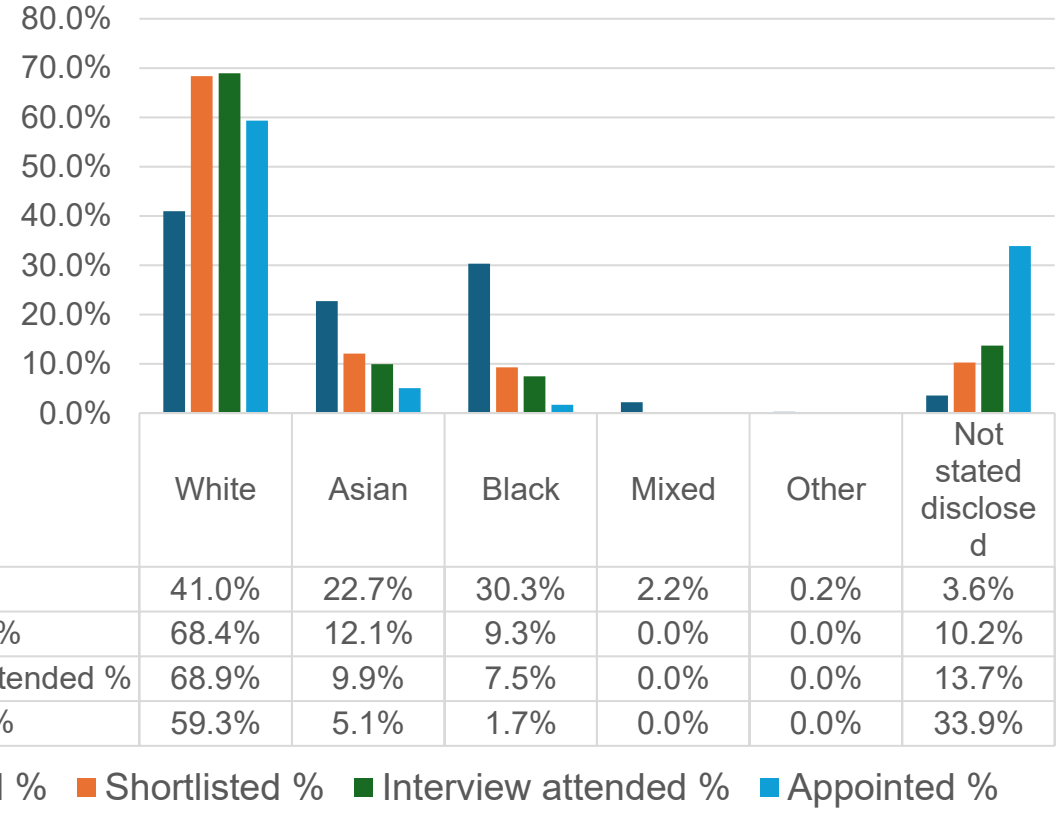


	Single	Married	Civil Partnership	Legally Seperated	Divorced	Widowed	Other	Not stated /disclose
Applied %	43.0%	44.4%	2.9%	0.5%	3.2%	0.4%	2.5%	3.1%
Shortlisted %	31.2%	45.6%	2.8%	0.5%	5.6%	0.5%	4.2%	9.8%
Interview attended %	26.1%	44.7%	3.7%	0.6%	7.5%	0.0%	4.3%	13.0%
Appointed %	18.6%	39.0%	1.7%	0.0%	3.4%	0.0%	3.4%	33.9%

Race/Ethnic Group

The data has been presented by broad ethnic groups. Of the 1228 applicants 215 were shortlisted of which 68.4% identified as White, 12.1% Asian, 9.3% Black, and 10.2% had not disclosed. Of the 59 applicants who were appointed 59.3% were White, 5.1% Asian, 1.7% with 33.9% of all appointees not having disclosing their Race/Ethnicity Group

Applicants by Broad Race/Ethnicity Group

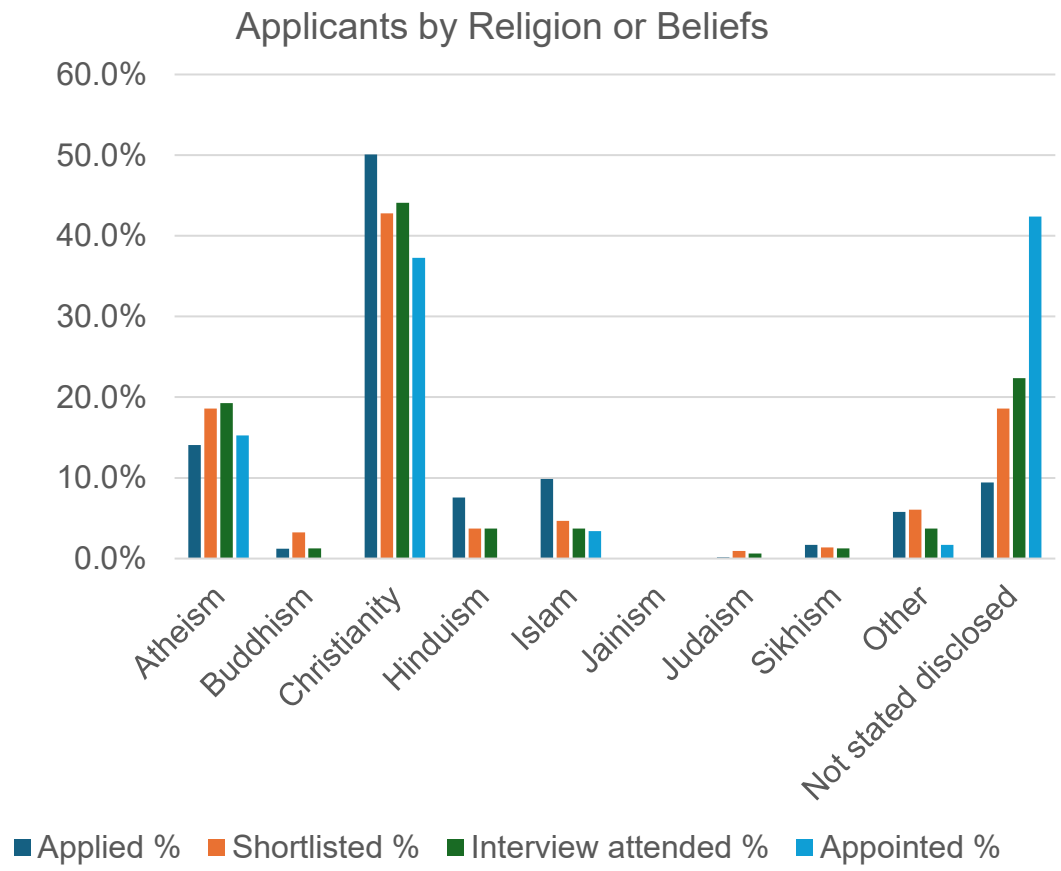


	White	Asian	Black	Mixed	Other	Not stated disclosed
Applied %	41.0%	22.7%	30.3%	2.2%	0.2%	3.6%
Shortlisted %	68.4%	12.1%	9.3%	0.0%	0.0%	10.2%
Interview attended %	68.9%	9.9%	7.5%	0.0%	0.0%	13.7%
Appointed %	59.3%	5.1%	1.7%	0.0%	0.0%	33.9%

*The Census Bureau defines a person of the Asian race as “having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.”

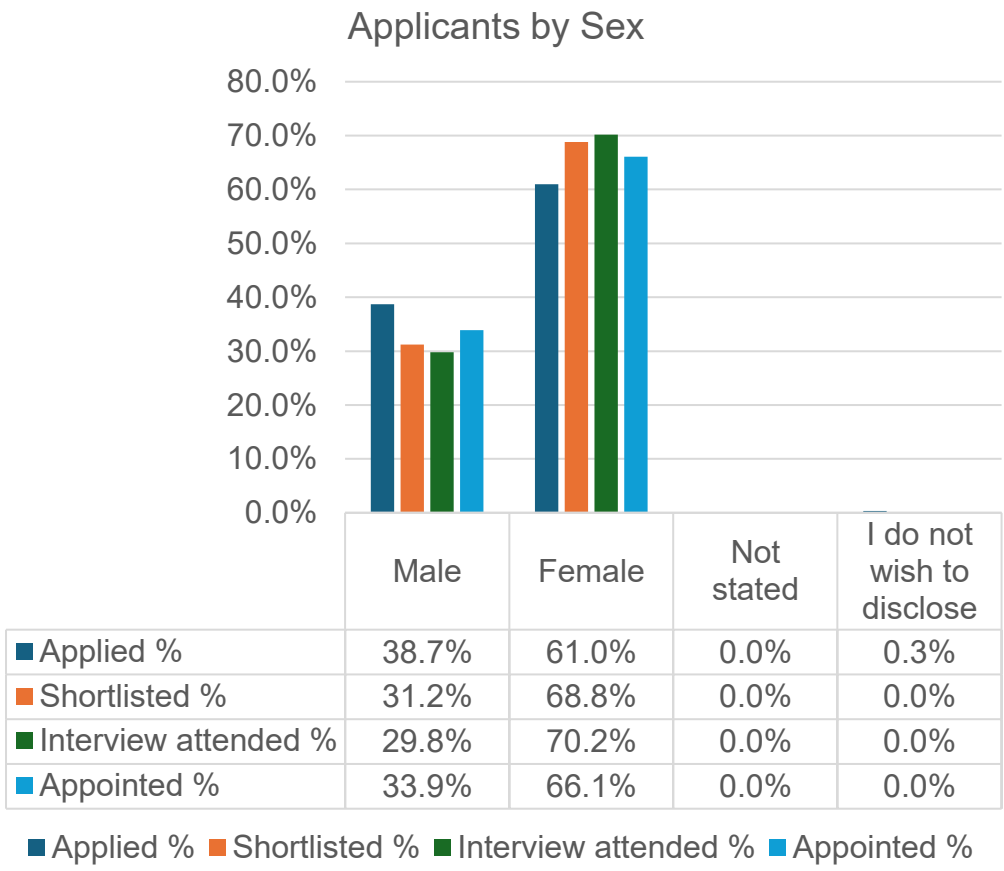
Religion or Belief

Most applicants who applied identified as Christian. Of the 1841 applicants who were appointed 40% were Christian, 27.8% either did not wish to disclose or not stated, 18.9% identified as Atheist, 2.2% Islam, 1.1% Hinduism and 10% Other.



Sex (Female Male)

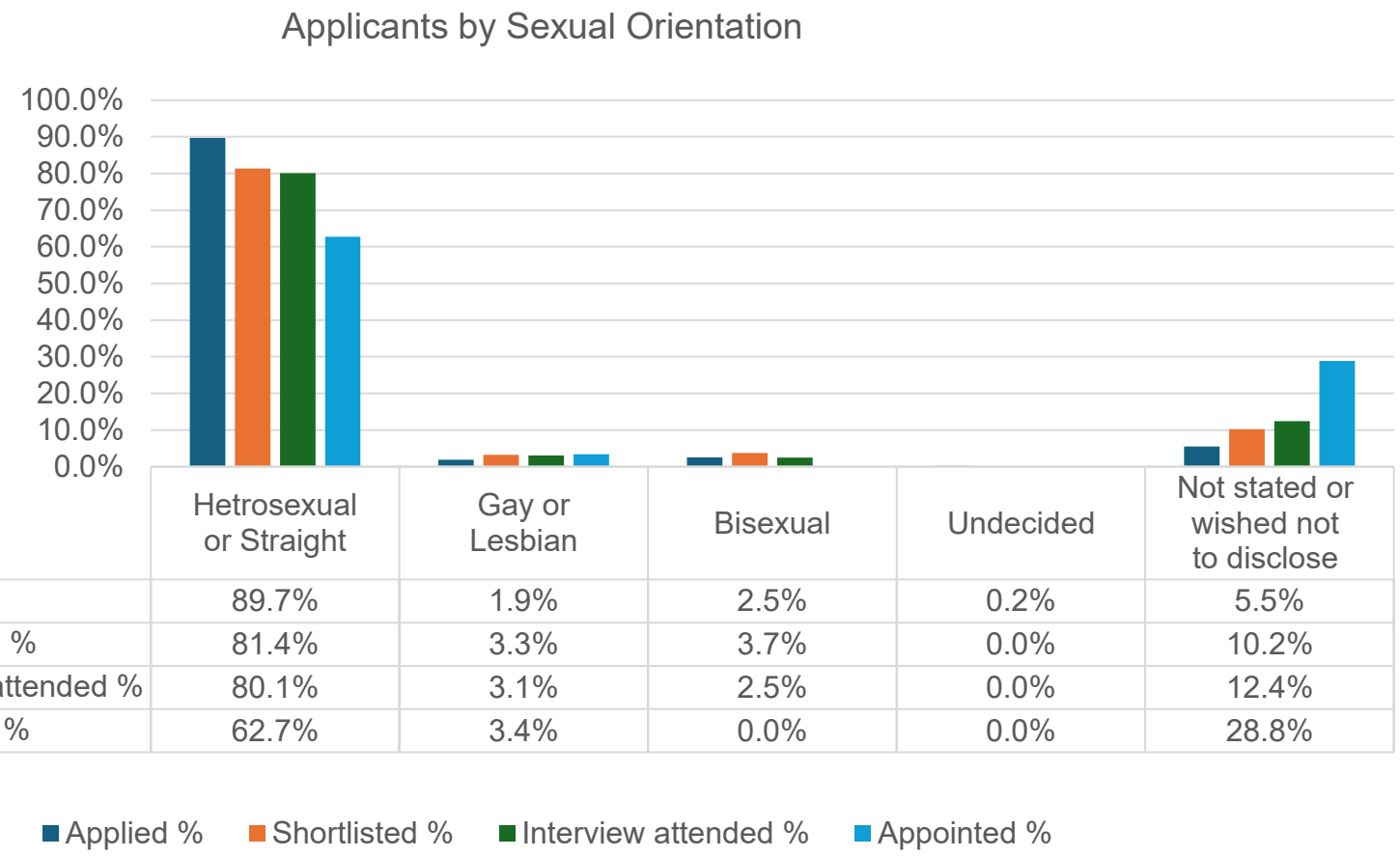
Of the 1228 applicants all but 0.3% identified their sex, 61.0% female and 38.7% male. Of the 59 applicants that were appointed 66.1% were female and 33.9% were male with 2.2%.



	Male	Female	Not stated	I do not wish to disclose
Applied %	38.7%	61.0%	0.0%	0.3%
Shortlisted %	31.2%	68.8%	0.0%	0.0%
Interview attended %	29.8%	70.2%	0.0%	0.0%
Appointed %	33.9%	66.1%	0.0%	0.0%

Sexual Orientation.

Of all 1228 applicants, % identified as Heterosexual or Straight, with applicants not stated or did not wish to disclose totalled %, identifying as Gay or Lesbian %, Bisexual %, orientation not listed or undecided 0.2%. Of the successful applicants; 73.3% identified as Heterosexual or Straight, 24.4% not stated or did not wish to disclose and 2.2% identified as Gay or Lesbian.



	Hetrosexual or Straight	Gay or Lesbian	Bisexual	Undecided	Not stated or wished not to disclose
Applied %	89.7%	1.9%	2.5%	0.2%	5.5%
Shortlisted %	81.4%	3.3%	3.7%	0.0%	10.2%
Interview attended %	80.1%	3.1%	2.5%	0.0%	12.4%
Appointed %	62.7%	3.4%	0.0%	0.0%	28.8%

Shropshire Telford and Wrekin Integrated Care Board – Next Steps.

ICB Priorities for 2026 - 2027

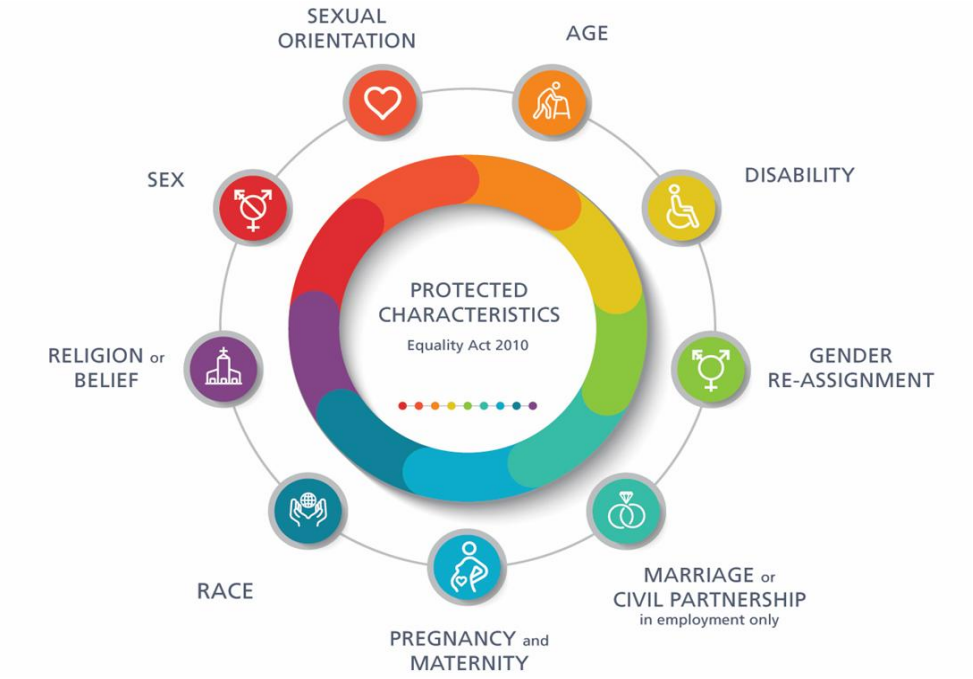
ICB priorities for 2026/2027

As the ICB enters 2026–27, a key organisational priority will be progressing the next phase of the ICB Reform Blueprint and operationalising the newly formed cluster with Staffordshire & Stoke-on-Trent (SSoT) ICB. This new cluster arrangement creates an opportunity to strengthen consistency, reduce duplication, and develop a shared approach to equality, diversity and inclusion (EDI) and the Public Sector Equality Duty (PSED). Establishing common standards, governance expectations and ways of working will be central to ensuring both ICBs operate with clarity, fairness and transparency in how workforce decisions are made.

During 2026–27, the ICB will focus on aligning policies, data practices, leadership responsibilities and cultural expectations across the cluster to create a coherent and collaborative EDI PSED agenda. The intention is to build a shared framework that supports inclusive employment practices, improves workforce experience, and ensures that both ICBs continue to meet their statutory duties while adapting to the evolving reform landscape. This work will require sustained engagement, careful change management and a continued emphasis on staff wellbeing and communication throughout the transition.

Staffordshire and Stoke-on- Trent Integrated Care Board Public Sector Equality Duty (PSED) Equality, Diversity, and Inclusion Annual Report 2025/2026

Workforce Equality



Documents or information from the Staffordshire and Stoke-on-Trent ICB website or key publications can be made available in alternative formats (such as audio, Clear Information, Easy Read, British Sign Language, interpreter services, large print, or Braille) on request.

Please contact the general reception number (01782 298002) and speak to any member of the administration team. Alternatively, deaf, and hard of hearing patients, carers and staff can use the Next Generation Text service.

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Introduction

PSED Annual Report (Workforce)

Staffordshire and Stoke-on-Trent ICB

The 2025–26 reporting period has been a year of organisational transition for Staffordshire and Stoke-on-Trent Integrated Care Board (ICB). As the ICB continues to embed the ambitions of the ICB Blueprint and respond to the direction set within the NHS Long Term Plan, our operating environment has evolved considerably. In parallel, the development of the cluster arrangement with Shropshire, Telford and Wrekin ICB has created new opportunities for shared leadership, alignment of functions, and a more collaborative approach to workforce planning.

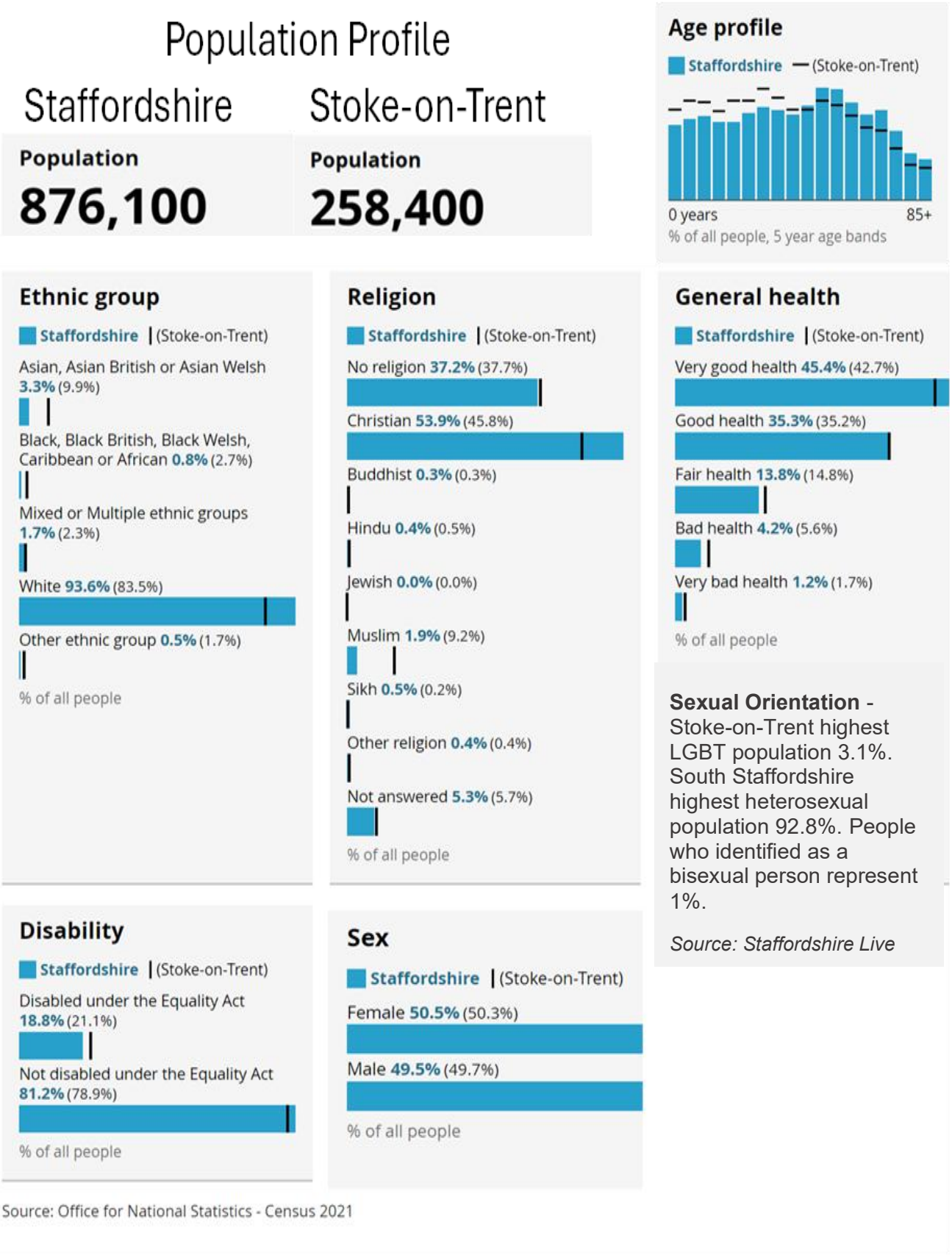
These developments have inevitably shaped the focus and pace of our Equality, Diversity, and Inclusion (EDI) work. While our statutory responsibilities under the Public Sector Equality Duty (PSED) remain unchanged, the organisational restructuring required to support the Blueprint and cluster model has, at times, taken priority. As a result, some EDI workforce initiatives were paused or deferred to ensure safe transition of services, clarity of roles, and stability for our people during a period of operational change.

Despite these challenges, the ICB has continued to act on its duty to eliminate discrimination, advance equality of opportunity, and foster good relations across its workforce. This report outlines the activity undertaken over the year to meet our PSED requirements, highlights areas of progress, and acknowledges where work will resume once structural changes are fully embedded. Importantly, it provides a transparent account of how system-level transformation has influenced our capacity, our priorities, and the shape of our future workforce EDI programmes.

Moving forward, an alignment created through the cluster arrangement presents a renewed opportunity to build a stronger, more consistent approach to EDI across organisational boundaries. As our new structures settle, the ICB remains committed to strengthening its culture, embedding equality into decision making, and ensuring that our workforce reflects, represents, and is equipped to serve the diverse communities of Staffordshire and Stoke-on-Trent. -making, and ensuring that our workforce reflects, represents, and is equipped to serve the diverse communities of Staffordshire and Stoke-on-Trent.

Population Profiles Staffordshire and Stoke-on-Trent.

The populations of Staffordshire and Stoke-on-Trent (SSoT) are diverse with complex health and care needs, comprising both rural and urban areas, extremes of affluence, deprivation, as well as health inequalities. Nineteen percent of the SSoT population are in the two most deprived national deciles (i.e. the most deprived 20%, or the most deprived quintile). The majority (63%) of the most deprived population with SSoT reside in Stoke-on-Trent.



Sexual Orientation - Stoke-on-Trent highest LGBT population 3.1%. South Staffordshire highest heterosexual population 92.8%. People who identified as a bisexual person represent 1%.

Source: Staffordshire Live

Equality legislation

Equality Act 2010 and its Public Sector Equality Duty (PSED)

The Public Sector Equality Duty came into force in April 2011 (s.149 of the Equality Act 2010) and public authorities like the NHS are now required, in carrying out their functions, to have due regard to the need to achieve the objectives set out under s149 of the Equality Act 2010 to:

(a) eliminate discrimination, harassment, victimisation, and any other conduct that is prohibited by or under the Equality Act 2010.

(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.

(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The Equality Act 2010 (Specific Duties) Regulations 2011 require the ICB to:

- Publish information to show compliance with the PSED, at least once a year.
- Produce Equality Objectives at least every four years.

The Equality Act 2010 (Gender Pay Gap Information) Regulations 2017

- These Regulations impose obligations on employers with 250 or more employees to publish information relating to the gender pay gap in their organisation.

The Equality Act 2010 was amended in 2024 to include new duties aimed at preventing sexual harassment in the workplace. These changes came into force on October 26, 2024, under the Worker Protection (Amendment of Equality Act 2010) Act 2023.

Human Rights Act 1998

The Human Rights Act 1998 sets out universal standards to make sure that an individual's basic needs as a human being are recognised and met. Public authorities have a mandated duty to ensure they have arrangements in place to comply with the Act.

It is unlawful for a healthcare organisation to act in any way that is incompatible with the Act. In practice, this means we must treat individuals with Fairness, Respect, Equality, Dignity and Autonomy – known as the FREDA principles.

Click here to read more about the Human Rights Act (equalityhumanrights.com).

Associated legislation - Health and Social Care Act 2022

Statutory obligations on ICBs under the NHS Act 2006 (as amended by the Health and Care Act 2022)

Section 14Z35 of the 2006 Act (as added by section 25(2) of the 2022 Act) imposes the general inequality duty on an ICB that it: must, in the exercise of its functions, have regard to the need to:

1. reduce inequalities between persons with respect to their ability to access health services.

- reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services (including the outcomes described in section 14Z34(3).

ICB Equality Objectives 2025

Draft ICB PSED Objectives 2025-2027

Equality Objective 1 – Workforce Equality
Embed fair and inclusive recruitment processes across each ICB Directorate until such a time where the diversity of each Directorate is equivalent to the population demographic or overall workforce demographic whichever is the greater.
Specific Action 1: Refresh the language of our job descriptions, person specifications and recruitment information/adverts through an EDI lens. When shortlisting and recruiting– where candidates are of equal merit use positive action to recruit groups that are under-represented.
Specific Action 2: Reduce Gender Pay Gap - When appointing to Bands 2-6, where candidates are of equal merit consider positive action to recruit male staff where there is under-representation as a proportion of the total ICB male workforce.
Specific Action 3: Reduce Gender Pay Gap - When appointing to Bands 8c-9, VSM and Local Clinical & Professional Pay Framework roles, where candidates are of equal merit consider positive action to recruit female staff where there is under-representation as a proportion of the total ICB female workforce.

Workforce Equality

Improving the Diversity Profile

Staffordshire and Stoke-on-Trent Integrated Care Board (ICB) continues to move through a period of organisational transformation driven by the requirements of the ICB Blueprint, the NHS Long Term Plan, and the development of the emerging cluster arrangement with Shropshire, Telford, and Wrekin ICB. These changes are reshaping our leadership structures, workforce configuration, and future operating model.

During 2025–26, a major milestone was achieved with the appointment of the cluster Executive Team, establishing shared strategic leadership across the two ICBs. Building on this, the organisation is now progressing through the next phase of the Management of Change (MoC) process, which focuses on redesigning the senior management team structures within the ICB. This work is essential to ensuring clear governance, aligned responsibilities and the right leadership capacity for the new cluster model. A final, wider restructure of the remaining ICB workforce will follow once senior structures are fully established.

Running in parallel to the MoC activity is an ongoing Voluntary Redundancy (VR) programme, which has been introduced to support workforce realignment, ensure organisational affordability, and provide staff with choice and stability during a period of structural change. The VR programme forms one of several mechanisms enabling the ICB to transition safely and responsibly into its future operating arrangements, while continuing to mitigate the impact on staff wherever possible.

In addition to this the ICBs workforce increased as a result of the Continuing Health Care Team and function was tuped into the increasing the workforce 484 emplyees.

Given this transitional landscape, and the fact that organisational design, team structures, and workforce data remain fluid, each ICB has produced its own separate PSED Workforce Report and Workforce Profile Report for the 2025–26 cycle. This approach ensures clarity, accuracy and accountability against each organisation's statutory obligations under the Public Sector Equality Duty (PSED) at a time when structures are not yet fully aligned.

As the cluster arrangements mature and the new workforce model becomes fully embedded, it is anticipated that future reporting cycles will move towards joint cluster workforce reporting. This will allow for a more unified view of equality, diversity and

inclusion across the cluster footprint, support consistent workforce planning, and promote shared learning and improvement across both ICBs.

Throughout this period of transformation including MoC, VR activity, and the development of new shared leadership structures the ICB remains committed to fulfilling its PSED responsibilities. Equality considerations continue to be integral to decision-making, organisational design, and the support offered to our workforce during this complex period of change.

Workforce Diversity Profile Report

We aim to employ a diverse workforce that is representative of our local communities, as we believe this will improve our decision making in the development of health and care services.

This section of the report illustrates the demographics of Staffordshire and Stoke-on-Trent ICB workforce as of 30 September 2024. The ICB will use this data to measure the diversity of our staff across the full range of NHS pay grades and in influence future EDI workforce planning.

It is also worth noting that when working with small staff numbers any variation in these numbers can have, what may appear to be, disproportionate changes in percentages.

Overview

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

Workforce Profile – Key Patterns

Age

The profile remains concentrated in the 35–64 age range. Under-25 representation is disproportionately low (2.3%), potentially affecting future pipelines.

Disability

Declared disability increased to 7.9% (fourth annual rise), but nondisclosure rose to 9.9%, especially in Bands 1–4 and Non-AfC roles. Disabled staff remain underrepresented relative to the local population.

Ethnicity

Non-White representation increased to (9.9%). Asian and Black staff increased in some senior AfC bands, though numbers remain small. Non-AfC roles show greatest diversity but also the highest nondisclosure.

Sex

Women represent 81.6% of the workforce (up from 76.3%), influenced by new female Directors. Men remain concentrated in Non-AfC roles.

Other Characteristics

Religion and sexual orientation disclosures remain inconsistent, with high nondisclosure in Non-AfC roles.

Flexible working continues to grow part-time increased to 33.5%.

Directorate-Level Overview

The ICB analyses workforce profile trends down to Directorate level. These demonstrate:

- Directorates show variation shaped by small numbers and functional differences:
- Medical: One of the most diverse directorates, particularly in Non-AfC roles.
- Nursing & Therapies: Most female-dominated (89–94%).
- Delivery: Strongest growth in ethnic diversity.
- Corporate Governance: Higher disability declaration and more younger staff in Bands 1–4.
- Finance/Performance/Information: Predominantly White, mid-career.
- People and Transformation: High nondisclosure limits reliable interpretation.

- Across all areas: under-25 staff remain absent.

Recruitment Profile (Oct 2024–Sep 2025)

574 applied → 104 shortlisted → 79 interviewed → 35 appointed

Findings

- High diversity at application stage (22% Asian and 22% Black).
- Female applicants successful throughout (65.7% of appointments).

Areas of focus

- No Under-25 applicants were shortlisted, interviewed, or appointed, despite representing almost 4% of applicants.
- Disability representation reduced at each recruitment stage (10.8% applied → 2.9% appointed).
- Black applicants were represented at the application stage 22% of applicants, though 0% appointed, with 3.8% reaching the short list stage.
- More than half of appointed candidates had not disclosed their ethnicity, religion, or sexual orientation.
- Female applicants were slightly more successful overall (65.7% of appointments), aligning with wider ICB gender patterns.

Overall Conclusion

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

- Recruitment outcomes for disabled and Black candidates require review.
- High nondisclosure at appointment stage limits PSED transparency.
- Early-career underrepresentation is not currently evident.
- Gender imbalance between AfC and Non-AfC roles remains.
- Directorate variation indicates the need for tailored EDI plans rather than a single ICB-wide approach.

As ICB reform and cluster arrangements with STW continue, establishing a consistent cross-ICB approach to workforce equality and PSED delivery will be crucial for accountability and improved outcomes.

The Workforce Diversity Profile Report also provides a workforce profile of the ICB directorates and a profile of all the applicants who applied for posts within the ICB. This data shows how applicants by protected characteristics faired across the different recruitment stages.

Workforce Race Equality Standard (WRES) & Workforce Disability Equality Standard

NHS Integrated Care Boards (ICBs) are not mandated to produce Workforce Race Equality Standard (WRES) or Workforce Disability Equality Standard (WDES) reports. These requirements primarily apply to NHS Trusts and Foundation Trusts. However, we are encouraged to adopt the principles of these standards and apply them as much as possible to our own workforce. This is reflected in this and our Workforce Diversity Profile report.

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

Gender Pay Gap (GPG) Report

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

Any targeted actions based on this year's figures may also become quickly outdated as the new staffing structure is finalised. Once the new organisation design is fully embedded and workforce numbers stabilise, the ICB will be in a stronger position to

undertake a more accurate analysis of the gender pay gap and implement actions that reflect the future workforce.

The ICB remains committed to transparency and to addressing gender-based inequalities and will continue to monitor developments closely throughout this period of transition.

Average & Median Hourly Rates 2025

Gender	Avg. Hourly Rate	Median Hourly Rate
Male	£38.72	£31.79
Female	£27.99	£25.60
Difference	£10.73	£6.19
Pay Gap %	27.71%	19.46%

Average Hourly Rate Pay Gap

The difference in the average hourly rate between Male and Female is £10.73 compared to the previous reporting period average hourly rate of £13.97. The pay gap in percentage terms is now 27.71 % compared to the previous reporting period of 34.34% a reduction of 6.63%.

Median Hourly Rate Pay Gap

The difference in the median hourly rate between Male and Female is £6.19 compared to the previous reporting period average hourly rate of £9.00. The pay gap in percentage terms is now 19.46% compared to the previous reporting period of 26.96% a reduction of 7.5%

As mentioned at the top of this report a median average might show a better indication of the 'middle of the road' pay gap where higher paid employees and board members might distort the average hourly rate.

A reason for variations in hourly pay rates may be a result of:

- Female staff taking up roles which have historically been taken up by male staff, such as Information Technology.
- Female staff taking up roles part time roles, which are higher within Non AfC pay structures and historically taken up by male staff.
- Female staff taking up highly specialised roles which are sessional and occupied by males.
- Male staff have left the above roles and positions have not been filled.

It is also worth noting that when working with small staff numbers any variation in these numbers can have, what may appear to be, disproportionate changes in percentages.

The ICB combined workforce by female or male for 2025 was as follows:

- Female Staff 81.6%
- Male Staff 18.4%

The above figure can be used to give an approximation if the quartiles are representative of the ICB workforce profile by sex.

Proportion of Male and Female Staff by Quartile Pay Bands 2025

Quartile	Female	Male	Female %	Male %
1. Lower	57	10	85.07%	14.93%
2.	61	12	83.56%	16.44%
3.	60	18	76.92%	23.08%
4. Higher	50	37	57.47%	42.53%

Staff Survey

The NHS Staff Survey results are aimed at NHS organisations, to inform local improvements in staff experience and well-being. Several ICBs took the decision to not participate in the national Staff Survey in 2025 due to the scale of the national change programme. It is positive that both NHS STW and NHS SSoT took part and had strong levels of engagement.

The Staff Survey offers a snapshot in time of how people experience their working lives, gathered at the same time each year. The tables below are staff response to a sample of questions disaggregated by protected characteristics.

This year's staff survey results must be viewed in the context of the organisational change taking place within the ICB. The ongoing restructure, the cluster development, and the increase in recently TUPE'd staff have all shaped how people are experiencing work during this period. Because the workforce profile has changed, it would not be meaningful to compare this year's results with previous years.

Throughout the year, the ICB has prioritised supporting staff by providing regular communication, wellbeing resources, and opportunities to raise concerns. As the

new structures stabilise, future surveys will offer a clearer picture of staff experience and help guide ongoing improvement.

The relevant Staff Survey Questions are:

Q14b Not experienced harassment, bullying, or abuse from managers.	Q14c Not experienced harassment, bullying, or abuse from colleagues.	Q15 Organisation acts fairly, career progression.
Q16b Not experienced discrimination from manager/team leader or other colleagues	Q17b Not experienced unwanted behaviour of a sexual nature from other colleagues	Q21 Feel organisation respects individual differences

Protected Characteristic data for Gender Re-assignment, Maternity & Pregnancy, Marriage, and Civil Partnership are not collated or analysed.

In the tables below, the key is as follows:

Key	Overall ICB staff survey response %.	Green – at least 3% above overall staff response	Red - at least 3% below overall staff response	Amber - within 3% of overall staff response	* Below reporting threshold of 10 staff

* Indicates the total staff responses was less than ten.

Summary

Age		Comparator (Organisation Overall)	16-20	21-30	31-40	41-50	51-65	66+
Q	Description	n = 343	n = *	n = 13	n = 71	n = 114	n = 129	n = *
Q14b	Not experienced harassment, bullying or abuse from managers	87.1%	*	92.3%	88.7%	86.8%	86.7%	*
Q14c	Not experienced harassment, bullying or abuse from other colleagues	87.0%	*	92.3%	90.1%	81.3%	90.6%	*
Q15	Organisation acts fairly: career progression	58.6%	*	76.9%	62.0%	55.3%	57.4%	*
Q16b	Not experienced discrimination from manager/team leader or other colleagues	94.2%	*	92.3%	91.5%	94.7%	95.3%	*
Q17b	Not experienced unwanted behaviour of a sexual nature from other colleagues	98.5%	*	92.3%	98.6%	99.1%	98.4%	*
Q21	Feel organisation respects individual differences	73.0%	*	76.9%	70.4%	72.6%	74.2%	*

Younger staff (21–30) reported highly positive experiences, including 92.3% not experiencing harassment or bullying from managers or colleagues. In contrast, staff aged 41–50 reported lower experiences of positive colleague behaviour (81.3%

versus 87% overall). This may indicate a need to explore cultural or team-level issues affecting mid-career staff.

Disability		Comparator (Organisation Overall)	Yes	No
Q	Description	n = 343	n = 98	n = 240
Q14b	Not experienced harassment, bullying or abuse from managers	87.1%	76.3%	91.3%
Q14c	Not experienced harassment, bullying or abuse from other colleagues	87.0%	81.3%	89.9%
Q15	Organisation acts fairly: career progression	58.6%	50.0%	61.3%
Q16b	Not experienced discrimination from manager/team leader or other colleagues	94.2%	87.8%	96.7%
Q17b	Not experienced unwanted behaviour of a sexual nature from other colleagues	98.5%	99.0%	98.3%
Q21	Feel organisation respects individual differences	73.0%	63.3%	77.3%
Q31b	Disability: organisation made reasonable adjustment(s) to enable me to carry out work	80.4%	80.4%	*

Summary

Staff generally showed lower levels of positive experience regarding harassment, bullying or abuse, discrimination or respect compared to non-disabled colleagues across most indicators.

Race/Ethnicity		Comparator (Organisation Overall)	White	Mixed/ Multiple ethnic groups	Asian/ Asian British	Black/ African/ Caribbean/ Black British	Other ethnic groups
Q	Description	n = 343	n=309	n=<10	n=16	n=<10	n=0
Q14b	Not experienced harassment, bullying or abuse from managers	87.1%	87.7%	*	87.5%	*	*
Q14c	Not experienced harassment, bullying or abuse from other colleagues	87.0%	87.9%	*	93.8%	*	*
Q15	Organisation acts fairly: career progression	58.6%	60.5%	*	31.3%	*	*
Q16b	Not experienced discrimination from manager/team leader or other colleagues	94.2%	94.5%	*	87.5%	*	*
Q17b	Not experienced unwanted behaviour of a sexual nature from other colleagues	98.5%	98.5%	*	100.0%	*	*
Q21	Feel organisation respects individual differences	73.0%	73.3%	*	81.3%	*	*

Summary

There are two indicators where Asian staff report poorer experiences. Q15 which asks if the ICB acts fairly regarding career progression Asian staff experience citing

career progression fairness at 31.3% compared to 60.5% for White staff. Other non-white groups were below the reporting threshold of 10 staff.

Sex (Gender)		Comparatyo (Organisation Overall)	Female	Male	Non-binary	Prefer to self-describe:	Prefer not to say
Q	Description	n = 343	n = 268	n = 47	n = 0	n = <10	n = 25
Q14b	Not experienced harassment, bullying or abuse from managers	86.1%	86.9%	95.7%	*	*	72.0%
Q14c	Not experienced harassment, bullying or abuse from other colleagues	87.0%	87.2%	91.3%	*	*	80.0%
Q15	Organisation acts fairly: career progression	58.6%	61.6%	61.7%	*	*	20.0%
Q16b	Not experienced discrimination from manager/team leader or other colleagues	94.2%	94.4%	95.7%	*	*	88.0%
Q17b	Not experienced unwanted behaviour of a sexual nature from other colleagues	98.5%	98.5%	97.9%	*	*	100.0%
Q21	Feel organisation respects individual differences	73.0%	74.2%	80.4%	*	*	48.0%

Summary

Women and men reported broadly similar outcomes, with men reporting slightly more positive on several indicators. The “prefer not to say” group scored lower, including 20% on career progression, signalling reduced trust or psychological safety. 98.5% of female staff reported to not experiencing unwanted behaviour of a sexual nature from colleagues

Sexual Orientation		Comparator (Organisation Overall)	Heterosexual or straight	Gay or Lesbian	Bisexual	Other	I would prefer not to say
Q	Description	n = 343	n = 294	n = <10	n = <10	n = <10	n = 34
Q14b	Not experienced harassment, bullying or abuse from managers	87.1%	88.0%	*	*	*	73.5%
Q14c	Not experienced harassment, bullying or abuse from other colleagues	87.0%	87.9%	*	*	*	82.4%
Q15	Organisation acts fairly: career progression	58.6%	63.3%	*	*	*	20.6%
Q16b	Not experienced discrimination from manager/team leader or other colleagues	94.2%	94.9%	*	*	*	88.2%
Q17b	Not experienced unwanted behaviour of a sexual nature from other colleagues	98.5%	98.6%	*	*	*	97.1%
Q21	Feel organisation respects individual differences	73.0%	75.7%	*	*	*	52.9%

Summary

Heterosexual staff rated their experience close to or above the organisational average.

As in other categories, “prefer not to say” reported weaker outcomes (e.g., 20.6% for career progression fairness compared to the organisational average of 58.6% or

52.9% who felt the organisation respects individual differences compared to the organisations average of 73%.

Religion or Belief		Comparator (Organisation Overall)	No religion	Christian	Hindu	Muslim	Sikh	Any other religion (please specify)	I would prefer not to say
Q	Description	n = 343	n = 125	n = 163	n = <10	n = <10	n = <10	n = <10	n = 32
Q14b	Not experienced harassment, bullying or abuse from managers	87.1%	83.1%	90.2%					87.5%
Q14c	Not experienced harassment, bullying or abuse from other colleagues	87.0%	87.9%	88.8%					87.1%
Q15	Organisation acts fairly: career progression	58.6%	62.4%	63.8%					28.1%
Q16b	Not experienced discrimination from manager/team leader or other colleagues	94.2%	93.6%	96.9%					90.6%
Q17b	Not experienced unwanted behaviour of a sexual nature from other colleagues	98.5%	99.2%	98.2%					96.8%
Q21	Feel organisation respects individual differences	73.0%	72.6%	74.7%					68.8%

Summary

Staff who identified has Christian, or No Religion groups reported experiences broadly aligned with or better than organisational averages, with the exception of the No religions group who had experienced higher level of harassment, bullying or abuse compared to the; ICB average, Christian or the preferred not to state groups. Minority faith staff fell below the reporting threshold of 10 staff. The “prefer not to say” group which totalled 32 staff reported low levels of experiences in three indicators compared to the other groups. These were; career progression, discrimination from staff at all levels and feeling the organisation respects individual difference

The table below looks at each directorate within the ICB and compares staff responses to the questions.

Directortaes		Comparator (Organisation Overall)	Corprate Governance	Delivery Directorate	Finance Perf & Intel Directorate	Management Directorate	Medical Directorate	Nursing & Therapies Directorate	People Directorate	Transformation Directorate
	Description	n = 343	n = 35	n = 26	n = 49	n = <10	n = 73	n = 105	n = 22	n = 24
Q14b	Not experienced harassment, bullying or abuse from managers	87.1%	34.3%	88.5%	89.8%	*	84.9%	86.5%	95.5%	70.8%
Q14c	Not experienced harassment, bullying or abuse from other colleagues	87.0%	34.3%	80.8%	79.2%	*	84.7%	92.2%	90.9%	79.2%
Q15	Organisation acts fairly: career progression	58.6%	68.6%	50.0%	63.3%	*	54.8%	58.1%	72.7%	37.5%
Q16b	Not experienced discrimination from manager/team leader or other colleagues	94.2%	100.0%	84.6%	100.0%	*	91.8%	95.2%	95.5%	83.3%
Q17b	Not experienced unwanted behaviour of a sexual nature from other colleagues	98.5%	100.0%	100.0%	95.9%	*	98.6%	100.0%	100.0%	91.7%
Q21	Feel organisation respects individual differences	73.0%	85.3%	88.5%	70.8%	*	76.7%	65.7%	81.8%	45.8%

Summary

Overall, colleagues report prominent levels of safety from discrimination and sexual harassment, but perceptions of fairness in career progression remain comparatively weak and show the widest disparities across several characteristics and directorates. Disabled staff, some ethnic minority groups, and colleagues who prefer not to disclose their sex or sexual orientation report poorer experiences. There are also directorate-level hotspots that require focused follow-up and leadership attention

Overall Summary

Overall, colleagues report prominent levels of safety from discrimination and sexual harassment, but perceptions of fairness in career progression remains a concern across several characteristics and directorates. Disabled staff, some ethnic minority groups, and colleagues who prefer not to disclose their sex or sexual orientation report poorer experiences. There are also directorate-level hotspots that require focused follow-up and leadership attention.

ICB Staff Networks

The ICB's staff networks have remained active and in place throughout the period of organisational reform, although their capacity to deliver regular programmes of activity has been understandably reduced due to the scale and pace of change. Despite this, network members have continued to contribute to the wider staff voice and inclusion agenda, with several colleagues also participating in other groups such as the Staff Engagement Group and local workforce forums. Their ongoing involvement has ensured that lived experience and diverse perspectives continue to inform organisational decision making during a period of transition. As the new cluster arrangements for 2026–27 take shape, reenergising and supporting the networks will be an important priority to strengthen staff voice and reinforce the ICB's wider EDI commitments.

Wider workforce equality in recruitment, retention, training, and development.

We reviewed our mandated training in 2024 and as a result changed the content to align closer with ICB strategic EDI aims and objectives. The new training now focuses on two key areas

- Reasonable Adjustments
- Equality Impact Assessments

Focusing on reasonable adjustments and equality impact assessments promotes a more comprehensive approach to inclusion. It ensures that our commissioning, policies, and practices are evaluated for their impact on diverse groups, leading to systemic changes that benefit everyone, as an alternative to raising awareness of biases.

Staff Feedback – Reasonable Adjustment

100% participants said the session fully met their expectations, previous 92%

100% said the trainers were easy to understand and engaging to listen to, previous 86%

- "Detailed and engaging training session, the presentation was informative with just the right amount of information on,"
- 'The knowledge of the trainers was excellent; it really helped having practical examples."

- "Interesting and important to have this knowledge."

Staff feedback – Equality Health Impact Assessment

- It was really well thought out and in sequence - clear and concise speech. Very informative."
- "Really informative and engaging."

- “Informative and necessary for all to learn about - contact name given if assistance is needed.”

ICB corporate communications and involvement - Staff

Organisational time and leadership focus has been dedicated to delivering the ICB Reform 10-Year Plan, alongside Management of Change (MoC) Stages 1 and 2 and the associated voluntary redundancy process. This period has involved restructuring at Executive and senior management levels and has understandably created uncertainty and pressure for many colleagues.

Throughout this process, the ICB has prioritised clear communication and enhanced staff support. Regular weekly briefs, targeted engagement sessions, and direct leadership updates have been used to keep colleagues informed at every stage. Additional wellbeing resources, accessible HR guidance, and opportunities for one-to-one support were provided to help staff navigate what has been a challenging and emotionally demanding time. The organisation remains committed to delivering change in a fair, inclusive and compassionate way, consistent with its Public Sector Equality Duty.

The ICB staff intranet is a digital resource for ICB staff and members, which holds a wealth of information. For example, IAN stores information on health and wellbeing and organisational development, and has dedicated equality, diversity and inclusion and general resource sections. Friday and mid-week staff messages have links to a range of this internal resource.

ICB priorities for 2026/2027

As the ICB enters 2026–27, a key organisational priority will be progressing the next phase of the ICB Reform Blueprint and operationalising the newly formed cluster between Staffordshire & Stoke-on-Trent (SSoT) ICB and Shropshire, Telford & Wrekin (STW) ICB. This new cluster arrangement creates an opportunity to strengthen consistency, reduce duplication, and develop a shared approach to equality, diversity and inclusion (EDI) and the Public Sector Equality Duty (PSED). Establishing common standards, governance expectations and ways of working will be central to ensuring both ICBs operate with clarity, fairness, and transparency in how workforce decisions are made.

During 2026–27, the ICB will focus on aligning policies, data practices, leadership responsibilities, and cultural expectations across the cluster to create a coherent and collaborative EDIPSED agenda. The intention is to build a shared framework that supports inclusive employment practices, improves workforce experience, and ensures that both ICBs continue to meet their statutory duties while adapting to the

evolving reform landscape. This work will require sustained engagement, careful change management and a continued emphasis on staff wellbeing and communication throughout the transition.

Future Joint Reporting Intentions:

From 2026, SSoT and STW ICBs will move to a single cluster workforce profile and implementation of a joint equality objective and action plan following completion of the MoC.

Staffordshire and Stoke-on-Trent Integrated Care Board

Workforce Diversity Profile Report 2025

This report was produced by the ICB Equality Diversity and Inclusion Business Partner January 2025

Introduction

This will be Staffordshire and Stoke-on-Trent (SSoT) Integrated Care Boards (ICB) third workforce diversity profile report since transitioning from Clinical Commissioning Boards in July 2022. Public authorities with over 150 employees must consider its employee profile and if it representative of the communities it serves, if staff are treated equitably and without discrimination. This information should be published considering protected characteristics.

This report will focus on two areas, the workforce profile of the ICB and the recruitment process. Other activities and outcomes in relation to workforce equality diversity and inclusion e.g. , training and development, staff engagement, staff experience and feedback, health and wellbeing will be captured in the ICB's 2025-26 Public Sector Equality Duty Annual report which will be published in March 2026.

The report provides a profile of ICB staff in post as of the 30.09.2025 which at that point totalled 484. The increase in staff numbers compared to last year was a result of a large Continuing Health Care team TUPE'd into the ICB. To preserve anonymity staff numbers are replaced with percentages as to make it difficult to identify individual staff. It is worth considering that when working with relatively small figures, small changes in staff numbers can substantially alter the demographic profile of a workforce.

This year, SSOT ICB has produced a separate workforce profile rather than a joint report with Shropshire, Telford and Wrekin (STW) ICB. This reflects our current organisational differences, including how workforce data is structured, reported, and published. Each ICB operates under distinct governance and reporting frameworks, which makes a combined profile unfeasible at this time. However, we remain committed to ongoing alignment and will revisit this approach once formal clustering arrangements are in place and organisational changes, including any workforce transitions, have been completed

Note: Most figures have been rounded up to one decimal place. Afc which is used within the tables is an abbreviation for Agenda for Change Pay Scales

Staffordshire and Stoke-on-Trent Integrated Care Board.

ICB

Workforce Profile

Summary of findings 2025

Positive movements

📈 **Disability declaration increased** again.

📈 **Non-White representation increased** slightly.

📈 **Female representation increased**, strengthened further by senior hires in 2024.

📉 **Religion and sexual orientation nondisclosure** improved slightly in some bands.

Areas for Improvement

⚠️ **Major rise in disability nondisclosure** (5.5% → 9.9%).

⚠️ **Male representation fell by 5.3 points** (23.7 → 18.4%), widening gender imbalance.

⚠️ **Under-25 representation dipped slightly**, despite workforce growth.

⚠️ Some directorates (especially Non-AfC) still show **very high nondisclosure rates** across multiple characteristics.

Summary of findings 2025 continued

Overall ICB Workforce Profile

The ICB workforce increased to **484 staff** in 2025 due to the TUPE transfer of the Continuing Healthcare team. The age profile remains predominantly **mid-to-late career**, with dips in younger age groups: the proportion of **under-25s decreased slightly** (2.4% → 2.3%).

The proportion of staff **declaring a disability increased** again to **7.9%**, marking the fourth consecutive annual rise. However, this was overshadowed by a **sharp increase in nondisclosure** (5.5% → 9.9%), particularly in Bands 1–4 and Non-AfC roles, suggesting a need for improved trust and data confidence.

Ethnic diversity increased modestly, with Non-White representation rising from 9.4% to **9.9%** and the proportion of White staff falling correspondingly. Representation of Asian and Black staff improved in key senior pay bands, although numbers remain low.

Female representation increased significantly (76.3% → **81.6%**), influenced by the appointment of three female Directors the previous year. However, **male representation decreased** at all AfC bands except Non-AfC, where men remain overrepresented.

Working patterns continue to shift gradually toward flexibility, with **part-time work increasing** to **33.5%**. Nondisclosure for religion and sexual orientation remains high but has improved slightly in some pay bands

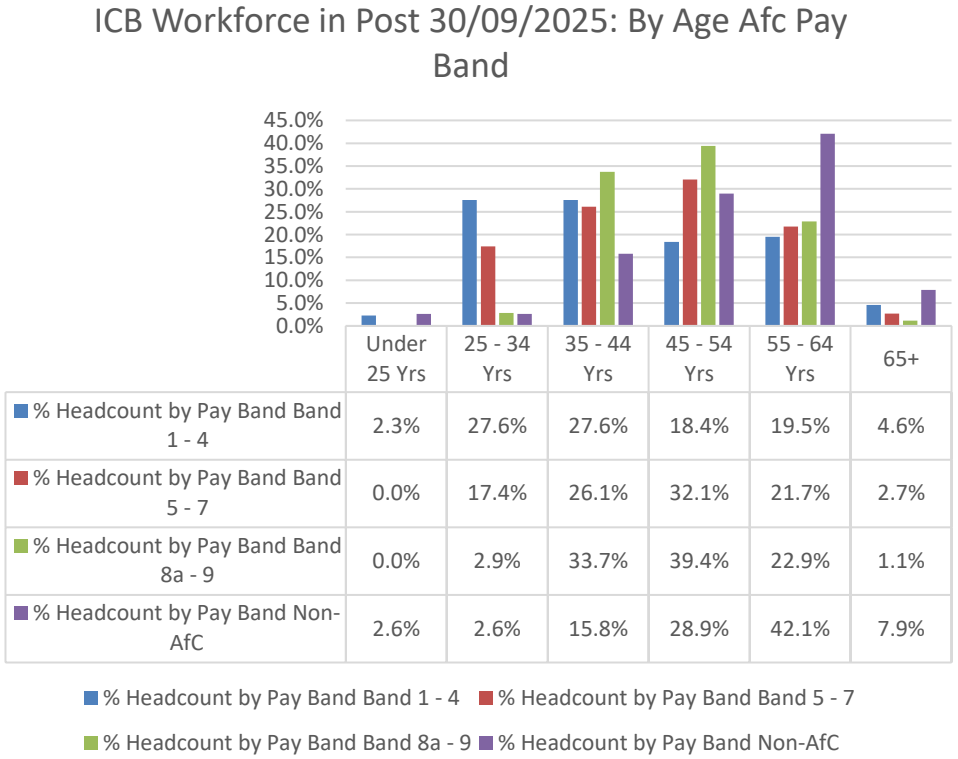
2025 workforce profile by Age

Under 25: **2.3%** (2024 = 2.4%) - 25–34: **12.8% -** 35–44: **28.3% -** 45–54: **32.0% -** 55–64: **23.4% -** 65+: **2.9%**

Key Changes vs 2024

- **Under-25 representation decreased slightly** (2.4% → 2.3%), after previously increasing since 2022.
- **45–54 age group decreased** across several pay bands.
- **55–64 grew slightly**, consistent with an ageing workforce trend.
- Overall pattern remains **middle-aged heavy (45–64)**, consistent with non-clinical commissioning bodies.

% Headcount for years 2023 – 2024	2023	2024	2023	2024	2023	2024	2023	2024
Afc Pay Bands	**1 – 4**	**1 – 4**	**5 – 7**	**5 - 7**	**8a – 9**	**8a – 9**	**Non-AfC**	**Non-AfC**
Under 25 Yrs	2.8%	2.4%	3.6%	0%	0%	0%	2.9%	0%
25 – 34 Yrs	22.2%	23.8%	16.7%	20.8%	4.7%	4.7%	2.9%	0%
35 – 44 Yrs	19.5%	26.2%	25%	25.5%	35.7%	31.7%	20%	18.2%
45 – 54 Yrs	30.6%	21.7%	25%	28.3%	40.2%	41.2%	31.4%	23.4%
55 – 64 Yrs	16.7%	21.4%	28.6%	22.7%	20.5%	21.6%	37.1%	39.4%
65+	8.3%	4.8%	1.2%	2.8%	0%	0.7%	5.7%	9.1%



2023: 16 – 25 yrs olds as a percentage of the ICB workforce **1.8%.**

2024: 16 – 25 yrs olds as a percentage of the ICB workforce **2.4%**

2025: 16 – 25 yrs olds as a percentage of the ICB workforce **2.3%**

2025 workforce profile by Disability

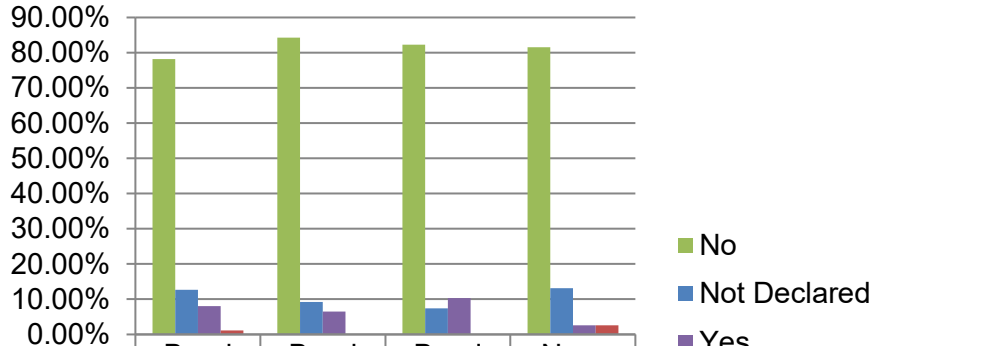
- **7.9%** declared disability (2024 = 7.3%)
- **9.9%** not declared / preferred not to say (2024 = 5.5%) → **major increase**
- Declared disability increased in: Bands 1–4 and Bands 8a–9
- Non-AfC: Responded **Yes**: 2.6% **Not declared**: 13.2% (highest)

Key Changes vs 2024

- **Positive improvement**: disability declaration rate increased again (fourth consecutive year).
- **Decline in improvement: rise** in nondisclosure (5.5% → 9.9%), particularly in: Band 1–4 (4.8% → 14.8%) Non-AfC (already high)
- **Disabled staff underrepresented** compared with local population (19.5%).

% Headcount for years 2023 - 2024	2023	2024	2023	2024	2023	2024	2023	2024
Afc Pay Bands	**1 – 4**	**1 – 4**	**5 – 7**	**5 - 7**	**8a – 9**	**8a – 9**	**Non-AfC**	**Non-AfC**
No	86.1%	88.1%	89.3%	86.8%	88.2%	89.9%	82.9%	75.8%
Yes	5.6%	7.1%	7.1%	8.5%	5.5%	6.8%	2.9%	6.1%
Not Declared	2.8%	2.4%	3.6%	4.7%	6.3%	3.4%	11.4%	15.2%
Prefer Not To Answer	5.6%	2.4%	0%	0%	0%	0%	2.9%	3%

Staffs and SoT ICB Workforce 30/09/2025 : Payscale By Disability Status



	Band 1 - 4	Band 5 - 7	Band 8a - 9	Non-AfC
No	78.16%	84.24%	82.29%	81.58%
Not Declared	12.64%	9.24%	7.43%	13.16%
Yes	8.05%	6.52%	10.29%	2.63%
Prefer Not To Answer	1.15%	0.00%	0.00%	2.63%

Payscale

2023: all ICB Staff by Disability **5.7%.** Not declared/preferred not to answer **6.7%**

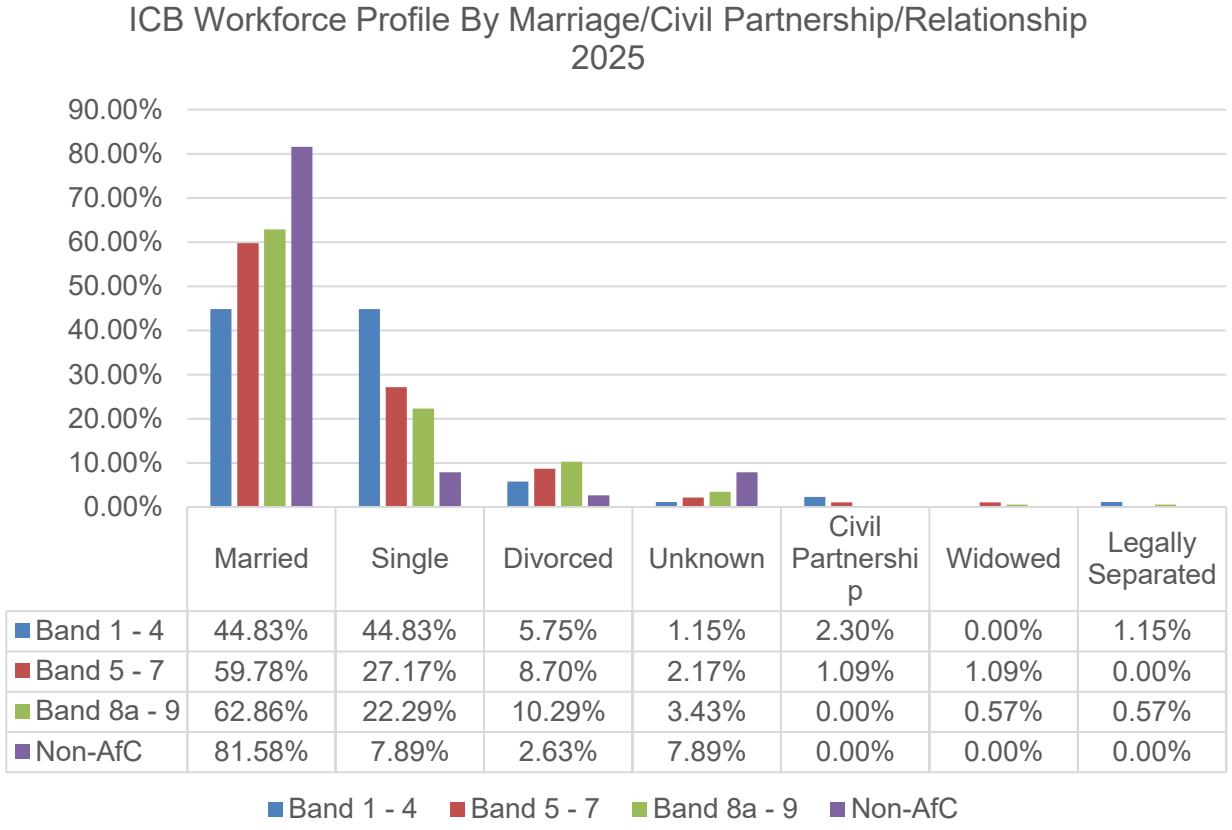
2024: all ICB Staff by Disability **7.3%.** Not declared/preferred not to say **5.5%**

2025: all ICB Staff by Disability **7.9% .** Not declared/preferred not to say **9.9%**

Marriage and Civil Partnership

The overall percentage figure of ICB staff identifying has being in a civil relationship for this reporting period was 0.8% this is above the combined Staffordshire and Stoke-on-Trent (SSoT) profile figure of 0.2%. 59.9% of the ICB workforce identified has being married which is higher than the (SSoT) profile figure of 50%. The highest pay band group who identify as married is the Non- AfC with 84.9%.

% Headcount for years 2023 and 2024	2023	2024	2023	2024	2023	2024	2023	2024
Marital Status	**Afc Pay Band 1 – 4**	**Afc Pay Band 1 – 4**	**Afc Pay Band 5 - 7**	**Afc Pay Band 5 - 7**	**Afc Pay Band 8a - 9**	**Afc Pay Band 8a – 9**	**Non-Afc**	**Non-AfC**
Married	52.8 %	50%	53.6%	57.6%	62.2%	61.5%	88.6%	84.9%
Single	36.1 %	45.2%	28.6%	25.5%	20.5%	23.0%	2.7%	3.0%
Divorced	5.6%	4.8%	13.1%	10.4%	11%	10.1%	0.0%	3.0%
Unknown	2.8%	0.0%	3.6%	4.7%	3.9%	3.4%	8.6%	9.1%
Civil Partnership	0.0%	0.0%	0.0%	0.0%	0.8%	0.7%	0.0%	0.0%
Widowed	2.8%	0.0%	1.2%	1.9%	0.8%	0.7%	0.8%	0.0%
Legally separated	0.0%	0.0%	0.0%	0.0%	0.8%	0.7%	0.0%	0.0%



2025 workforce profile by Broad Race/Ethnic Groups

- **White:** 87.8% (2024 = 89.4%)
- **Non-White:** 9.9% (2024 = 9.4%)
- **Not stated:** 1.7% (2024 = 1.2%)

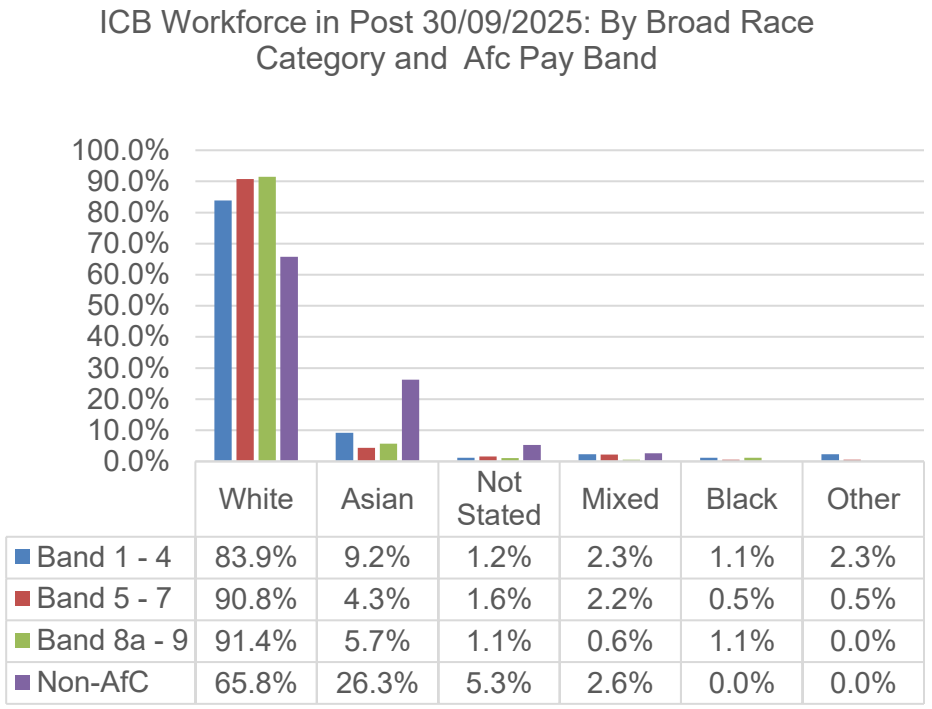
Main ethnicity patterns

- **Asian staff** positively represented in all bands except Bands 5–7.
- **Black staff** represented in Bands 1–4 and 8a–9.
- **Mixed heritage** small but represented in Bands 1–4.

Key Changes vs 2024

- **White staff reduced** (89.4 → 87.8%).
- **Non-White staff increased** (9.4 → 9.9%).
- **Representation improved most in senior roles (8a–9)** for Asian and Black staff.
- Small absolute numbers mean any recruitment/exit significantly shifts proportions.

% Headcount for years 2023 and 2024	2023	2024	2023	2024	2023	2024	2023	2024
Broad Race/Ethnic Category	**Afc Pay Band 1 – 4**	**Afc Pay Band 1 – 4**	**Afc Pay Band 5 - 7**	**Afc Pay Band 5 - 7**	**Afc Pay Band 8a - 9**	**Afc Pay Band 8a – 9**	**Non-Afc**	**Non-AfC**
White	88.9%	88.1%	96.4%	91.5%	89.8%	90.4	77.1%	78.8%
Asian*	5.6%	4.8%	2.4%	5.7%	7.1%	6.8%	20.0%	18.2%
Mixed	5.6%	2.4%	1.2%	1.9%	0.8%	0.7%	0.0%	0%
Black	0.0%	2.4%	0.0%	0%	0.8%	1.4%	2.7%	0%
Not Stated	0.0%	2.4%	0.0%	0.9%	0.8%	0.7%	0.0%	3%
Other	0.0%	0%	0.0%	0%	0.8%	0%	0.0%	0%



*The Census Bureau defines a person of the Asian race as "having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

2023 all ICB Staff: Non-White Staff 9.2% - White staff 90.0% - Not stated 0.7%

2024 all ICB Staff: Non-White Staff 9.4% - White Staff 89.4% - Not stated 1.2%

2025 all ICB Staff: Non-White Staff 9.9% - White Staff 87.8% - Not stated 1.7%

2025 workforce by Religion and belief

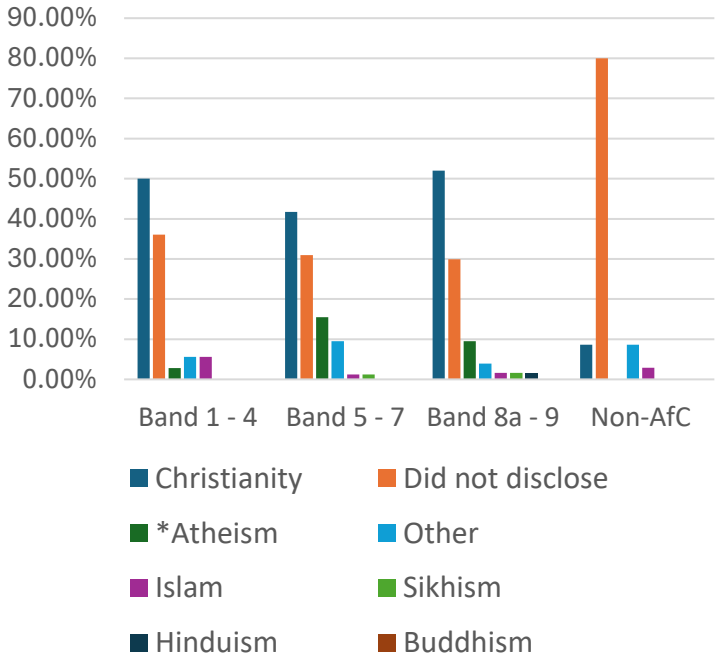
Trends

- Large proportion of staff continue to **not disclose**:
- Non-AfC: **~73.7%**
- Bands 1–4: **42–43%**
- Christianity remains the largest declared group.

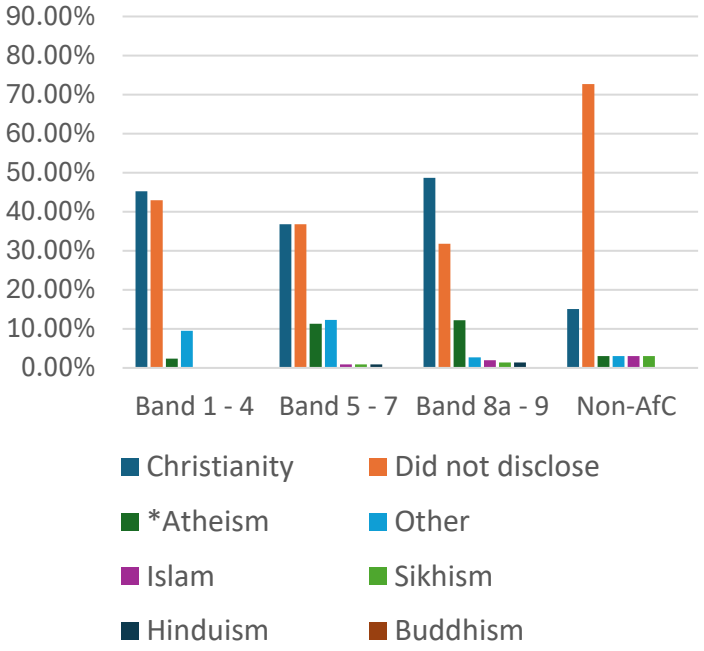
Key Changes vs 2024

- **Nondisclosure remains high**, but:
- Slight improvement in Non-AfC (80% → 73.7%).
- Minimal movement in declared categories.

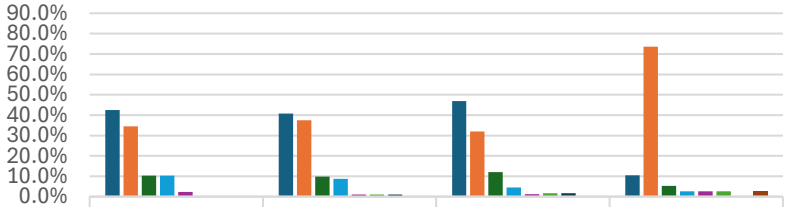
ICB Workforce Profile By Religion and Belief 2023



ICB Workforce Profile By Religion and Belief 2024



ICB Workforce Profile By Religion and Belief 2025



	Band 1 - 4	Band 5 - 7	Band 8a - 9	Non-AfC
Christianity	42.5%	40.76%	46.86%	10.53%
Did not disclose	34.5%	37.50%	32.00%	73.68%
*Atheism	10.3%	9.78%	12.00%	5.26%
Other	10.3%	8.70%	4.57%	2.63%
Islam	2.3%	1.09%	1.14%	2.63%
Sikhism	0.0%	1.09%	1.71%	2.63%
Hinduism	0.0%	1.09%	1.71%	0.00%
Buddhism	0.0%	0.00%	0.00%	2.63%

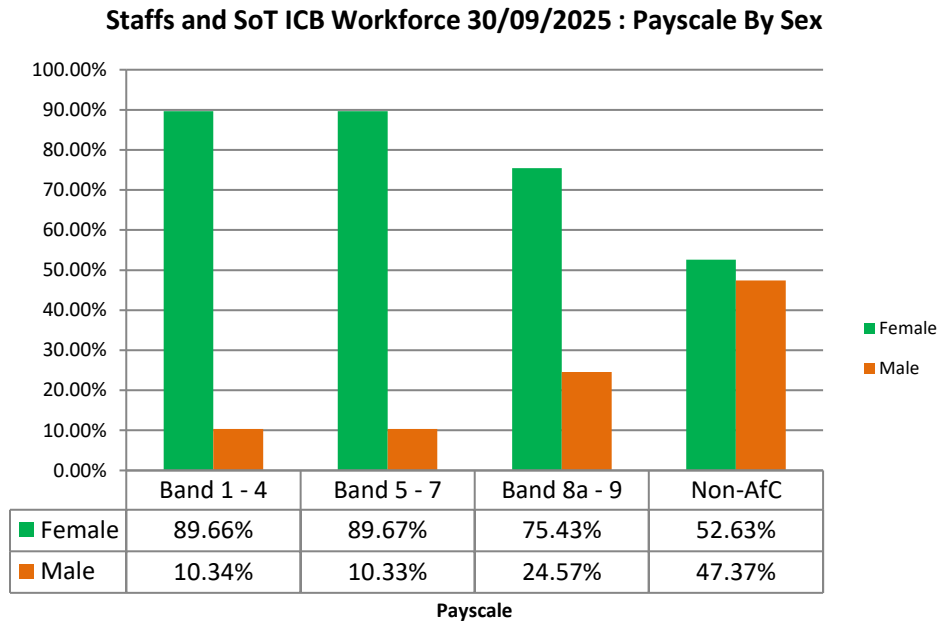
2025 workforce profile by Sex

- **Female: 81.6%**
- **Male: 18.4%**
- NHS national benchmark: **76.7% female / 23.3% male**

Key Changes vs 2024

- **Female representation increased** (76.3% → 81.6%).
- **Male representation decreased** (23.7% → 18.4%).
- Senior Non-Afc roles remain **male-heavy**, but:
- 2024 saw **three women appointed as Directors**, improving executive diversity and reducing the gender pay gap.

% Headcount for years 2023 and 2024	2023	2024	2023	2024	2023	2024	2023	2024
Pay Band	**1 – 4**	**1 – 4**	**5 – 7**	**5 – 7**	**8a – 9**	**8a – 9**	**Non-AfC**	**Non-AfC**
Female	91.7%	88.1%	86.9%	86.8%	74.8%	71.6%	48.6%	48.5%
Male	8.3%	11.9%	13.1%	13.2%	25.2%	28.4%	51.4%	51.5%



2023 All ICB Staff by Sex: **Female 77.3% - Male 22.7%**

2024 All ICB Staff by Sex: Female 76.3% - Male 23.7 %

2025 All ICB Staff by Sex: Female 81.6 % - Male 18.4%

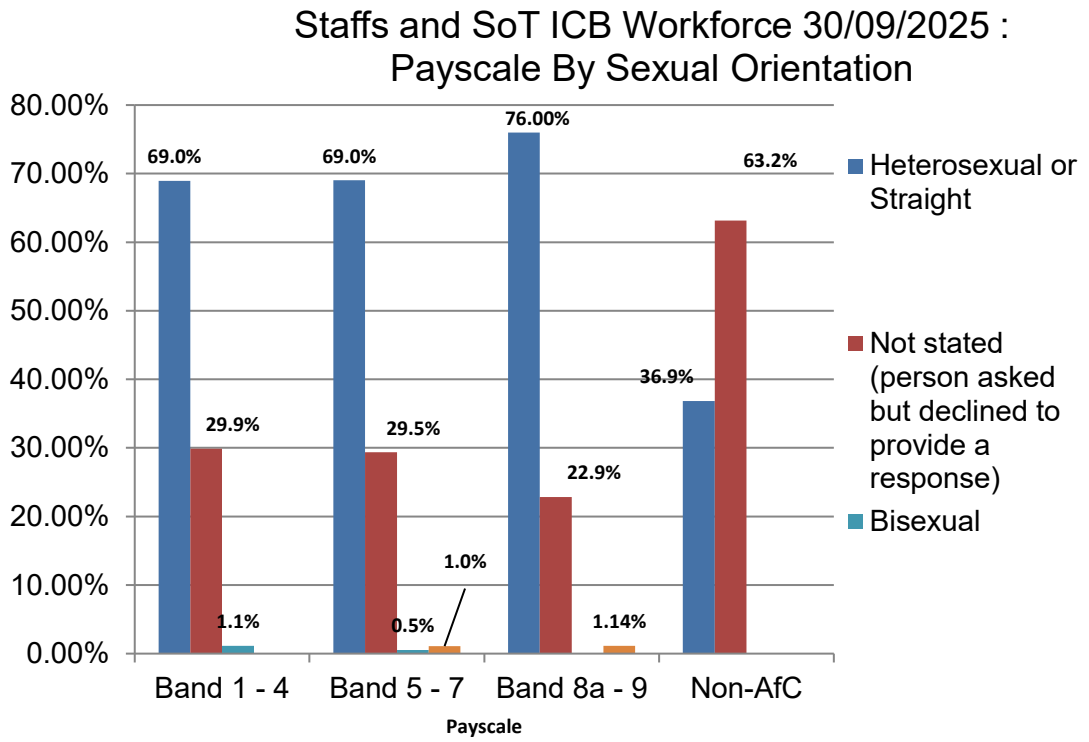
2025 workforce profile by Sexual Orientation

- Heterosexual/Straight: **69%** (2024 = 67.8%)
- LGB: **1.2%** (2024 = 1.5%)
- Not stated: **29.8%** (2024 = 30.7%)

Key Changes vs 2024

- **Small decrease in LGB disclosure** (likely linked to nondisclosure trends).
- Slight **increase in heterosexual identification**.
- **Nondisclosure reduced slightly**, but remains high especially in Non-AfC roles.

% Headcount for years 2023 2024	2023	2024	2023	2024	2023	2024	2023	2024
Pay Bands	**1 – 4**	**1 – 4**	**5 – 7**	**5 - 7**	**8a – 9**	**8a – 9**	**Non-AfC**	**Non-AfC**
Heterosexual or Straight	66.7%	59.5%	78.6%	69.8%	75.6%	75.7%	40.0%	36.4%
Not stated	33.3%	40.5%	17.9%	28.3%	22.1%	22.3%	60.0%	63.6%
Gay or Lesbian	0.0%	0%	1.2%	0.9%	2.4%	0%	0.0%	0%
Bisexual	0.0%	0%	2.4%	0.9%	0.0%	2%	0.0%	0%



2023 ICB Staff: **: LGB 2.1% - Heterosexual or Straight 70.9% - Not stated 27.0%**	**2024 ICB Staff: : LGB 1.5% - Heterosexual or Straight 67.8% - Not stated 30.7 %**	**2025 ICB Staff: : LGB 1.2% - Heterosexual or Straight 69% - Not stated 29.8%**

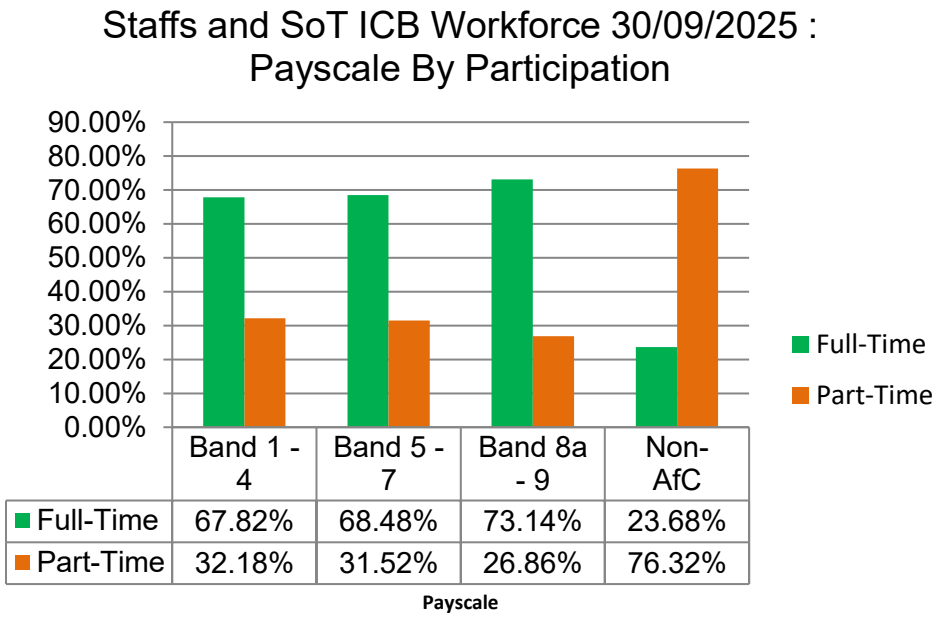
2025 workforce profile by Working Pattern

- Full-time: **66.5%**
- Part-time: **33.5%**

Key Changes vs 2024

- **Full-time decreased** slightly (67.2 → 66.5%)
- **Part-time increased** (32.8 → 33.5%)
- Continues multiyear trend toward more flexible working

% Headcount for years 2023 – 2024	2023	2024	2023	2024	2023	2024	2023	2024
Participation	**Afc Pay Band 1 – 4**	**Afc Pay Band 1 – 4**	**Afc Pay Band 5 – 7**	**Afc Pay Band 5 - 7**	**Afc Pay Band 8a – 9**	**Afc Pay Band 8a – 9**	**Non-AfC**	**Non-AfC**
Full-Time	66.7%	59.5%	84.5%	76.4%	75.6%	73.7%	25.7%	18.2%
Part-Time	33.3%	40.5%	15.5%	23.6%	24.4%	26.3%	74.3%	81.8%



2023: ICB Staff by Participation: **Full Time 70.9% - Part-Time 29.1%**	2024: ICB Staff by Participation: Full Time 67.2 % - Part-Time 32.8%	2025: ICB Staff by Participation: Full Time 66.5% - Part-Time 33.5%

ICB Workforce Profile by Directorate

ICB Workforce Profile by Directorate

This section of the report provides a profile of ICB staff in post as of the 30.09.2024 by ICB directorate. To preserve anonymity staff numbers are replaced with percentages as to make it difficult to identify individual staff.

While the ICB will always continue to monitor its workforce profile from all 9 protected characteristics, we must also consider low staff numbers (and their anonymity) within directorates. Any directorate with fewer than 10 staff will not be included in this section of the report.

We publish equality-driven data and focus on areas where EDI is most relevant and evidence-based. For this section, we will concentrate on Age, Disability, Race, and Sex, as these are most represented in our workforce. Other characteristics, such as sexual orientation and religion or belief, are not consistently disclosed, limiting reliable analysis.

These figures represent individual directorates it is important to understand that when working with such small figures, small changes in staff numbers can substantially alter the demographic profile of a workforce.

Summary by Directorate

Directorate analysis shows **considerable variation** in workforce composition, driven by functional differences and small cohort effects.

- **Corporate Governance** shows increased disability declaration and a growing younger workforce (25–34).
- **Delivery** exhibits the **strongest growth in ethnic diversity**, particularly at Bands 1–4, and a more balanced gender mix in Bands 5–7.
- **Finance, Performance & Information** remains predominantly White and mid-career, with some increase in female representation in senior AfC roles but growing male dominance in Non-AfC positions.
- **Medical** continues to be **one of the ICB's most diverse directorates**, with strong Asian representation in Non-AfC roles and balanced gender representation at senior levels.
- **Nursing & Therapies** is the most female-dominated directorate (89–94% across AfC bands) with small increases in disability declaration.
- **People Directorate** patterns are heavily affected by high nondisclosure, though some improvement in ethnic diversity is visible.
- **Transformation** shows slight increases in senior ethnic diversity and disability declaration, with diverging gender patterns across pay bands.

Across all directorates, **Under-25 representation remains extremely low**, disability nondisclosure is disproportionately high in Non-AfC roles, and directorate-level diversity is sensitive to small staffing changes.

ICB Workforce Profile by Directorate – Corporate Governance

Age	2024	2025	2024	2025	2024	2025
Pay Bands	1 – 4	1 – 4	5 – 7	5 - 7	8a – 9	8a – 9
Under 25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25-34	21.1%	29.4%	24.0%	25.0%	0.0%	0.0%
35-44	10.5%	11.8%	12.0%	12.5%	33.3%	33.3%
45-54	21.1%	17.6%	24.0%	20.8%	66.7%	50.0%
55-64	36.8%	35.3%	28.0%	33.3%	0.0%	16.7%
65+	10.5%	5.9%	12.0%	8.3%	0.0%	0.0%

Broad Ethnic Group	2024	2025	2024	2025	2024	2025
Pay Bands	1 – 4	1 – 4	5 – 7	5 - 7	8a – 9	8a – 9
White	89.5%	88.2%	96.0%	95.8%	100.0%	100.0%
Asian*	0.0%	0.0%	4.0%	4.2%	0.0%	0.0%
Mixed	5.3%	5.9%	0.0%	0.0%	0.0%	0.0%
Black	5.3%	5.9%	0.0%	0.0%	0.0%	0.0%
Not Stated	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Disability	2024	2025	2024	2025	2024	2025
Afc Pay Bands	1 – 4	1 – 4	5 – 7	5 - 7	8a – 9	8a – 9
No	84.2%	76.5%	88.0%	87.5%	83.3%	83.3%
Yes	15.8%	23.5%	8.0%	8.3%	16.7%	16.7%
Not Stated	0.0%	0.0%	4.0%	4.2%	0.0%	0.0%

Sex	2024	2025	2024	2025	2024	2025
Pay Band	1 – 4	1 – 4	5 – 7	5 – 7	8a – 9	8a – 9
Female	100.0%	100.0%	100.0%	100.0%	83.3%	83.3%
Male	0.0%	0.0%	0.0%	0.0%	16.7%	16.7%

ICB Workforce Profile by Directorate – Delivery

Age	2024	2025	2024	2025	2024	2025	2024	2025
Pay Bands	1 – 4	1 – 4	5 – 7	5 - 7	8a – 9	8a – 9	Non-Afc	Non-Afc
Under 25	0.0%	14.3%	0.0%	0.0%	0.0%	0.0%		0.0%
25-34	0.0%	14.3%	20.0%	33.3%	10.0%	9.5%		0.0%
35-44	33.3%	42.9%	20.0%	16.7%	25.0%	23.8%		33.3%
45-54	66.7%	14.3%	60.0%	33.3%	30.0%	33.3%		66.7%
55-64	0.0%	14.3%	0.0%	16.7%	35.0%	33.3%		0.0%
65+	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		0.0%

Broad Ethnic Group	2024	2025	2024	2025	2024	2025	2024	2025
Pay Bands	1 – 4	1 – 4	5 – 7	5 - 7	8a – 9	8a – 9	Non-Afc	Non-Afc
White	100.0%	57.1%	80.0%	83.3%	95.0%	95.2%		66.7%
Asian*	0%	28.6%	20%	16.7%	5%	4.8%		33.3%
Mixed	0%	14.3%	0%	0.0%	0%	0.0%		0.0%
Black	0%	0.0%	0%	0.0%	0%	0.0%		0.0%
Not Stated	0%	0.0%	0%	0.0%	0%	0.0%		0.0%
Other	0%	0.0%	0%	0.0%	0%	0.0%		0.0%

Disability	2024	2025	2024	2025	2024	2025	2024	2025
Pay Bands	1 – 4	1 – 4	5 – 7	5 - 7	8a – 9	8a – 9	Non-Afc	Non-Afc
No	100.0%	85.7%	80.0%	100.0%	70.0%	81.0%		66.7%
Yes	0.0%	0.0%	20.0%	0.0%	30.0%	19.0%		0.0%
Not Stated	0.0%	14.3%	0.0%	0.0%	0.0%	0.0%		33.3%

Sex	2024	2025	2024	2025	2024	2025	2024	2025
Pay Band	1 – 4	1 – 4	5 – 7	5 – 7	8a – 9	8a – 9	Non-Afc	Non-Afc
Female	100.0%	100.0%	80.0%	66.7%	70.0%	71.4%		66.7%
Male	0.0%	0.0%	20.0%	33.3%	30.0%	28.6%		33.3%

ICB Workforce Profile by Directorate – Finance Performance and Information

Age	2024	2025	2024	2025	2024	2025	2024	2025
Pay Bands	1 – 4	1 – 4	5 – 7	5 - 7	8a – 9	8a – 9	Non-Afc	Non-Afc
Under 25	10.0%	10.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
25-34	20.0%	20.0%	20.0%	19.0%	10.0%	3.2%	0.0%	0.0%
35-44	60.0%	60.0%	30.0%	23.8%	33.3%	35.5%	0.0%	0.0%
45-54	10.0%	10.0%	35.0%	38.1%	43.3%	38.7%	0.0%	0.0%
55-64	0.0%	0.0%	15.0%	19.0%	13.3%	22.6%	0.0%	0.0%
65+	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Broad Ethnic Group	2024	2025	2024	2025	2024	2025	2024	2025
Pay Bands	1 – 4	1 – 4	5 – 7	5 - 7	8a – 9	8a – 9	Non-Afc	Non-Afc
White	80.0%	80.0%	90.0%	90.5%	93.3%	93.6%	0.0%	0.0%
Asian*	20.0%	20.0%	5.0%	4.8%	6.7%	6.5%	0.0%	0.0%
Mixed	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Black	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Not Stated	0.0%	0.0%	5.0%	4.8%	0.0%	0.0%	0.0%	0.0%
Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Disability	2024	2025	2024	2025	2024	2025	2024	2025
Afc Pay Bands	1 – 4	1 – 4	5 – 7	5 - 7	8a – 9	8a – 9	Non-Afc	Non-Afc
No	100.0%	100.0%	90.0%	90.5%	96.7%	90.3%	0.0%	100.0%
Yes	0.0%	0.0%	5.0%	4.8%	0.0%	3.2%	0.0%	0.0%
Not Stated	0.0%	0.0%	5.0%	4.8%	3.3%	6.5%	0.0%	0.0%

Sex	2024	2025	2024	2025	2024	2025	2024	2025
Pay Band	1 – 4	1 – 4	5 – 7	5 – 7	8a – 9	8a – 9	Non-Afc	Non-Afc
Female	50.0%	50.0%	65.0%	66.7%	46.7%	54.8%	0.0%	0.00%
Male	50.0%	50.0%	35.0%	33.3%	53.3%	45.2%	0.0%	100.0%

ICB Workforce Profile by Directorate – Medical

Age	2024	2025	2024	2025	2024	2025	2024	2025
Pay Bands	1 – 4	1 – 4	5 – 7	5 - 7	8a – 9	8a – 9	Non-Afc	Non-Afc
Under 25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25-34	0.0%	0.0%	22.2%	19.4%	2.0%	1.9%	0.0%	5.9%
35-44	0.0%	0.0%	30.6%	22.2%	42.0%	37.7%	22.2%	17.6%
45-54	0.0%	0.0%	27.8%	33.3%	36.0%	39.6%	44.4%	23.5%
55-64	0.0%	0.0%	19.4%	22.2%	20.0%	20.8%	33.3%	52.9%
65+	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%	0.0%

Broad Ethnic Group	2024	2025	2024	2025	2024	2025	2024	2025
Pay Bands	1 – 4	1 – 4	5 – 7	5 - 7	8a – 9	8a – 9	Non-Afc	Non-Afc
White	0.0%	0.0%	94.4%	91.7%	80.0%	79.2%	61.1%	58.8%
Asian*	0.0%	0.0%	5.6%	5.6%	14.0%	13.2%	33.3%	35.3%
Mixed	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Black	0.0%	0.0%	0.0%	2.8%	4.0%	3.8%	0.0%	0.0%
Not Stated	0.0%	0.0%	0.0%	0.0%	2.0%	0.0%	5.6%	0.0%
Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Disability	2024	2025	2024	2025	2024	2025	2024	2025
Afc Pay Bands	1 – 4	1 – 4	5 – 7	5 - 7	8a – 9	8a – 9	Non-Afc	Non-Afc
No	0.0%	0.0%	86.1%	91.7%	88.0%	84.9%	77.8%	76.5%
Yes	0.0%	0.0%	8.3%	5.6%	8.0%	9.4%	0.0%	0.0%
Not Stated	0.0%	0.0%	5.6%	2.8%	4.0%	5.7%	22.2%	23.5%

Sex	2024	2025	2024	2025	2024	2025	2024	2025
Pay Band	1 – 4	1 – 4	5 – 7	5 – 7	8a – 9	8a – 9	Non-Afc	Non-Afc
Female	0.0%	0.0%	91.7%	91.7%	72.0%	75.5%	50.0%	47.1%
Male	0.0%	0.0%	8.3%	8.3%	28.0%	24.5%	50.0%	52.9%

ICB Workforce Profile by Directorate – Nursing and Therapies

Age	2024	2025	2024	2025	2024	2025	2024	2025
Pay Bands	1 – 4	1 – 4	5 – 7	5 - 7	8a – 9	8a – 9	Non-Afc	Non-Afc
Under 25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25-34	40.0%	31.9%	20.0%	10.9%	3.7%	0.0%	0.0%	0.0%
35-44	20.0%	19.1%	20.0%	32.8%	22.2%	32.4%	0.0%	0.0%
45-54	20.0%	23.4%	20.0%	34.4%	40.7%	35.1%	0.0%	0.0%
55-64	20.0%	19.1%	40.0%	20.3%	29.6%	27.0%	100.0%	0.0%
65+	0.0%	6.4%	0.0%	1.6%	3.7%	5.4%	0.0%	0.0%

Broad Ethnic Group	2024	2025	2024	2025	2024	2025	2024	2025
Pay Bands	1 – 4	1 – 4	5 – 7	5 - 7	8a – 9	8a – 9	Non-Afc	Non-Afc
White	90.0%	89.4%	90.0%	95.3%	100.0%	100.0%	100.0%	0.0%
Asian*	0.0%	6.4%	10.0%	4.7%	0.0%	0.0%	0.0%	0.0%
Mixed	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Black	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Not Stated	10.0%	2.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Other	0.0%	2.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Disability	2024	2025	2024	2025	2024	2025	2024	2025
Pay Bands	1 – 4	1 – 4	5 – 7	5 - 7	8a – 9	8a – 9	Non-Afc	Non-Afc
No	90.0%	83.0%	80.0%	84.4%	96.3%	89.2%	0.0%	0.0%
Yes	0.0%	6.4%	10.0%	7.8%	0.0%	8.1%	100.0%	0.0%
Not Stated	10.0%	10.6%	10.0%	7.8%	3.7%	2.7%	0.0%	0.0%

Sex	2024	2025	2024	2025	2024	2025	2024	2025
Pay Band	1 – 4	1 – 4	5 – 7	5 – 7	8a – 9	8a – 9	Non-Afc	Non-Afc
Female	100.0%	93.6%	90.0%	92.2%	88.9%	89.2%	100.0%	0.0%
Male	0.0%	6.4%	10.0%	7.8%	11.1%	10.8%	0.0%	0.0%

ICB Workforce Profile by Directorate – People

Age	2024	2025	2024	2025	2024	2025	2024	2025
Pay Bands	1 – 4	1 – 4	5 – 7	5 - 7	8a – 9	8a – 9	Non-Afc	Non-Afc
Under 25	<10	0.0%	<10	0.0%	<10	0.0%	<10	0.0%
25-34	<10	16.7%	<10	18.8%	<10	0.0%	<10	0.0%
35-44	<10	66.7%	<10	31.3%	<10	50.0%	<10	0.0%
45-54	<10	0.0%	<10	31.3%	<10	50.0%	<10	0.0%
55-64	<10	16.7%	<10	12.5%	<10	0.0%	<10	0.0%
65+	<10	0.0%	<10	6.3%	<10	0.0%	<10	0.0%

Broad Ethnic Group	2024	2025	2024	2025	2024	2025	2024	2025
Pay Bands	1 – 4	1 – 4	5 – 7	5 - 7	8a – 9	8a – 9	Non-Afc	Non-Afc
White	<10	66.7%	<10	87.5%	<10	100.0%	<10	0.0%
Asian*	<10	16.7%	<10	0.0%	<10	0.0%	<10	0.0%
Mixed	<10	0.0%	<10	6.3%	<10	0.0%	<10	0.0%
Black	<10	0.0%	<10	0.0%	<10	0.0%	<10	0.0%
Not Stated	<10	0.0%	<10	0.0%	<10	0.0%	<10	0.0%
Other	<10	16.7%	<10	6.3%	<10	0.0%	<10	0.0%

Disability	2024	2025	2024	2025	2024	2025	2024	2025
Afc Pay Bands	1 – 4	1 – 4	5 – 7	5 - 7	8a – 9	8a – 9	Non-Afc	Non-Afc
No	<10	0.0%	<10	37.5%	<10	12.5%	<10	0.0%
Yes	<10	0.0%	<10	6.3%	<10	12.5%	<10	0.0%
Not Stated	<10	100.0%	<10	56.3%	<10	75.0%	<10	0.0%

Sex	2024	2025	2024	2025	2024	2025	2024	2025
Pay Band	1 – 4	1 – 4	5 – 7	5 – 7	8a – 9	8a – 9	Non-Afc	Non-Afc
Female	<10	83.3%	<10	93.8%	<10	87.5%	<10	0.0%
Male	<10	16.7%	<10	6.3%	<10	12.5%	<10	0.0%

ICB Workforce Profile by Directorate – Transformation

Age	2024	2025	2024	2025	2024	2025		
Pay Bands	**1 – 4**	**1 – 4**	**5 – 7**	**5 - 7**	**8a – 9**	**8a – 9**	**Non-Afc**	**Non-Afc**
Under 25	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25-34	0.0%	0.0%	14.3%	17.6%	0.0%	5.3%	0.0%	0.0%
35-44	0.0%	0.0%	42.9%	29.4%	21.4%	26.3%	0.0%	0.0%
45-54	0.0%	0.0%	14.3%	29.4%	57.1%	47.4%	0.0%	0.0%
55-64	0.0%	0.0%	28.6%	23.5%	21.4%	21.1%	0.0%	0.0%
65+	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Broad Ethnic Group	2024	2025	2024	2025	2024	2025	2024	2025
Pay Bands	**1 – 4**	**1 – 4**	**5 – 7**	**5 - 7**	**8a – 9**	**8a – 9**	**Non-Afc**	**Non-Afc**
White	0.0%	0.0%	85.7%	70.6%	92.9%	94.7%	0.0%	0.0%
Asian*	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Mixed	0.0%	0.0%	14.3%	17.6%	7.1%	5.3%	0.0%	0.0%
Black	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Not Stated	0.0%	0.0%	0.0%	11.8%	0.0%	0.0%	0.0%	0.0%
Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Disability	2024	2025	2024	2025	2024	2025	2024	2025
Afc Pay Bands	**1 – 4**	**1 – 4**	**5 – 7**	**5 - 7**	**8a – 9**	**8a – 9**	**Non-Afc**	**Non-Afc**
No	0.0%	0.0%	85.7%	94.1%	85.7%	78.9%	0.0%	0.0%
Yes	0.0%	0.0%	14.3%	5.9%	7.1%	15.8%	0.0%	0.0%
Not Stated	0.0%	0.0%	0.0%	0.0%	7.1%	5.3%	0.0%	0.0%

Sex	2024	2025	2024	2025	2024	2025	2024	2025
Pay Band	**1 – 4**	**1 – 4**	**5 – 7**	**5 – 7**	**8a – 9**	**8a – 9**	**Non-Afc**	**Non-Afc**
Female	0.0%	0.0%	85.7%	94.1%	85.7%	78.9%	0.0%	0.0%
Male	0.0%	0.0%	14.3%	5.9%	14.3%	21.1%	0.0%	0.0%

Staffordshire and Stoke-on-Trent Integrated Care Board - Recruitment.

Recruitment process data by disaggregated Protected Characteristics 2025

Summary Recruitment Profile (Oct 2024–Sep 2025)

This section explains who applied for jobs at Staffordshire & Stoke-on-Trent ICB, and who went on to be shortlisted, interviewed, and finally appointed. The information is shown by different protected characteristics to help us understand whether people are having fair and equal experiences during recruitment. In total:

574 people applied for roles
104 were shortlisted
79 attended for interview
35 were appointed

In Summary

What this data suggests:

- No Under-25 applicants were shortlisted, interviewed, or appointed, despite representing almost 4% of applicants.
- Disability representation reduced at each recruitment stage (10.8% applied → 2.9% appointed).
- Black applicants are not represented appointment stage although there were 22% at applicant stage.
- More than half of appointed candidates did not disclose their ethnicity, religion, or sexual orientation.
- Female applicants were slightly more successful overall (65.7% of appointments), aligning with wider ICB gender patterns.

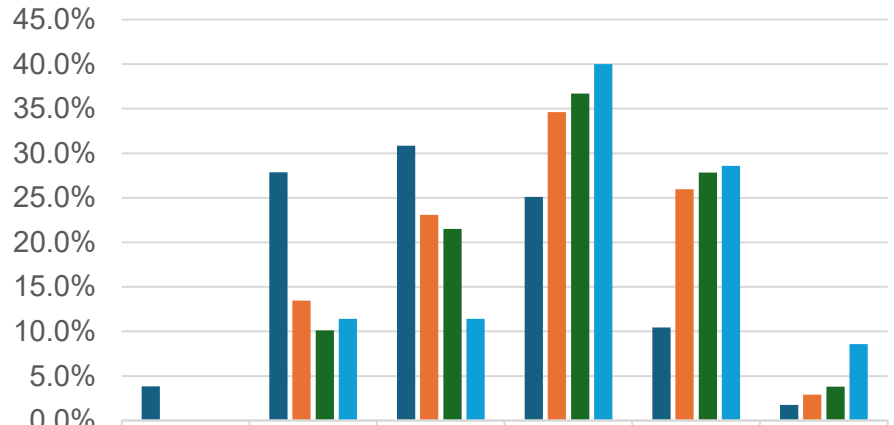
What could help improve fairness and understanding:

- Making it easier and more reassuring for new starters to share their equality information (if they choose to).
- Looking more closely at each stage, especially shortlisting and final decision-making, to understand why patterns differ for some groups.
- Continuing good practice that supports disabled applicants through each step of the process.

Age.

Of the 574 applicants, 99.8% of applicants provided this information and represented a broad range of age groups. Applicants who were shortlisted, interviewed and appointed represented a wide spread of age groups. 3.8% of applicants who applied were under 25, none were shortlisted, interviewed or appointed.

Applicants by Age



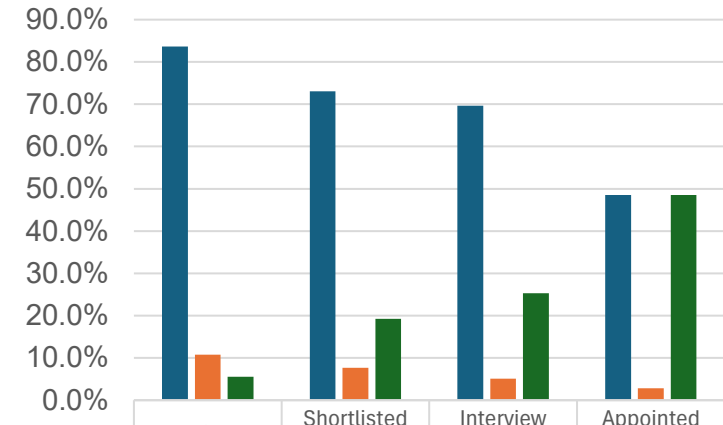
	Under 25	25 - 34	35 - 44	45 - 54	55 - 64	65+
Applied %	3.8%	27.9%	30.8%	25.1%	10.5%	1.7%
Shortlisted %	0.0%	13.5%	23.1%	34.6%	26.0%	2.9%
Interview attended %	0.0%	10.1%	21.5%	36.7%	27.8%	3.8%
Appointed %	0.0%	11.4%	11.4%	40.0%	28.6%	8.6%

Applied % Shortlisted % Interview attended % Appointed %

Disability

Of the 574 applicants 10.8% identified as having a disability. Of the 104 applicants who were shortlisted 7.7% were disabled. 79 applicants were interviewed 5.1 % of which identified as having a disability. Of the 35 applicants who were appointed 2.9% were disabled . 5.6% of the 574 applicants either did not state or chose not to disclose their status.

Applicants by Disability

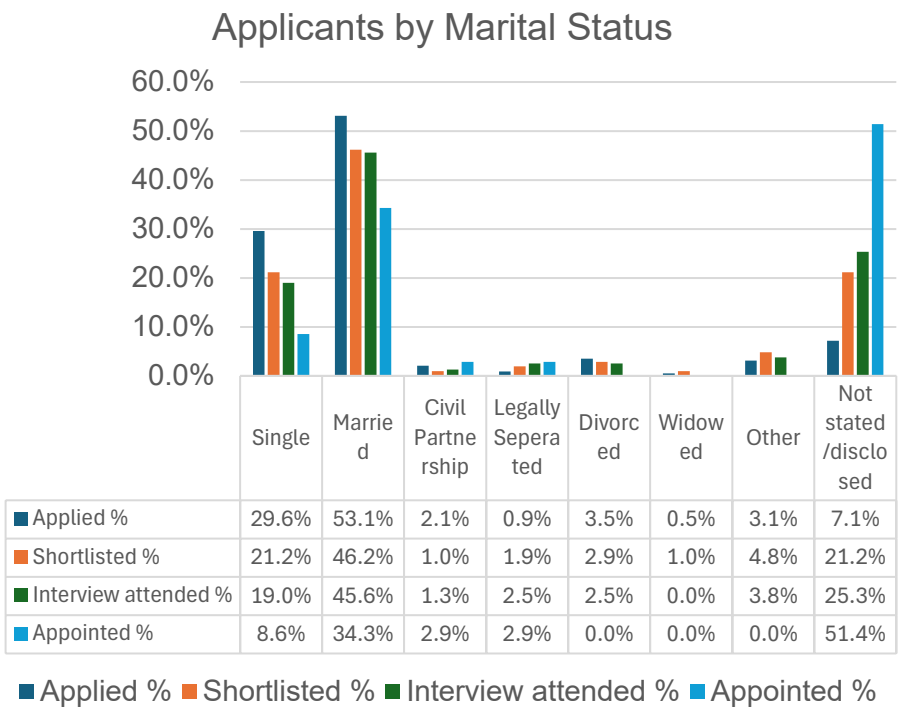


	Applied %	Shortlisted %	Interview attended %	Appointed %
No	83.6%	73.1%	69.6%	48.6%
Yes	10.8%	7.7%	5.1%	2.9%
Not stated or wished not to disclose	5.6%	19.2%	25.3%	48.6%

No Yes Not stated or wished not to disclose

Marriage and Civil Partnership

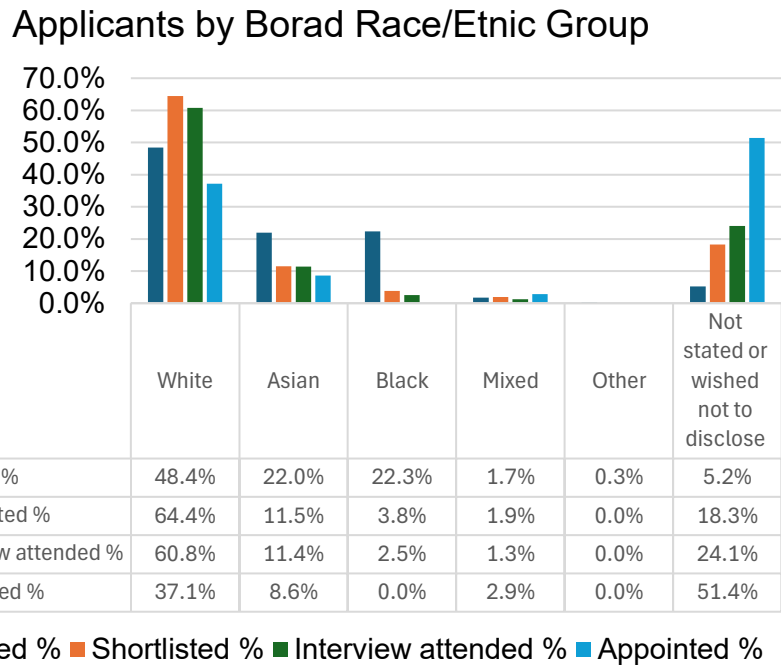
Of the applicants 574, 104 were shortlisted of which 46.2 % identified as being married and 1% identified as being in a civil partnership. Of the 35 applicants who were appointed, 34.3% were married, 2.3 % in a civil partnership and 51.4% did not disclose their status.



	Single	Married	Civil Partnership	Legally Seperated	Divorced	Widowed	Other	Not stated /disclosed
Applied %	29.6%	53.1%	2.1%	0.9%	3.5%	0.5%	3.1%	7.1%
Shortlisted %	21.2%	46.2%	1.0%	1.9%	2.9%	1.0%	4.8%	21.2%
Interview attended %	19.0%	45.6%	1.3%	2.5%	2.5%	0.0%	3.8%	25.3%
Appointed %	8.6%	34.3%	2.9%	2.9%	0.0%	0.0%	0.0%	51.4%

Race

The data has been presented by broad ethnic groups. Of the 104 applicants who were shortlisted 48.4 % identified as White, 22 % Asian, 22.3 % Black, 5.2% did not disclose. Of the 35 applicants who were appointed 37.1% were White, 8.6% Asian, 2.9% and 51.4 % of applicants who did not disclose their ethnicity were appointed.

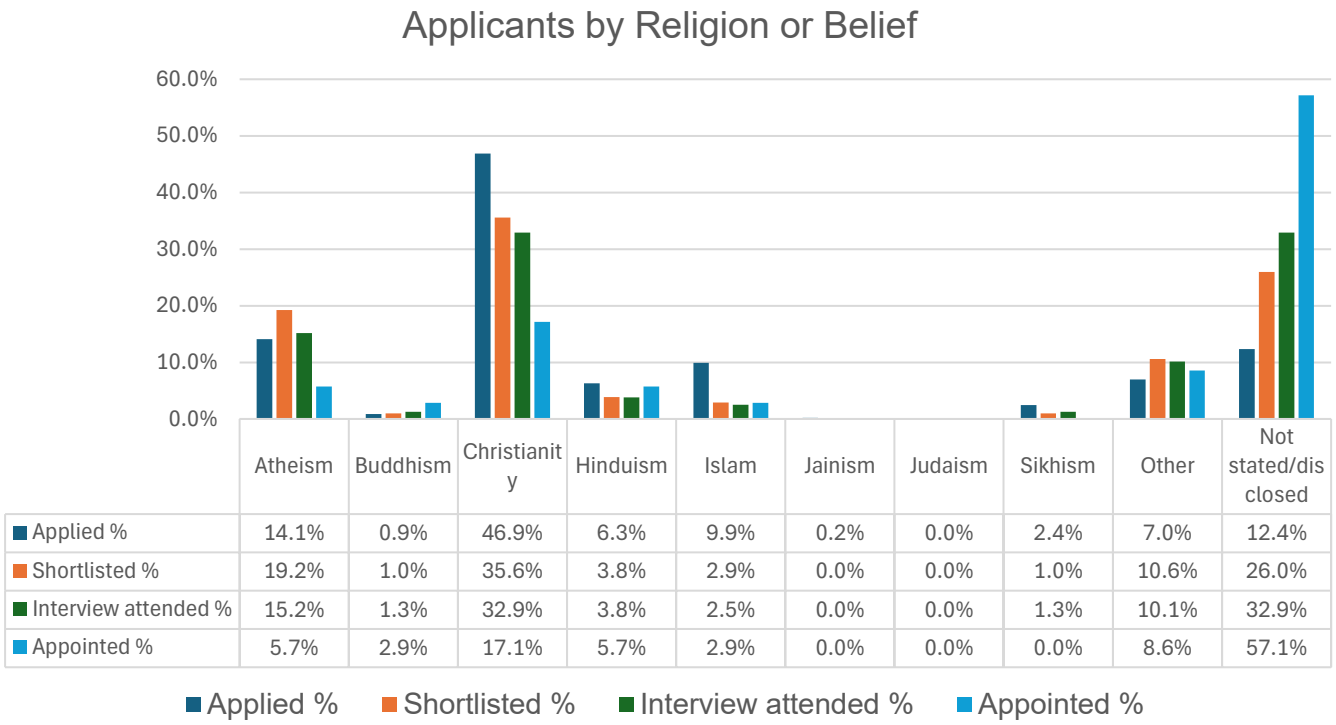


	White	Asian	Black	Mixed	Other	Not stated or wished not to disclose
Applied %	48.4%	22.0%	22.3%	1.7%	0.3%	5.2%
Shortlisted %	64.4%	11.5%	3.8%	1.9%	0.0%	18.3%
Interview attended %	60.8%	11.4%	2.5%	1.3%	0.0%	24.1%
Appointed %	37.1%	8.6%	0.0%	2.9%	0.0%	51.4%

*The Census Bureau defines a person of the Asian race as “having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.”

Religion or Belief

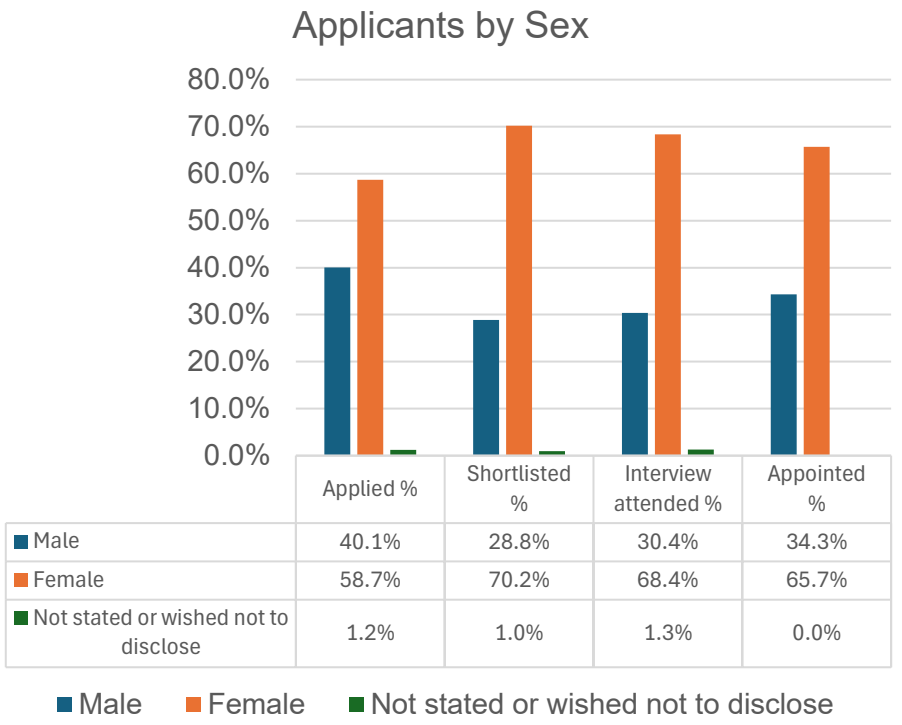
Most applicants who applied identified as Christian. Of the 574 applicants 46.9% were Christian, 12.4 % either did not wish to disclose or not stated, 14.1 % identified as Atheist, 9.9 % Islam, 6.3 % Hinduism and 7 % Other. Of the successful applicants 57.1% came from the group that did not disclose their religion.



	Atheism	Buddhism	Christianity	Hinduism	Islam	Jainism	Judaism	Sikhism	Other	Not stated/disclosed
Applied %	14.1%	0.9%	46.9%	6.3%	9.9%	0.2%	0.0%	2.4%	7.0%	12.4%
Shortlisted %	19.2%	1.0%	35.6%	3.8%	2.9%	0.0%	0.0%	1.0%	10.6%	26.0%
Interview attended %	15.2%	1.3%	32.9%	3.8%	2.5%	0.0%	0.0%	1.3%	10.1%	32.9%
Appointed %	5.7%	2.9%	17.1%	5.7%	2.9%	0.0%	0.0%	0.0%	8.6%	57.1%

Sex (Female Male)

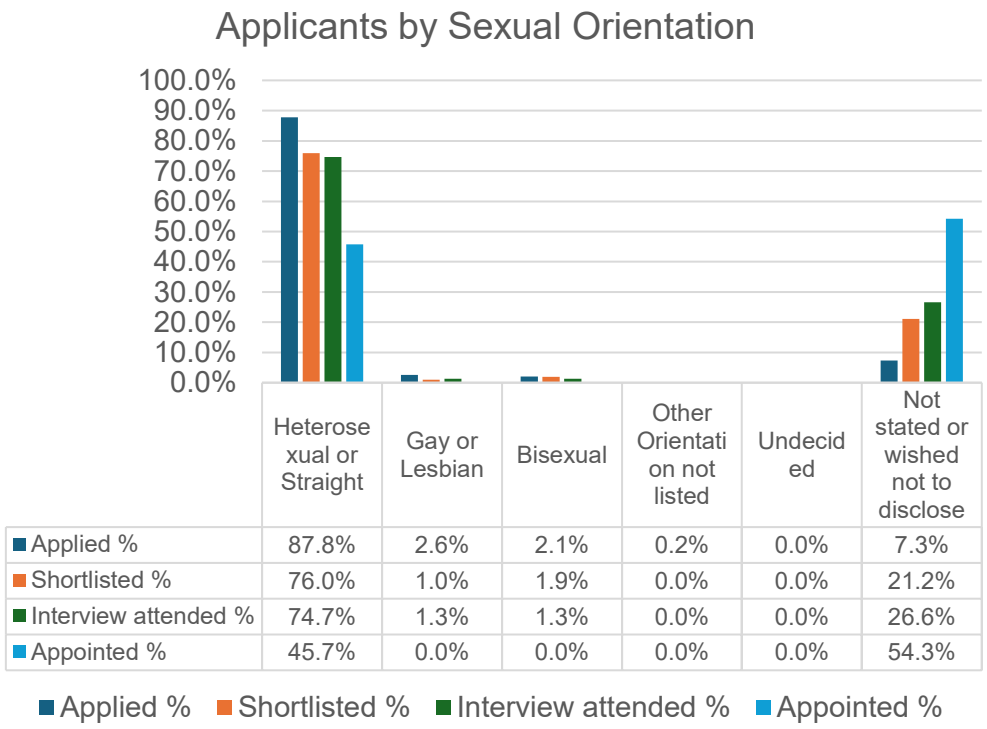
Of the 574 applicants all but 1.2 % identified their sex, with 58.7% female and 40.1% male. Of the applicants that were appointed 65.7% were female and 34.3% were male.



	Applied %	Shortlisted %	Interview attended %	Appointed %
Male	40.1%	28.8%	30.4%	34.3%
Female	58.7%	70.2%	68.4%	65.7%
Not stated or wished not to disclose	1.2%	1.0%	1.3%	0.0%

Sexual Orientation.

Of the 574 applicants, 87.8% identified as Heterosexual or Straight, 7.3% not stated or did not wish to disclose totalling 7.3%, 2.6% Gay or Lesbian , 2.1% Bisexual %, 0.2% other orientation not stated. Of the successful applicants; 45.7% identified as Heterosexual or Straight, 54.3% had not stated or did not wish to disclose their status.



	Heterosexual or Straight	Gay or Lesbian	Bisexual	Other Orientation not listed	Undecided	Not stated or wished not to disclose
Applied %	87.8%	2.6%	2.1%	0.2%	0.0%	7.3%
Shortlisted %	76.0%	1.0%	1.9%	0.0%	0.0%	21.2%
Interview attended %	74.7%	1.3%	1.3%	0.0%	0.0%	26.6%
Appointed %	45.7%	0.0%	0.0%	0.0%	0.0%	54.3%

Conclusion

During 2025, progress against the ICB's Workforce Diversity Profile Report actions was unavoidably impacted by the wider ICB reform programme, including substantial structural changes across the organisation. These changes required significant operational focus and resulted in some planned equality, diversity and inclusion (EDI) activities being paused or scaled back.

In addition, the establishment of a shared cluster arrangement with Shropshire, Telford and Wrekin ICB has introduced existing and new opportunities for collaboration but has also highlighted variation in how each ICB interprets and implements EDI and its Public Sector Equality Duty (PSED) responsibilities.

As these operational and governance arrangements continue to embed, it is anticipated that a unified and consistent cross-ICB approach to PSED and workforce equality will be required to ensure alignment, accountability, and improved collective impact going forward.

Overall Summary Conclusion

Some areas show encouraging progress particularly improvements in ethnic diversity at senior levels, rising disability declaration, and strong female representation in leadership. However, significant challenges remain:

- Underrepresentation of disabled and Black applicants during recruitment
- High nondisclosure among appointed candidates, limiting visibility of equality outcomes
- Low early-career representation, affecting talent pipelines
- Persistent gender imbalance, particularly between AfC and Non-AfC roles
- Marked directorate variation, demonstrating a need for tailored EDI action planning

As the ICB continues to embed organisational reform and cluster arrangements, the data signals clear priorities and opportunities for strengthening equality, diversity and inclusion, ensuring a more representative workforce and a fair, transparent recruitment process.

Staffordshire and Stoke-on-Trent Integrated Care Board – Next Steps.

ICB Priorities for 2026 - 2027

ICB priorities for 2026/2027

As the ICB enters 2026–27, a key organisational priority will be progressing the next phase of the ICB Reform Blueprint and operationalising the newly formed cluster with Shropshire Telford and Wrekin (SWT) ICB. This new cluster arrangement creates an opportunity to strengthen consistency, reduce duplication, and develop a shared approach to equality, diversity and inclusion (EDI) and the Public Sector Equality Duty (PSED). Establishing common standards, governance expectations and ways of working will be central to ensuring both ICBs operate with clarity, fairness and transparency in how workforce decisions are made.

During 2026–27, the ICB will focus on aligning policies, data practices, leadership responsibilities and cultural expectations across the cluster to create a coherent and collaborative EDI PSED agenda. The intention is to build a shared framework that supports inclusive employment practices, improves workforce experience, and ensures that both ICBs continue to meet their statutory duties while adapting to the evolving reform landscape. This work will require sustained engagement, careful change management and a continued emphasis on staff wellbeing and communication throughout the transition.

Integrated Care System
Shropshire, Telford and Wrekin

Staffordshire and Stoke-on-Trent Integrated Care System

NHS
NHS Shropshire, Telford and Wrekin
NHS Staffordshire and Stoke-on-Trent

Enclosure No: 11

Report to:	ICB Boards in Common
Date:	30 April 2026
Title:	ICB Performance Reports
Presenting Officer:	Claire Skidmore, NHSSTW and NHSSSOT
Author(s):	Angela Parkes, NHSSTW and Vicki Inch, NHSSSOT

Document Type:				**Action Required (select):**			
Report	☒	**Business Plan**	☐	**Information (I)**	☐	**Discussion (D)**	☐
Strategy	☐	**Policy**	☐	**Assurance (S)**	☒	**Approval (A)**	☐
Other	☐	*(please describe)*		**Ratification (R)**	☐	*(check as necessary)*	

Is the decision within SOFD powers & limits	**Yes**	☐	**No**	☐
Any potential / actual Conflict of Interest?	**Yes**	☐	**No**	☒
If Y, the mitigation recommendations:	*E.g. Staff have Financial + Non-Financial Professional Interests which can be managed by recording those in minutes and allowing presence in discussions with recusals from formal decisions*			
Any financial impacts: ICB or ICS?	**Yes**	☐	**No**	☒
If Y, are those signed off by and date:	*E.g. Chief Finance Office, dd-mmm-yyyy*			
Any impacts on ICB Undertakings?	**Yes**	☐	**No**	☒
If Y, are those signed off by and date:	*E.g. Chief Finance Office, dd-mmm-yyyy*			
Appendices:	Appendix A: NHSSTW Integrated Performance Report; Appendix B: NHSSSOT Performance report; Appendix C: NHSSSOT Finance report			

(1) Purpose of the Paper:

The Performance Report is brought to the Board to provide the latest position regarding finance, quality, performance and workforce across the two ICBs. It provides assurance on the delivery of our key measurable outcomes and informs the Board of the current risks and issues related to that delivery.

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

(3) Implications:

Legal / Regulatory	No legal, regulatory or equality implications identified as a direct result of this report
CQC / Patient Safety	Quality Leads have worked with Planning and Performance Leads to ensure Quality is reflected throughout the report.
Financial (CFO-assured)	Delivery of the financial plan and efficiency plan targets supports financial recovery and sustainability.
Sustainability	*n/a*
Workforce / Training	Workforce is reflected at relevant points in the report.
Equality & Diversity	*n/a*
Due Regard: Inequalities	The report seeks to provide assurance against key measurable outcomes and to highlight areas of concern and actions being taken to address these, to support improving outcomes in population health.
Due Regard: wider effect	*n/a*

(4) Statutory Dependencies & Impact Assessments:

	Completed?			If N - N/A, Rationale	If Y, Outcome / Date Reported & Signed off
DPIA	**Yes**	**No**	**N/A**	Click or tap here to enter text.	*Reported to IG Committee:* Click or tap to enter a date.
	☐	☐	☒		
EIA	**Yes**	**No**	**N/A**	Click or tap here to enter text.	*Outcome and date of completion:* Click or tap here to enter text.
	☐	☐	☒		
QIA	**Yes**	**No**	**N/A**	*E.g. per QIA Policy, that it doesn't impact quality of services* Click or tap here to enter text.	*SRO sign-off, outcome & date of completion:* Click or tap here to enter text.
	☐	☐	☒		

Has there been Public / Patient Involvement?	**Yes**	**No**	**N/A**	
	☐	☐	☒	*Click or tap here to enter text.*

(5) Integration with SBAF (for NHS SSOT) / Strategic Risks (SR, for NHS STW)

SBAF1	Responsive Patient Care - Elective	☒	**SBAF5**	High Quality, Safe Outcomes	☒
SBAF2	Responsive Patient Care - UEC	☒	**SBAF6**	Sustainable Finances	☒
SBAF3	Transforming Community Services	☒	**SBAF7**	Improving Productivity	☒
SBAF4	Reducing Health Inequalities	☒	**SBAF8**	Sustainable Workforce	☒
SR1	Strategic Collaboration & Partnership	☐	**SR4**	ICS Workforce (retention/wellbeing)	☒
SR2a	ICB & System Financial Balance	☒	**SR5**	Digital & Data Systems / Strategy	☐
SR2b	ICB & System RRL / CRL Plans	☒	**SR6**	ICS Strategic Response (e.g. EPRR)	☐

SR3	Reducing Health Inequalities	☒	SR7	ICS Socio-Economic Development	☐
			SR8	Patient & Public Involvement	☐

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

The Performance Report is brought to the Board to provide the latest position regarding finance, quality, performance and workforce across the two ICBs. It provides assurance on the delivery of our key measurable outcomes and informs the Board of the current risks and issues related to that delivery.

There are two appendices, one containing the Shropshire, Telford and Wrekin Integrated Performance Report and the second containing the Staffordshire and Stoke on Trent Performance Report.

Shropshire, Telford and Wrekin

Areas showing improvement include:

- UEC: Cat 2 response times. Ambulance handover time met local plan and requires an improvement of 17 minutes to reach the next quartile.
- Elective care: RTT performance above plan. Cancer standards better than plan with 31 day standard ranked jointly first out of 42 ICBs. DM01 6 week waits for diagnostics showing improvement but further work required to meet target.
- Mental health: Eating disorder routine appointments at 100%. CYP MH access showing sustained improvement. Talking therapies measures.
- Maternity: Maternity bookings before 10 weeks. Mothers smoking at time of delivery.
- IPC: All areas below trajectory and learning identified from cases.

Areas showing concern include:

- Primary care: Appointments in GP practices decreased in month (total, face to face, same day/next day)
- UEC: 4-hour A&E and 12-hour A&E both off track. Proportion of pathway 3 discharges showing concerning variation which indicates reliance on capacity outside of home first model.
- Elective care: RTT long waits with 41 over 65 weeks.
- Mental health: Inappropriate out of area placements concerning as published data is rounded to the nearest 5 affecting ability to effectively track position. Local reporting will be used to mitigate this from 26/27
- LDA: 24 Adult inpatients in a MH bed against a target of 14. Waiting lists for ASD and ADHD assessments high.
- FFT: Low response rates in multiple specialties

Workforce

- Overall provider workforce expenditure for the year is adverse to plan by £22.3m - bank overspend at Month 12 £15.8m.
- Overall WTE is 2% above plan (which equates to 264 WTE)
- NHS Infrastructure Support WTE exceeding plan by 9% (which equates to 214 WTE). Corresponding costs remain under plan by £5.8m

Headline financial position: Note Figures Not Yet Audited
Revenue:

- STW ICS is reporting a £10.6m full year surplus against a breakeven plan, giving a £10.6m favourable variance - largely due to an additional £8.2m deficit support funding received in Month 12. Total deficit support funding received in 2025/16 is £92.0m
- NHS Shropshire Telford and Wrekin system has delivered full year efficiency savings of £99.5m against a plan of £91.6m which is £7.9m favourable to plan.

Capital:

- The system has met it's capital financial plan limit for the year.
- STW ICS at year end is reporting a £0.4m underspend against plan namely due to the deferral of ICB Primary Care Utilisation and Modernisation Fund (PCUMF) (£0.8m) offset by additional Provider PDC to fund Estates safety schemes at SaTH and RJAH.

Staffordshire and Stoke on Trent
Areas showing improvement include:

- Elective care: Time to first appointment. Incomplete pathways. DM01 showing continued improvement since April 25. Cancer standards 31 day and 28-day
- UEC: 4-hour improved by 1.6% and 12-hour standard also showed improvement. Ambulance handovers within 45 minutes improved by 3.5%. Emergency admissions for children for asthma, epilepsy and diabetes
- Mental health: Inappropriate out of area placements. Access to perinatal mental health.
- LDA: Health checks
- Community transformation: Diabetes patients receiving 3 treatment targets. Emergency admissions for 65+ total/falls/care homes
- Improving population measures all meeting plan

Areas showing concern include:

- Elective care: 52+ week waits and 65+ week waits increased when compared to previous month. 62-day cancer standard not meeting target.
- UEC: Children's A&E Type 1 4-hour performance. Virtual ward occupancy. Urgent community response. Readmissions to hospital.
- Primary care: Appointments in general practice. Dental activity.
- LDA: Reduce inpatient MH care for learning disability which is 4 over plan and for autistic people which is 11 over plan. Waiting times for autism assessment average wait 118 weeks
- Maternity: Stillbirth rates increased in real terms by 4 (March 26 vs March 25). Full term babies admitted to neonatal unit increased by 6 admissions (December 25 vs December 26).

Workforce

- The system workforce numbers across providers and ICB (substantive + bank + agency) were 25,528 WTE in March 2026. This is an increase on month 11 of 255 WTE. Much of this increase can be attributed to an increase in bank staff at UHNM (121 WTE) and MPFT

(65 WTE). Month 12 workforce numbers were 1,045 WTE above plan which was seen in substantive (737 WTE), bank (305 WTE), and agency (3 WTE).

Headline financial position: Note Figures Not Yet Audited

Revenue

- At month 12, the system is reporting a £6.6m surplus breakeven position. (£4.9m adverse at month 11). This includes a deficit of £4.7m for UHNM, offset by a surplus of £7.1m at MPFT, £3.4m at NSCHT and £0.7m for the ICB. The surplus was driven by the late receipt of additional deficit support funding released by NHSE.
- The reported system efficiency delivery YTD is £26.3m behind our submitted plan of £306.3m, this comprises of MPFT (£0.3m) and UHNM (£26.7m). As a system this equates to 91% delivery in-year.

Capital

- The ICS met its capital financial plan limit for the year.

(7) Recommendations to Board:

To **note** and **discuss** the contents of the report.

Appendix A: NHSSTW Integrated Performance Report

Contents

1 Introduction

1.1 Assurance Matrix Summary

Interpreting SPC charts

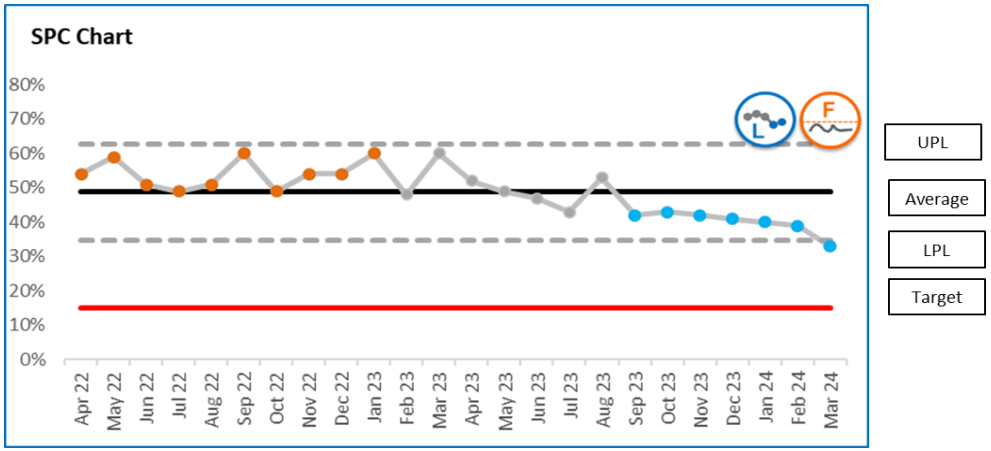
A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly).

The following colour convention identifies important patterns evident within the SPC charts in this report.

Orange – there is a concerning pattern of data which needs to be investigated, and improvement actions implemented.

Blue – there is a pattern of improvement which should be learnt from

Grey – the pattern of variation is to be expected. The key question to be asked is whether the level of variation is acceptable.



The dotted lines on SPC charts (upper and lower process limits) describe the range of variation that can be expected.
Process limits are very helpful in understanding whether a target or standard (the red line) can be achieved always, never (as in this example) or sometimes.
SPC charts therefore describe not only the type of variation in data but also provide an indication of the likelihood of achieving target.
Summary icons have been developed to provide an at-a-glance view. These are described on the following page.

1.2 Interpreting summary icons

These icons provide a summary view of the important messages from SPC charts.

	Variation / performance icons		
Icon	**Technical description**	**What does this mean?**	**What should we do?**
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of a CONCERNING nature.	**Something's going on!** Something, a one-off or a continued trend or shift of numbers in the wrong direction	**Investigate** to find out what is happening or has happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an IMPROVING nature.	**Something good is happening!** Something, a one-off or a continued trend or shift of numbers in the right direction. Well done!	Find out what is happening or has happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?
	Assurance icons		
Icon	**Technical description**	**What does this mean?**	**What should we do?**
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is the target will be achieved or missed at random.	Consider whether this is acceptable and, if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	If a target lies **outside of those limits in the wrong direction** then you know the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	If a target lies **outside of those limits in the right direction** then you know the target can consistently be achieved.	**Celebrate the achievement**. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

2 Performance report

2.1 Overview Matrix

SPC Matrix		Assurance: Consistently Achieving the Target	Assurance: Inconsistently Achieving the Target	Assurance: Consistently Failing the Target	Assurance: No National Target	Movement in Month
		P	?	F		
Improving Variation	H	◆ Patients accessing perinatal mental health - STW	◆ Time to first appointment <18 weeks - STW ◆ % Urgent Community Response patients seen within 2hrs - STW ◆ 28 Day Faster Diagnosis Standard - STW ◆ Diagnosis to First Treatment< 31 days - STW ◆ CYP Eating Disorders (Routine) seen within 4 weeks - STW	◆ All Diagnostics - < 6ww against target - STW ◆ All Diagnostics - < 13ww against target - STW ◆ Referral to treatment < 62 days % - STW ◆ CYP - persons U18 supported with at least 1 contact - STW ◆ % Annual Health checks per LD register aged 14 or over - STW	◆ ARRS - WTE - STW ◆ Number of people accessing IPS (rolling 12 months) - STW ◆ Proportion of PW split by discharge P1 - SaTH ◆ FFT: AE % Responded - SaTH ◆ Maternity Booking before ten weeks - SaTH	Metric Performance deteriorated from improving to normal variation or from normal to concerning variation
	L		◆ LD adults currently inpatient in MH setting - STW	◆ Incomplete RTT pathways of 65+ weeks - STW ◆ Incomplete RTT pathways of 52+ weeks - STW ◆ Incomplete RTT pathways of 52+ weeks where patient age is <=18 - STW ◆ LDA children currently inpatient in MH setting - STW ◆ Community Waits of 52 or more weeks for CYP services - SCHT ◆ Community Waits of 52 or more weeks for adult services - SCHT	◆ CYP - ASD Total waits (5-17) - STW ◆ CYP - ADHD Total waits (5-17) - STW ◆ Adult - ADHD Total waits - STW ◆ Proportion of PW split by discharge P2 - SaTH ◆ Mothers Smoking at Time of Delivery - SaTH ◆ Community Waits for CYP services, total - SCHT	
Normal Variation		◆ % of GP appointments attended within 2 weeks (ACC-08) - STW ◆ Talking Therapies patients reliably improved after 2+ contacts - STW	◆ FIT - % of suspected Lower GI cancers with FIT - STW ◆ Talking Therapies reliable recovery after 2+ contacts - STW ◆ No. of cases - C-difficile - STW ◆ No. of cases - E-coli - STW ◆ No. of cases - Pseudomonas aeruginosa - STW ◆ Number of cases - Klebsiella - STW ◆ No. of cases - MRSA - STW ◆ Cat 2 Response Mean time - WMAS ◆ Average handover time - WMAS	◆ A&E 4 hour performance achievement (Type 1&3) - STW ◆ Talking Therapies First seen <18 weeks - STW ◆ Proportion of Adult SMI having Physical Health Checks - STW ◆ A&E 4 hour performance achievement (Type 1&3) - SaTH ◆ A&E 4 hour performance achievement (Type 1) - SaTH ◆ % of Ambulance Handovers within - 45 mins - WMAS	◆ Total Primary care appointments - STW ◆ Total Face to Face appointments - STW ◆ % of GP appointments attended same or next day - STW ◆ GPs in Post (FTE) - STW ◆ Direct Patient Care in Post (FTE) - STW ◆ Units of dental activity delivered in the period - STW ◆ Dental activity as a proportion of contracted activity - STW ◆ Pharmacy First consultations - STW ◆ Referrals U18 from A&E to liaison psychiatry <1hr - STW ◆ No. of cases - MSSA - STW ◆ Total A&E attendances against plan - SaTH ◆ FFT: Maternity Antenatal Care % Positive - SaTH ◆ FFT: Maternity Postnatal Community % Positive - SaTH ◆ FFT: AE % Positive - SaTH ◆ Mothers per 1000 with post-partum haemorrhage >=1500ml - SaTH ◆ FFT: Inpatient % Responded - RJAH ◆ FFT: Inpatient % Positive - RJAH ◆ FFT: Community % Positive - SCHT ◆ FFT: MH % Responded - MPFT ◆ FFT: MH % Positive - MPFT	Metric Performance improved from concerning to normal variation or from normal to improving variation

SPC Matrix	Assurance Matrix - Concerning Variation				Movement in Month
	Consistently Achieving the Target	Inconsistently Achieving the Target	Consistently Failing the Target	No National Target	
	P	?	F		
Concerning Variation H		◆ LDA: Autistic adults currently inpatient in MH setting - STW		◆ Adult - ASD Total waits - STW ◆ Proportion of PW split by discharge P3 - SaTH ◆ Community Waits for adult services, total - SCHT	Metric Performance remained static
Concerning Variation L				◆ FFT: Inpatient % Responded - SaTH ◆ FFT: Inpatient % Positive - SaTH ◆ FFT: Maternity Birth % Responded - SaTH ◆ FFT: Community % Responded - SCHT	
Insufficient data				◆ OAP - Active inappropriate out of area adult placements - STW ◆ FFT: Maternity Birth % Positive - SaTH ◆ FFT: Maternity Postnatal Ward % Positive - SaTH	New metric for this report

Monthly Movement in Metrics:

Metrics where performance deteriorated from improving to normal variation or from normal to concerning variation

- ◆ Talking Therapies First seen <18 weeks – STW
- ◆ Direct Patient Care in Post (FTE) – STW
- ◆ Dental activity as a proportion of contracted activity – STW
- ◆ Pharmacy First consultations (CP,BP,OC) - STW
- ◆ FFT: AE % Positive - SaTH

Metrics where performance improved from concerning to normal variation or from normal to improving variation.

- ◆ Time to first appointment <18 weeks – STW
- ◆ % Urgent Community Response patients seen within 2hrs - STW
- ◆ 28 Day Faster Diagnosis Standard - STW
- ◆ LD adults currently inpatient in MH setting – STW
- ◆ Talking Therapies patients reliably improved after 2+ contacts - STW

New metrics this report – no new metrics this month but the following metrics have moved into insufficient data category, due to the SPC format capturing a rolling 24months data.

- ◆ OAP – Active inappropriate out of are adult placements – STW
- ◆ FFT: Maternity Birth % Positive – SaTH
- ◆ FFT: Maternity Postnatal Ward % Positive - SaTH

2.2 Primary Care

Primary Care

Metric Table

Metric Name	Workstream	Metric Type	Latest Date	Target	Value	Var.	Ass.	Target Met	Plan Met	Mean
Total Primary care appointments	Primary Care	STW	Feb 26		260,097					260,010
Total Face to Face appointments	Primary Care	STW	Feb 26		161,745					169,840
% of GP appointments attended within 2 weeks (ACC-08)	Primary Care	STW	Feb 26	85%	89.2%					88.6%
% of GP appointments attended same or next day	Primary Care	STW	Feb 26		53.7%					52.5%
ARRS - WTE	Primary Care	STW	Mar 26		440					284
GPs in Post (FTE)	Primary Care	STW	Feb 26		239					237
Direct Patient Care in Post (FTE)	Primary Care	STW	Feb 26		167					165
Units of dental activity delivered in the period	Primary Care	STW	Jan 26		59,183					54,442
Dental activity as a proportion of contracted activity	Primary Care	STW	Jan 26		90%					82.6%
Pharmacy First consultations (CP,BP,OC)	Primary Care	STW	Jan 26		4,645					4,515

Escalation charts

No concerning variation reported, so no charts required this month.

Primary Care Escalation Points

Focus Headlines:

- **Appointments in GP practices:** Reductions in total number of appointments, face to face appointments and same day or next day appointments this month. Appointments in 14 days has consistently achieved the target since May 2023.
- **Workforce:** ARSS (Additional Roles Reimbursement Scheme) increased by 110 WTE which represents a 58% increase since November 2025 (when first reported).
- **CQC:** The ICB continues to offer support to the General Practice that is under review following the Care Quality Commission (CQC) visit. A further inspection will be undertaken to assess compliance against the notices.

Narrative:

- **Practice Level Support (PLS) Programme update:** Two remain actively engaged. Three others have withdrawn but are considered by NHSE to have completed the programme.
- **Pharmacy First**: Reduction in activity of 430 compared to last month.
- **Dental**: One dental contract rebased from 25,580 Units of Dental Activity (UDA) to 18,000
- **Business as usual Capital Funding**: 5 bids for premises improvements accepted for 26/27 using the total allocation
- **Primary care Utilisation and Modernisation Fund**: ICB allocated £892k capital funding and four projects received approval to proceed by NHSE. One practice has formally withdrawn, and funds allocated to two of the other approved schemes. One scheme completed while remaining schemes carry forward to 26/27.

Key Actions:

- General Practice Local Enhanced Service (LES) agreements for 26/27 currently have 10 gaps in coverage for one of the six agreements. Work is ongoing to address and will be reviewed at Primary Care Commissioning Group in June.

Key Risks and mitigations:

- General practice identified with concerns following feedback from CQC visit. Mitigating actions include practice support and mentoring

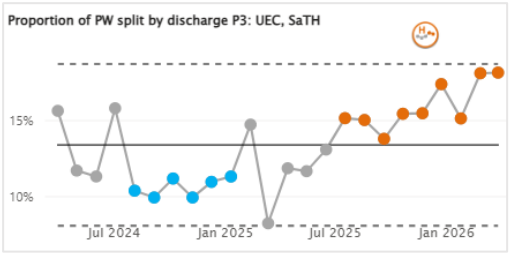
2.3 Urgent and Emergency Care

Urgent and Emergency Care (UEC)

Metric Table

Metric Name	Workstream	Metric Type	Latest Date	Target	Value	Var.	Ass.	Target Met	Plan Met	Mean
Cat 2 Response Mean time	UEC	WMAS	Mar 26	00:30	00:25					00:34
Average handover time	UEC	WMAS	Mar 26	00:45	00:46					01:14
% of Ambulance Handovers within - 45 mins	UEC	WMAS	Mar 26	100%	72.6%					57.6%
A&E 4 hour performance achievement (Type 1&3)	UEC	SaTH	Mar 26	76%	52.8%					52.0%
A&E 4 hour performance achievement (Type 1&3)	UEC	STW	Mar 26	76%	61.5%					61.2%
A&E 4 hour performance achievement (Type 1)	UEC	SaTH	Mar 26	76%	45.1%					43.6%
Total A&E attendances against plan	UEC	SaTH	Mar 26		14,083					13,094
Proportion of PW split by discharge P1	UEC	SaTH	Mar 26		52.8%					45.6%
Proportion of PW split by discharge P2	UEC	SaTH	Mar 26		29.1%					35.1%
Proportion of PW split by discharge P3	UEC	SaTH	Mar 26		18.1%					13.4%
% Urgent Community Response patients seen within 2hrs	Community	STW	Feb 26	70%	84.9%					81.4%

Escalation charts



Focus Headlines:

- **Ambulance:** Category 2 response time improved to 25 minutes and is ranked 16th out of 42 reporting systems. Ambulance handover time at 46 minutes achieved the local plan. STW improved to 112th out of the 120 reporting trusts. An improvement of 17 minutes is required to reach the next quartile.
- **A&E:** 4-hour performance significantly off track against national target.12-hour waits remain off track with SaTH ranked 112th out of 116 trusts. 12 hour waits improved to 19% but benchmarks poorly with the national average of circa 9% ranking 113 out of 117 trusts.
- **Discharge delays:** The proportion of pathway 3 discharges continues to show concerning variation at 18.1% which indicates reliance on capacity outside of home first models.

Narrative:

- **Ambulances:** SaTH have put in a range of interventions to improve flow as part of the Spring Reset in March which has led to a promising position since mid-March
- **Alternatives:** Extension of Urgent Community Response to midnight beginning to provide additional same day alternatives to conveyance, supporting admissions avoidance during peak evening periods.
- **A&E:** Sustained pressure from high acuity attendances and downstream discharge constraints. Virtual ward utilisation remains below trajectory limiting its impact on admission avoidance and contributing to sustained pressure on inpatient capacity.
- **Discharge delays:** Delays are largely driven by complexity in domiciliary care provision, reablement capacity and housing-related barriers. A focused approach being applied to reduce 48+ hour delays and improve discharge timeliness.

Key Actions:

- **Flow:** Continue agreed changes implemented as part of winter plan. Maximum Handover Threshold SaTH commitment has progressively reduced from 4 hours in Jan to 2 hours in March (at time of writing is below the 45 min national standard).
- **In hospital capacity:** Modular wards to support gastro and surgery wards at RSH (56 beds). UEC Recovery at PRH (40 beds/assessment spaces). Acute trauma assessment area pilot for surgery patients presenting to ED overnight.
- **A&E:** National Spring Reset in March focused on improving A&E waiting times, maximising 4 hour performance without detriment to 12 hour performance.
- **Discharge delays:** "Preparing for Tomorrow" model embedded on targeted wards. Strengthened system engagement with community providers to increase pace of home first discharges. SHOP model (Structured Board Round – Sick. Home. Other. Plan) implemented on Ward 25.

Urgent and Emergency Care (UEC) ctd.

Key Risks and mitigations:

- Prolonged ambulance handover delays create compounding operational risk — impacting patient safety, increasing time to definitive care, and reducing available ambulance resource across the system. Mitigating actions include deployment of Offload to Assess pathways, escalation framework for prolonged waits and executive monitoring through system operational calls.
- Delay to PRH bed reconfiguration and SDEC capacity may limit performance. Mitigating actions including close monitoring of progress.
- Sustained delays beyond 48 hours risk maintaining bed occupancy above safe operating levels, directly impacting ED performance, ambulance handovers and overall system resilience. Overnight boarding in Discharge Lounge at RSH impacts on the ability to pull patients prior to 08.45. Mitigating actions include a dedicated workstream to reduce >48 hour NCTR delays through improved coordination of packages of care, transport and placement brokerage. Additional discharge transport capacity commissioned to remove non-clinical delays. Ongoing monitoring of pathway mix to rebalance discharge flow toward home-first trajectories. Boarding overnight has been escalated in SaTH and is part of the improvement work for the discharge improvement group – part of the hospital full policy.

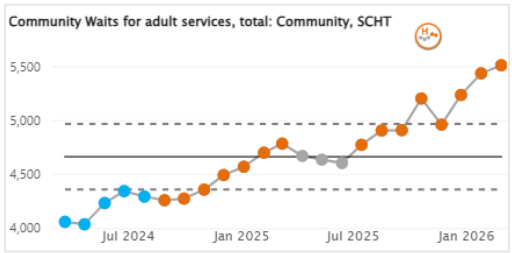
2.4 Planned Care

Planned Care

Metric Table

Metric Name	Workstream	Metric Type	Latest Date	Target	Value	Var.	Ass.	Target Met	Plan Met	Mean
Incomplete RTT pathways of 65+ weeks	Planned Care	STW	Feb 26	0	41					399
Incomplete RTT pathways of 52+ weeks	Planned Care	STW	Feb 26	0	529					3,061
Incomplete RTT pathways of 52+ weeks where patient age is <=18	Planned Care	STW	Mar 26	0	24					238
Time to first appointment <18 weeks	Planned Care	STW	Mar 26	67%	77.0%					62.2%
All Diagnostics - <6ww against target	Diagnostics	STW	Feb 26	95%	86.6%					74.6%
All Diagnostics - <13ww against target	Diagnostics	STW	Feb 26	100%	98.5%					94.0%
28 Day Faster Diagnosis Standard	Cancer	STW	Feb 26	80%	85.3%					73.1%
FIT - % of suspected Lower GI cancers with FIT	Cancer	STW	Mar 26	80%	87%					87.6%
Referral to treatment < 62 days %	Cancer	STW	Feb 26	85%	73.4%					61.8%
Diagnosis to First Treatment< 31 days	Cancer	STW	Feb 26	96%	97.5%					89.6%
Community Waits of 52 or more weeks for CYP services	Community	SCHT	Feb 26	0	0					96.6
Community Waits of 52 or more weeks for adult services	Community	SCHT	Feb 26	0	3					37.7
Community Waits for CYP services, total	Community	SCHT	Feb 26		2,777					3,034
Community Waits for adult services, total	Community	SCHT	Feb 26		5,508					4,661

Escalation charts



Focus Headlines:

- **RTT:** 2 patients waiting over 78 weeks, 41 patients waiting over 65 weeks all at RJAH. 529 patients waiting over 52 weeks forecasts indicate significant improvements expected in March. Incomplete pathways seen within 18 weeks meeting target at 64.8%. First appointment within 18 weeks meeting target at 77%
- **CYP:** 52 week waits reduced to 24 against a local plan of 41. CYP RTT waitlist reducing 7,074 (Jan 25) to 4,693 (Mar 26).
- **Cancer:** All cancer standards above plan. 62 day ranked 11th out of 42 ICBs and 31 day jointly ranked 1st
- **Community waits:** No CYP waiting over 52 weeks; 3 adult patients (Pulmonary rehab, Diabetic Nursing, Continence service)
- **DM01 diagnostics:** Increase to 86.6% for patients seen within 6 weeks. 13-week waits have decreased to 251. Echo and Urodynamics are a concern.

Narrative:

- **RTT:** All RTT continues to show improving variation. Tiering calls with NHSE continue for both providers for RTT and diagnostics
- **Cancer:** SaTH has delivered strong and sustained improvement in cancer performance. Focus on sustaining gains and accelerating improvement through Phase 2 of the Cancer Improvement Programme
- **Community waits:** Wheelchair service have a small number of children waiting over 40 weeks who are neurodivergent with complex needs. The ICB continues to provide monthly updates to NHSE of key lines of enquiry for long waits.
- **Diagnostics:** Diagnostics recovery plans in place for both RJAH and SaTH, which are being monitored via the ICB and tiering calls.

Key Risks and mitigations:

- **Risks**: 1) Backlogs in specialties will continue to cause long waits. 2) Capacity constraints. 3) Impact not at level expected. 4) Clinical and operational workforce constraints 5) Pathways requiring multiple diagnostics have greater chance of delays. 6) CYP with already complex difficulties may develop more exacerbating needs whilst waiting for assessment or treatment which may then impact upon their treatment outcomes including wider impacts e.g. access to education. Clinical risk assessment to ensure impact of harm minimised.7) Reliance on outsourced reporting for diagnostics presents a sustainability and cost risk. 8) Reliance on mobile MRI capacity creates a continuity risk
- **Mitigations:** Actions outlined above

Planned Care ctd.

Key Actions:

- SaTH specific RTT actions: Using breach forecasting tool to improve specialty capacity planning and reduce waiting times. Continue Planned Care Improvement Programme for outpatient and inpatient productivity. Working with For Eyes consultancy on clinic template optimisation and implementation of digital tools including rollout of DrDoctor. Implement and sustain “route to zero” for 52 week waits
- RJAH specific RTT actions: Maximise early over-performance to support full year recovery trajectory. Dedicated sessions to identify and pull forward additional waiting list opportunities. Improve theatre productivity through earlier list sign off, better pre-op alignment and overall utilisation uplift. Track and manage 65 week cohort with clear plans to reduce tail. Mitigate external drivers, e.g. cross border patient changes/cancellations, through planning.
- SCHT specific RTT actions: Continue backlog reduction via community services (ENT and gynaecology). Sustain recruitment and overtime to support delivery. Address MSK constraints through review of clinic templates, improved utilisation and changes to booking practices to increase new capacity. BI deep dive session to reassess assumptions and identify key drivers. Provide weekly update and confirm a detailed recovery trajectory.
- SaTH specific cancer actions: Progress phase 2 cancer improvement plan to improve time to treatment. Address oncology pathway performance. Mitigate workforce gaps via recruitment, partnership working with neighbouring trust and insourcing additional capacity. Monitor national PET procurement and pathway impacts.
- RJAH specific cancer actions: Engage with Shropshire Cancer Programme Lead to address late external referrals. Work with ICB to improve communication from GPs so patients are aware they are on a cancer pathway. Provide update on the investigation into late referrals from external organisations impacting pathway timeliness.
- There is a cohort of children who may require restrictive buggies who are unable to access the current wheelchair provider. These families have been asked to contact the ICB if they have needs relating to wheelchairs/buggies. This will enable unmet needs to be identified and an approach to be determined.
- SaTH specific actions for diagnostics: Progress recruitment of radiologists, radiographers and sonographers. Maintain clinical prioritisation of urgent, cancer and long wait patients. Utilise mobile MRI unit to increase capacity and support cancer pathways. Expand ultrasound and urology cancer capacity through additional slots;
- RJAH specific actions for diagnostics: Strengthen booking team capacity and processes including rebooking of cancellations. Maintain focus on MRI recovery, particularly long waits and urgent pathways

2.5 Mental Health - Adults

Mental Health – Adults

Metric Table

Metric Name	Workstream	Metric Type	Latest Date	Target	Value	Var.	Ass.	Target Met	Plan Met	Mean
Talking Therapies reliable recovery after 2+ contacts	Mental Health	STW	Feb 26	48%	50%					49.6%
Talking Therapies patients reliably improved after 2+ contacts	Mental Health	STW	Feb 26	67%	73%					74.4%
Talking Therapies First seen <18 weeks	Mental Health	STW	Feb 26	95%	91%					90.6%
OAP – Active inappropriate out of area adult placements	Mental Health	STW	Nov 25	0	5					5
Patients accessing perinatal mental health	Mental Health	STW	Feb 26	501	985					803
Proportion of Adult SMI having Physical Health Checks (provisional)	Mental Health	STW	Mar 26	60%	58.5%					54.6%
Number of people accessing IPS (rolling 12 months)	Mental Health	STW	Feb 26		585					525

Escalation charts

No concerning variation reported, so no charts required this month.

Focus Headlines:

- **Talking therapies:** 18-week first seen performance improved but below target at 91%
- **SMI health checks:** Performance improved but remains below target at 58.5%. Official figures due mid-May.

Narrative:

- **Talking therapies:** Affected by patient preferences for specific appointment times
- **SMI health checks:** Long term sickness in Mental Health Practitioner Team impacting on performance.
- **Inappropriate out of area placements:** Published data rounded to nearest 5 affecting accuracy of reporting. Local reporting will be used to mitigate this from 26/27.

Key Actions:

- **Talking therapies:** Patients being offered more appointment choices
- **SMI health checks:** Action plan to be monitored to improve recording on registers and maintain full service provision for the SMI team in MPFT and GP practices
- **Long stays:** Inpatient Quality Transformation Programme (IQTP) will explore alternative local specialty services for Emotionally Unstable Personality Disorder patients with long stays
- **Out of area placements:** MPFT to work with independent providers to improve data quality relating to patients placed. MPFT reviewing rehabilitation and discharge pathways. Hospital at Home programme framework will support community reintegration and reduce admissions. MPFT review of rehabilitation pathway with Trident Reach at Elms House to improve the discharge process. MPFT developing business case for Housing Enablement Team to improve the discharge process focussing on accommodation challenges.

Key Risks and mitigating actions:

- **SMI Health Checks:** Patients not receiving health checks. Intensive and Assertive Outreach being developed to ensure SMI patients are registered and receive regular health checks
- **Out-of-Area Placements:** Limited local bed capacity can cause clinical harm, longer stays away from family, reduced therapeutic support, and higher supervision needs, with oversight more difficult due to distance. Regular reviews of OOA patients undertaken. OOA protocol monitoring and authorising OOA placements.
- **Housing and Rehabilitation Gaps:** Lack of appropriate pathways delays discharges, extending hospital stays unnecessarily. Elms Unit serving as the rehabilitation pathways from Redwoods

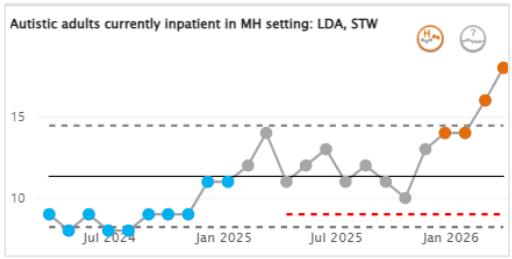
2.6 Learning Disability and Autism – LDA

Learning disability and Autism (LDA)

Metric Table

Metric Name	Workstream	Metric Type	Latest Date	Target	Value	Var.	Ass.	Target Met	Plan Met	Mean
% Annual Health checks per LD register aged 14 or over	LDA	STW	Feb 26	75%	67%					32.7%
Autistic adults currently inpatient in MH setting	LDA	STW	Mar 26	9	18					11.3
LD adults currently inpatient in MH setting	LDA	STW	Mar 26	7	6					9.3
LDA children currently inpatient in MH setting	LDA	STW	Mar 26	1	1					2.92

Escalation charts



Focus Headlines:

- **Adult inpatients:** There are 24 Adults occupying a MH bed of which 18 are Autistic and 6 with diagnosed LD, against Q4 plan of 14. Autistic inpatients in MH setting showing concerning variation.
- **Annual health checks**: Continue ahead of plan and on track to meet 75% target by year end.

Narrative:

- **Adult Inpatients:** One admission and two discharges in month remaining 10 above plan. Issue with admissions who are autistic where mental health issues not known to services and not on Dynamic Support Register. Some discharges planned but review required on estimated discharge dates and changes to these.
- **CYP Inpatients:** The remaining child has escalated to a red rated discharge score as in active treatment and complex needs.

Actions:

- Oswestry bungalows project – housing association selected and progressing with specifications for building adaptations. Work ongoing to confirm a support provider
- Procurement to support adults with complex needs in final moderation stage
- Review of Intensive Support Team (IST) to be undertaken as caseload is above capacity. To be monitored as part of Contract Review Meetings (CRM)
- Review of discharge planning completed and plan being developed to address the recommendations

Key Risks and mitigations:

- People are staying in hospital in more restrictive placement longer than necessary which can impact on their quality of life. Mitigating actions include: treatment and discharge plans monitored for longer stay patients; proactive strategies to prevent avoidable admissions; all inpatients regularly review through TCP; a Barriers to Discharge checklist developed to identify obstacles early supporting proactive planning and escalation, TCP Team attending Redwoods discharge meetings to monitor discharge progress for LDA patients admitted to Redwoods and St Georges.

2.7 ASD and ADHD

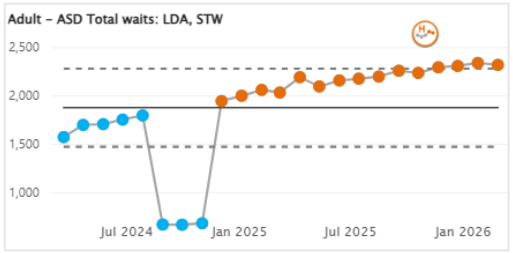
ASD and ADHD

All data in this section based on unvalidated local data

Metric Table

Metric Name	Workstream	Metric Type	Latest Date	Target	Value	Var.	Ass.	Target Met	Plan Met	Mean
CYP – ASD Total waits (5-17)	LDA	STW	Feb 26		0					718
CYP – ADHD Total waits (5-17)	LDA	STW	Feb 26		198					633
Adult – ASD Total waits	LDA	STW	Feb 26		2,316					1,873
Adult – ADHD Total waits	LDA	STW	Feb 26		2,409					2,838

Escalation charts



All Age ASD and ADHD Escalation Points

NB – This data is subject to validation, so must not be relied upon until fully validated.

Focus Headlines:

- Waiting lists remain high for adults and children waiting for ASD and ADHD assessments
- Adults ASD waiting list continues to show concerning variation as numbers continue to rise however numbers slightly reduced this month.
- It has been identified that some ADHD accredited providers waiting lists are not included in the reported figures. Work is in hand to identify how these waiting lists can be captured effectively.

Narrative:

- **Adult ADHD:** High demand continues to exceed commissioned capacity leading to long waits consistent with national trends. The average wait is 39 weeks.
- **Adult ASD:** High demand continues to exceed commissioned capacity however, the overall position has not deteriorated this month.
- **Children's ND:** Average waits around 52 weeks – awaiting waiting list validation. Remedial action plan in place.

Key Actions:

- **Childrens ND:** Recruitment ongoing for care navigators to increase capacity to support children and families while waiting for assessment. ASD / ADHD Task and Finish Group updating remedial actions plan. Validation of waiting lists for CYP with 100 suitable children requiring ADHD assessment to onboard with external provider.
- **Adult ASD**: Improvement plan and trajectory requested from MPFT. Progress reporting via CRM

Key Risks and mitigations:

- Longer waiting times for assessment and treatment that could potentially lead to Physical and Psychological Harm. Mitigating actions include access to 24/7 Mental Health Access Team for support reducing harm from long waits; Neurodevelopmental Waiting List Group reviewing opportunities to reduce waiting times and ensure system wide support; utilise Right to Choose for providers offering shorter waits; pilot specialist autism and ADHD service is proposed to support people with mental health needs in the community; and enhanced pre-diagnosis support,

2.8 Children and young people (CYP)

Children and Young People (CYP)

Metric Table

Metric Name	Workstream	Metric Type	Latest Date	Target	Value	Var.	Ass.	Target Met	Plan Met	Mean
Referrals aged u18 from A&E to liaison psychiatry <1 hour	Mental Health	STW	Feb 26		40%					42.8%
CYP Eating Disorders (Routine) seen within 4 weeks	Mental Health	STW	Feb 26	95%	100%					84.7%
CYP – persons U18 supported with at least 1 contact	Mental Health	STW	Feb 26	8,341	7,365					6,495

Escalation charts

No concerning variation reported, so no charts required this month.

Children and Young People Escalation Points

Focus Headlines:

- Eating Disorders (routine) standard achieved with 100% seen within 4 weeks. Urgent cases are subject to small numbers and no updated data received due to suppression.
- CYP access has improved again in-month but remains below plan; remedial action plan is in place.

Narrative:

- **Eating disorder**: Routine performance has sustained improvement.
- **CYP Access:** On target to meet planned recovery trajectory by summer 2026.

Key Actions:

- **Eating disorder:** Ongoing review of Urgent Eating Disorder provider data involving the NHS Digital regional lead stalled due to changes in NHSE. Provider to lead on reviewing the data submitted to STW.
- **CYP access:** Continued oversight through the Task and Finish Group. Ongoing recruitment plan in place and monitored through the remedial action plan. Quality improvement project to refine service processes which will increase the capacity.

Key Risks and mitigations:

- CYP risk harm or crisis while waiting for assessment or treatment. Mitigations include the 24/7 Mental Health Text Support Service remains in place, alongside the 24/7 Mental Health Access Team, with triage in place to prioritise higher-risk cases and reduce harm; Quality Improvement project outlined above. The “Proactive support whilst waiting” programme monitors CYP on waiting lists to identify changes in circumstances and mitigate risk.

2.9 Quality

Quality

Metric Tables

Metric Name	Workstream	Metric Type	Latest Date	Target	Value	Var.	Ass.	Target Met	Plan Met	Mean
FFT: Maternity Birth % Positive	Quality	SaTH	Dec 25		0%					71.8%
Mothers per 1000 with post-partum haemorrhage >=1500ml	Quality	SaTH	Jan 26		21					25
Mothers Smoking at Time of Delivery	Quality	SaTH	Jan 26		4.5%					6.5%
Maternity Booking before ten weeks	Quality	SaTH	Dec 25		71.6%					50.4%

Metric Name	Workstream	Metric Type	Latest Date	Target	Value	Var.	Ass.	Target Met	Plan Met	Mean
FFT: Inpatient % Responded	Quality	RJAH	Feb 26		100%					100%
FFT: Inpatient % Responded	Quality	SaTH	Feb 26		1.77%					10.9%
FFT: Inpatient % Positive	Quality	RJAH	Feb 26		99.0%					98.4%
FFT: Inpatient % Positive	Quality	SaTH	Feb 26		92.8%					96.9%
FFT: Community % Responded	Quality	SCHT	Feb 26		0.706%					1.24%
FFT: Community % Positive	Quality	SCHT	Feb 26		96.6%					97.2%
FFT: Maternity Antenatal Care % Positive	Quality	SaTH	Jan 26		80%					72.0%
FFT: Maternity Birth % Responded	Quality	SaTH	Feb 26		0.664%					3.46%
FFT: Maternity Birth % Positive	Quality	SaTH	Dec 25		0%					71.8%
FFT: Maternity Postnatal Ward % Positive	Quality	SaTH	Dec 25		0%					18.2%
FFT: Maternity Postnatal Community % Positive	Quality	SaTH	Jan 26		0%					72.3%
FFT: AE % Responded	Quality	SaTH	Feb 26		7.11%					4.00%
FFT: AE % Positive	Quality	SaTH	Feb 26		70.9%					66.0%
FFT: MH % Responded	Quality	MPFT	Feb 26		0.801%					1.21%
FFT: MH % Positive	Quality	MPFT	Feb 26		85.7%					88.4%

Metric Name	Workstream	Metric Type	Latest Date	Target	Value	Var.	Ass.	Target Met	Plan Met	Mean
Number of cases - C-difficile	Quality	STW	Feb 26	12	9					14.8
Number of cases - E-coli	Quality	STW	Feb 26	36	24					39.2
Number of cases - Pseudomonas aeruginosa	Quality	STW	Feb 26	2	5					3.78
Number of cases - Klebsiella	Quality	STW	Feb 26	7	8					10.1
Number of cases - MRSA	Quality	STW	Feb 26	0	2					0.696
Number of cases - MSSA	Quality	STW	Feb 26		12					11.7

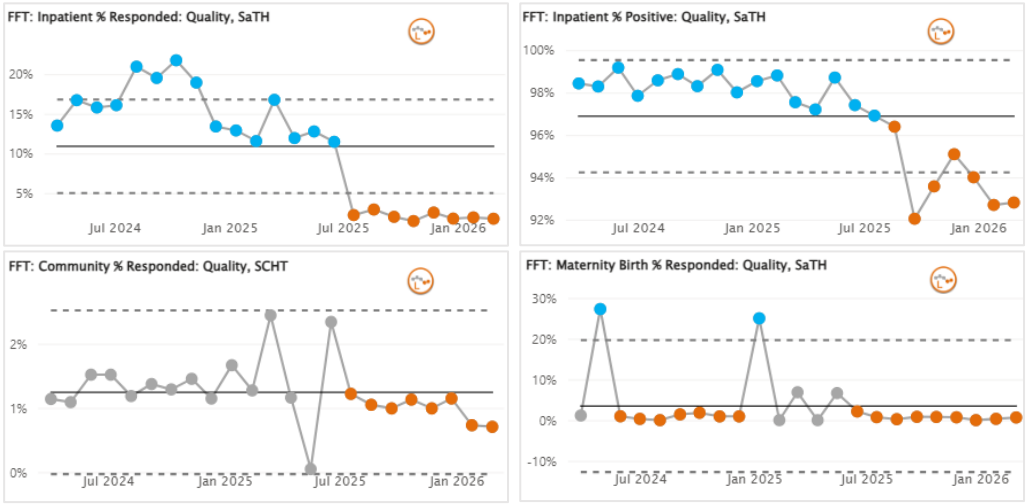
Focus Headlines:

- **Maternity:** Both mothers smoking at time of delivery (SATOD) and maternity booking before 10 weeks showing continued sustained improvement.
- **Maternity FFT:** Response rates remain extremely low currently at 0%. There are data gaps for December and January. This indicates existing mechanisms for collecting feedback are not generating meaningful engagement. Further targeted action required to improve accessibility, awareness and real-time completion of the survey.
- **SaTH FFT:** Inpatient response rates extremely low limiting insight into patient experience. Positive responses for inpatient continue to decline since mid 2025.
- **RJAH FFT:** Continues to remain over 95%
- **Community FFT:** Response levels insufficient to draw reliable conclusions
- **System wide FFT theme:** The shift to digital FFT collection is contributing to reduced response rates in some areas, exacerbating data quality concerns.
- **IPC:** C-diff under trajectory in February at 9 cases. Two cases linked to same ward within 28 days so enhanced cleaning and ward walkabouts to observe compliance identified delays in isolation and contaminated commode. E-coli is below monthly trajectory at 24 cases. Klebsiella above monthly trajectory at 8 cases. Pseudomonas above monthly trajectory at 5 cases where 3 were oncology patients are extremely susceptible. MRSA above monthly trajectory at 2 cases. Identified lack of following updated MRSA policy to swab both nose and groin on admission and a delay on taking blood culture on admission. One case was most likely community acquired.

Key Actions:

- **Maternity:** ICB Maternity Quality Lead and Analyst produce regular report highlighting areas of improvement and concern.
- **System wide FFT:** Strengthen real time FFT capture at point of care reducing reliance on post discharge and digital only methods. Increase staff ownership and accountability for FFT completion within clinical workflows
- **SaTH FFT:** Reintroduce ward based FFT collection to address low inpatient response. Target ED and inpatient areas with focused recovery plans. Embed FDT in postnatal discharge processes with midwife led completion.
- **SCHT FFT:** Continue team level engagement and escalation discussions where response rates are low. Expand FFT text messaging rollout to improve accessibility and timeliness of feedback
- **MPFT FFT:** Maintain consistent approach increasing proactive engagement in inpatient settings. Continue telephone and supported completion methods for patients unable to use digital tools.

Escalation charts



- **IPC:** Business case for Fidaxomicin going through governance. From April 2026 all care home residents for older adults will be eligible for Respiratory Syncytial Virus vaccinations.

Key Risks and mitigating actions:

- **FFT Risks:** 1) Switch to digital FFT resulting in decrease in completion. 2) Responses not representative due to low uptake
- **Mitigations for FFT:** Introduction of blended FFT model to improve inclusivity and response rates. Use SMS prompts/QR codes/bedside support to make completion timely and easier. Reinforce messaging to patients on why feedback matters. Provide targeted training and reminders to clinical teams on capturing FFT in real time. Share local performance data and feedback loops to drive ownership. Resolve submission and reporting inconsistencies (notably in maternity). Monitor response rates alongside positivity ensuring interpretation reflects data limitations.

2.10 Workforce

Workforce	
Focus Headlines: • Overall provider workforce expenditure (Year End) is adverse to plan by £22.3m (3%), driven primarily by a bank overspend of £15.8m (32%). • Overall WTE is 264 WTE (2%) above plan, with bank WTE exceeding plan by 144 WTE (22%), partially mitigated by agency WTE, which is 14 WTE (15%) below plan. • NHS Infrastructure Support WTE exceeds plan by 214 WTE (9%); however, corresponding costs remain under plan by £5.8m (0.6%).	**Key Actions:** • SaTH successfully fulfilled the criteria to exit Special Measures, including demonstrating increased grip and control over temporary staffing usage. • SCHT recruitment plans are in delivery to address the prison vacancy, with continued monitoring of the impact of UCR expansion on agency usage (including Band 2/3 agency) and the ongoing rollout of NHSP. • Contracted and actual worked WTE will be reconciled to better understand the underlying causes of misalignment between workforce expenditure and WTE. This work will be undertaken alongside the NHSE Regional Pay Spend Disaggregation Template, commencing April 2026

Shropshire, Telford and Wrekin: Workforce Highlight Report

STW M12 Workforce Expenditure (£000) * NB: Numbers below are provider only and exclude capital pay costs

	M12 Plan YTD £000	M12 Actual YTD £000	M12 VariationYTD £000	FY Forecast £000	FY Run Rate £000	FY Plan Vs Forecast £000	FY Plan Vs RunRate £000
Substantive							
Non-Medical Clinical	345,328	367,887	22,559	Not Applicable			
Non-Medical Non Clinical	91,372	84,927	-6,445				
Medical Dental	166,202	158,295	-7,907				
Total Substantive	**602,902**	**611,109**	**8,207**				
Bank							
Non-Medical Clinical	25,948	33,394	7,446	Not Applicable			
Non-Medical Non Clinical	3,774	4,589	815				
Medical Dental	19,834	27,385	7,551				
Total Bank	**49,556**	**65,368**	**15,812**				
Agency							
Non-Medical Clinical	6,283	4,838	-1,445	Not Applicable			
Non-Medical Non Clinical	700	563	-137				
Medical Dental	6,531	6,346	-185				
Total Agency	**13,514**	**11,747**	**-1,767**				
Grand Total	**665,972**	**688,224**	**22,252**				

KPI	Plan	Performance *exc MPFT
Delivery of 2025/26 Workforce Plan: WTE	WTE 11,270	WTE 11,534 (264 WTE or 2.3 % adverse variance)
Delivery of 2025/26 Workforce Plan: Expenditure across all staff types *(exc capitalised pay costs)*	£665.97 m	£688.22m (£22.25m or 3.3% adverse variance)
Turnover	9.8%	TBC
Sickness	5.2%	TBC
% Agency Framework Compliance	100%	100%
Agency as % Total Pay	2.0%	1.7%
Consultant Job Plans	95% (national target)	**STW 375/384 = 98%** SCHT 6/6 SATH 271/271 RJAH 98/107

Overall Headcount (WTE)

WTE	M12 Plan	M12 Actual	M12 Variance
Substantive	10,516	10,648	+132
Bank	664	809	+ 144
Agency	91	77	- 14
Total	**11,270**	**11,534**	**+ 264**

NHS Infrastructure Support (WTE & £000)

	WTE M12 Plan	WTE M12 Actual	WTE M12 Var	£000 M12 YTD Plan	£000 M12 YTD Actual	£000 M12 YTD Var
Subs	2,355	2,607	+252	91,372	84,927	-6,445
Bank	65	125	+ 60	3,774	4,589	+815
Agency	6	5	-1	700	563	-137
Total	**2,426**	**2,723**	**+214**	95,846	90,079	-5,767

Key Messages:

- Overall provider workforce expenditure (YTD / Year End) is adverse to plan by £22.3m (3%), driven primarily by a bank overspend of £15.8m (32%).
- Overall WTE is 264 WTE (2%) above plan, with bank WTE exceeding plan by 144 WTE (22%), partially mitigated by agency WTE, which is 14 WTE (15%) below plan.
- NHS Infrastructure Support WTE exceeds plan by 214 WTE (9%); however, corresponding costs remain under plan by £5.8m (0.6%).

Key Actions:

- SaTH successfully fulfilled the criteria to exit Special Measures, including demonstrating increased grip and control over temporary staffing usage.
- SCHT recruitment plans are in delivery to address the prison vacancy, with continued monitoring of the impact of UCR expansion on agency usage (including Band 2/3 agency) and the ongoing rollout of NHSP.
- Contracted and actual worked WTE will be reconciled to better understand the underlying causes of misalignment between workforce expenditure and WTE. This work will be undertaken alongside the NHSE Regional Pay Spend Disaggregation Template, commencing April 2026

2.11 System Financial Position

Finance (Month 12)	
Focus Headlines: Narrative - Revenue: The 2025/26 actual ICS outturn is a £10.6m favourable variance to plan, after £92m deficit support funding. The actual outturn includes delivery of efficiency of £103.4m against a target of £95.5m, an over delivery of £7.9m. **ICB** – Actual outturn is a favourable variance of £2m this is namely due to the delivery of additional efficiency and prior year benefits. **SaTH** – Actual outturn surplus and favourable variance of £4.9m due to additional deficit support funding. **RJAH** – Actual outturn surplus and favourable variance of £1.7m due to additional deficit support funding. **SCHT** – Actual outturn surplus and favourable variance of £3.9m due to delivery of the planned surplus, additional surplus and additional deficit support funding. Narrative - Capital: Actual ICS outturn capital spend was in line with plan for CDEL.	Key Actions: Revenue: **Note** that for 2025/26, the actual outturn reflects a surplus of £10.6m following deficit support funding totalling £92m (£83.8m planned and an additional £8.2m received in Month 12),the ICB achieving a favourable variance of £2m, and SCHT reporting a positive variance of £0.3m. Capital: **Note** that the ICS at Month 12 is reporting capital spend in line with plan for CDEL.

System Revenue Financial Position

Financial Performance	FULL YEAR		
Organisation	Plan Surplus/ (Deficit) £000	Forecast Surplus/ (Deficit) £000	Variance to Plan £000
Commissioners			
NHS Shropshire, Telford and Wrekin	(2,000)	65	2,065
Total Commissioners	**(2,000)**	**65**	**2,065**
Providers			
The Shrewsbury and Telford Hospital NHS Trust	0	4,922	4,922
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS FT	0	1,695	1,695
Shropshire Community Healthcare NHS Trust	2,000	3,910	1,910
Total Providers	**2,000**	**10,527**	**8,527**
TOTAL SYSTEM Performance Financial Position Surplus/(Deficit)	**0**	**10,592**	**10,592**
Non-Recurrent Deficit Funding	(83,795)	(91,986)	(8,191)
NHSE Approved Position	**(83,795)**	**(81,394)**	**2,401**

System Key Data:

System - In month 12 the system is reporting a full year surplus of £10,592k, £10,592k favourable variance to plan.

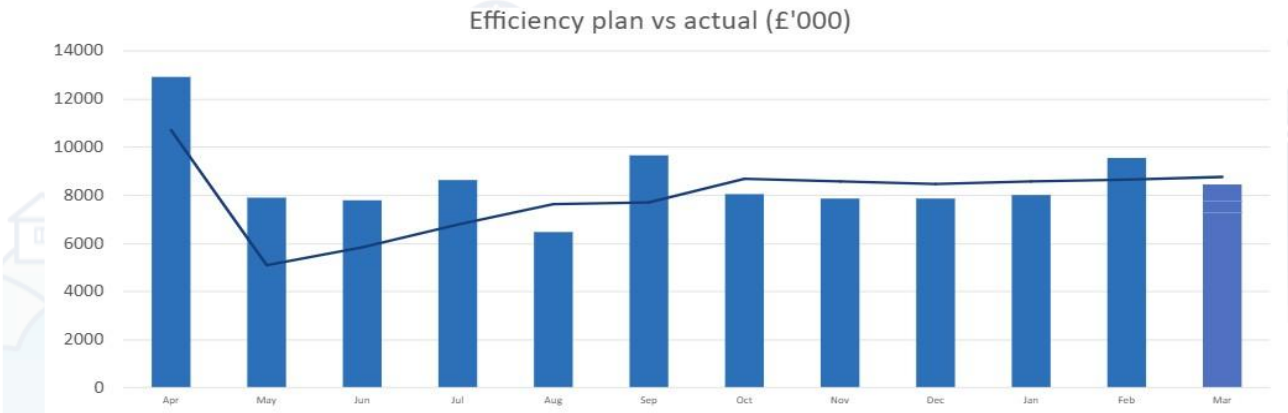
Organisation Specific Key Data:

- **ICB** - Full year surplus of £65k which is £2,065k favourable to plan. This is after the recognition of £38.6m non recurrent deficit funding. Efficiency delivery is ahead of the full year plan (£6.2m favourable) due to individual commissioning but is in line with the overall annual efficiency plan. 25/26 costs inclu de the impact of ICB government reform.
- **SaTH -** Full year surplus of £4,922k, supported by £50.1m of non-recurrent deficit support funding. £ 41.4m efficiency delivery year to date which is £0.1m favourable against plan. Pressures on pay of £26.9m year to date, partly offset by income backed posts overspend on bank is due to additional support for escalation activity and the effect of holding vacancies, however, is partially offset against reduced agency and substantive pay. SATH have mitigated non -delivery of wte reductions and bank overspend although additional funding for Industrial Action costs was provided in Month 9.
- **RJAH** - Full year surplus of £1,695k , £1,695k favourable to plan (including £1,638k of redistributed DSF). £10,916k efficiency delivery year to date, £1,322k favourable to plan . Shortfalls in clinical and commercial income are being offset by expenditure decreases from marginal cost reductions, recruitment slippage and continued delivery of Investigation and Interventions action.
- **SCHT** - Full year surplus of £1,910k, supported by £1.6m of non-recurrent deficit funding. C ost pressures in Prison mental health and Rehab and Recovery Unit out of hours are offset by non-recurrent pay savings and efficiency performance. Pay underspend £ 1,486k driven by delays in filling substantive vacancies. Bank staff overspend offset by substantive vacancies and agency underspend. Efficiency is £ 271k favourable to plan.

Efficiency Summary Month 12

25/26 Plan £000's	25/26 Actual £000's	25/26 Savings Variance
£95.5m	£103.4m	£7.9m

Partner Organisation	Annual Plan £'000	YTD Plan £'000	YTD Delivery £'000	YTD Variance to Plan £'000
ICB	39,180	39,180	45,349	6,169
SaTH	41,400	41,400	41,541	141
RJAH	9,594	9,594	10,941	1,347
SCHT	5,359	5,359	5,630	271
Total	**95,533**	**95,533**	**103,461**	**7,928**



Key Updates

- At Month 12 NHS Shropshire Telford and Wrekin has delivered **£103.4m** of efficiency savings against a plan of **£95.5m** which is **£7.9m** favourable to plan.
- This includes the delivery of some High-Risk schemes at SaTH including planned headcount reductions.
- Focus is now drawn to the development and delivery of 26/27 efficiency including the benefits from transformational plans which will deliver over the next 3 years.

Capital

CAPITAL PROGRAMME	FULL YEAR		
Organisation	Plan	Forecast	Variance to Plan
	£000	£000	£000
Total Charge against Capital Allocation (including impact of IFRS16)			
NHS Shropshire, Telford and Wrekin	6,191	1,191	(5,000)
The Shrewsbury and Telford Hospital NHS Trust	22,530	28,287	5,757
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS FT	6,336	6,790	454
Shropshire Community Healthcare NHS Trust	4,253	4,436	183
TOTAL SYSTEM	**39,310**	**40,704**	**1,394**
Total CDEL			
NHS Shropshire, Telford and Wrekin	7,083	1,331	(5,752)
The Shrewsbury and Telford Hospital NHS Trust	145,915	149,668	3,753
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS FT	9,243	10,831	1,588
Shropshire Community Healthcare NHS Trust	4,975	4,958	(17)
TOTAL SYSTEM	**167,216**	**166,788**	**(428)**

- Full year System spend against CDEL is ahead of plan by £1,394k primarily due to additional PDC funding at SaTH and RJAH for Estates safety schemes.
- The total system capital spend - CDEL plus national capital schemes including the Hospital Transformation Programme (HTP) - is £428k (0.3%) behind plan at year end due to the PCUMF underspend.
- ICB CDEL FOT is £5m underspent which is the system UEC incentive capital allocation where expenditure is recorded against SATH and SCHT.
- The total ICB capital underspend is £752k excluding UEC incentive capital due to changes in the Primary Care Modernisation and Utilisation Fund (PCUMF) schemes which are now deferred until 26/27 as agreed with NHS England, this is outside of the ICB Capital financial plan resource limit.

At month 12 provider key variances are:

- SATH full year operational capital is £5.7m above the original plan. This includes £4.8m additional allocation awarded for U EC capital with capital allocated to the ICB for this spend, and additional PDC funding for Estates safety schemes. Total SATH full year capital is £3.8m over the original plan due to UEC capital and additional PDC for Estates Safety schemes. Additional PDC of £8m has been received in year which is offset by HTP cash profiling of £9m as approved by NHSE. The HTP project is ahead of plan but under the original cash profile.
- RJAH operational capital is £0.5m over the original plan due to estates capital schemes funded by additional PDC. Full year capital spend is £1.6m above plan due to additional PDC funding received namely for estates safety.
- SCHT operational capital is £0.2m above the original plan due to additional allocation awarded for UEC capital. Full capital spend is delivered to plan which includes planned underspend of £0.2m schemes offset by the additional UEC allocation.

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

System Performance Report 2025 / 2026

Month 11 (February 2026)

Prepared by the Integrated Care Board (ICB) Intelligence Team, with drivers of underperformance and actions set out and signed off in the relevant Portfolios.

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	Feb-26	1,925	▲	n/a		-	1,958	-33	
	Elective - day case spells	Number	ICB	Feb-26	15,293	▼	n/a		-	15,595	-302	
	First outpatient attendances - Consultant-led	Number	ICB	Feb-26	42,048	▼	n/a		-	39,907	2,141	
	Follow-up outpatient attendances - Consultant-led	Number	ICB	Feb-26	65,595	▼	n/a		-	64,219	1,376	
Referral to Treatment (RTT)	Time to first attendance, waiting less than 18 weeks	%	ICB	Mar-26	73.5%	▲	71.8%	March 2026	*1.7%*	71.8%	1.7%	
	Total waiting list (Referral to Treatment - Incomplete Pathways)	Number	ICB	Feb-26	138,279	▼	147,032	March 2026	*-8,753*	147,712	-9,433	
	% Patients waiting less than 18 weeks (Referral to Treatment - Incomplete Pathways)	%	ICB	Feb-26	62.9%	▲	63.4%	March 2026	*-0.6%*	62.8%	0.1%	
	% Patients waiting more than 52 weeks (Referral to Treatment - Incomplete Pathways)	%	ICB	Feb-26	1.8%	▲	0.8%	March 2026	*1%*	1.0%	0.8%	
	Number patients waiting more than 65 weeks (Referral to Treatment - Incomplete Pathways)	Number	ICB	Feb-26	124	▲			*124*	0	124	
Diagnostics Tests	Diagnostic test activity	Number	ICB	Feb-26	48,613	▼	n/a		-	57,130	-8,517	
	Diagnostic Test Waiting List less than 6 weeks	%	ICB	Feb-26	81.5%	▲	n/a		-	94.3%	-12.8%	
Cancer	People treated beginning first or subsequent treatment of cancer within 31 days	%	ICB	Feb-26	94.1%	▲	94.0%	March 2026	*0.1%*	93.8%	0.3%	
	Total patients seen within 62 days (on cancer 62 day pathway)	%	ICB	Feb-26	62.6%	▲	75.2%	March 2026	*-12.6%*	74.9%	-12.3%	
	Cancer 28 day waits (faster diagnosis standard)	%	ICB	Feb-26	81.6%	▲	80.0%	March 2026	*1.6%*	79.7%	1.9%	
	Lower gastrointestinal (GI) referrals with an Faecal Immunochemical Test (FIT) result (Year to Date Cumulative)	%	ICB	Feb-26	81.8%	▲	n/a		-	78.0%	3.8%	
Procedures Completed (Local Metric)	Increase the proportion of procedures completed in outpatients or as a day case (UHNM)	%	UHNM	Feb-26	89.4%	▲	n/a		-	88.1%	1.3%	
Community	Community care contacts	Number	ICB	Jan-26	180,820	▲	n/a		-	152,877	27,943	
	52+ weeks in community services	Number	ICB	Feb-26	3	▼	n/a		-	0	3	
	Combined elective/non-elective length of stay (LOS) - community beds	Bed days	ICB	Feb-26	19.0	⇨	n/a		-	20.4	-1.4	

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

Planned Care National Planning Metrics off Plan and Actions, 1 of 4

Programme Area	Metric	Drivers for underperformance	Top 3 Planned actions provided by portfolio
Elective Activity	Elective Activity – Day Cases and Ordinary Spells In February 2026, the level of activity was below plan for Day Cases (302 under plan) and Ordinary Spells (33 under plan).	• Reduced level of activity with Independent Sector in line with agreed Activity Management Plans, therefore expected. • Across all of 2025/2026 Elective activity remains above plan.	**Actions remain the same as last month:** 1. NHS providers have 'Sprint' funding to increase elective capacity in spring 2026 to recover the waiting list position. 2. Continue to monitor Independent Sector providers against Activity Management Plans.
	Follow-up outpatient attendances - Consultant-led In February 2026, there were 65,595 Outpatient Follow-Up attendances, against a plan of 64,219 (a variance of 1,376 attendances). Year to date, there were 781,684 Outpatient Follow-Up attendances, against a plan of 724,709 (a variance of 56,979 attendances).	**Drivers remain consistent with those reported in the previous month.** • Although there has been a reduction in Follow-Up attendances compared to 2024/2025, providers, particularly NHS providers, have not yet reduced activity to the planned levels.	**Actions remain the same as last month:** 1. Indicative Activity Plans (IAPs) have been agreed with the two main Independent Sector Providers of acute care for the 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. Providers are being actively managed through the Contract Management process. The Activity Managements Plan (AMP) process commenced in October 2025 due to activity being over-trajectory at Month 5; the AMPs are now in place. 2. Work looking at productivity metrics has identified areas where levels of follow-up attendances are above peer organisations. This work is informing the planning round for 2026/2027.

Planned Care National Planning Metrics off Plan and Actions, 2 of 4

Programme Area	Metric	Drivers for underperformance	Top 3 Planned actions provided by portfolio
Referral to Treatment (RTT)	Number patients waiting more than 65 weeks (Referral to Treatment - Incomplete Pathways) Across all providers there were 124 patients waiting over 65 weeks to start treatment, at the end of February 2026. This is an increase from 90 at the end of January 2025.	• At University Hospitals North Midlands (UHNM) there are long waits in Gynaecology due to lack of Endometriosis capacity. Theatre, ward, and staffing capacity is also driving long waits in Orthopaedics and Ear Nose and Throat (ENT).	1. Review theatre reallocation, including swapping consultant clinic sessions for operating time. 2. Accelerating diagnostic reporting and test scheduling (notably sialograms (a specialised X-ray procedure used to examine the salivary glands) and imaging for spine and ENT). 3. UHNM engaging with Arrowe Park (Level 3 centre and nationally accredited Endometriosis service) to explore whether additional weekend support could be provided.
	% Patients waiting more than 52 weeks (Referral to Treatment - Incomplete Pathways) At the end of February 2026, there were 2,530 ICB patients waiting over 52 weeks at all providers. This is above the planned trajectory of 1,610 but a reduction from the number waiting at the end of April 2025 (3,392). As a percentage of the total waiting list, 1.8% of patients were waiting over 52 weeks, against a target of 1.0% (0.8% over plan).	• Drivers for 52 week breaches continue and reflect those for 65-week breaches (above).	

Planned Care National Planning Metrics off Plan and Actions, 3 of 4

Programme Area	Metric	Drivers for underperformance	Top 3 Planned actions provided by portfolio
Cancer	Total patients seen within 62 days (cancer 62-day pathway) Performance in February 2026 for ICB (all providers) was 62.6% against a target of 74.9%.	**Drivers remain consistent with those reported previously:** • Increased skin referrals over the summer period resulting in backlog for Skin Cancer. • Increased surgical capacity required, including weekend lists (Colorectal, Gynaecology & Skin Cancers).	1. Collaborative working group in process between Histopathology, Directorates and Cancer Services to identify specimens for reporting on appropriate triage pathway. iPortal shared pathology escalation currently live for all sites. 2. New Validation post has a function to review future fails for the 'near miss' patients and escalate for treatments in target and also to highlight solutions to pathway issues noted during validation. 3. Cancer services working with Oncology to gain weekly oversight of oncology capacity through the cancer improvement meetings.

Planned Care National Planning Metrics off Plan and Actions, 4 of 4

Programme Area	Metric	Drivers for underperformance	Top 3 Planned actions provided by portfolio
Diagnostic Tests	Diagnostic test activity Total Tests Completed: 48,254 in February 2026. Variance from Plan: 8,517 fewer tests (18% below the plan of 57,130). YTD position: 88,654 fewer tests (-17.5%) than plan.	**Driver as previously identified:** • UHNM; the 2025/2026 CT activity plan was set 34% higher than the actual delivery in 2024/2025 to meet rising demand. However, activity has not increased in line with the assumed planned uplift and remains consistent with 2024/2025 levels.	**Action as reported last month:** 1. Computed Tomography (CT) activity levels in line with 2024/2025. No action required.
	Diagnostic test waiting list less than 6 weeks The percentage of patients waiting less than 6 weeks for a diagnostic test at the end of February 2026 was 81.5% (below the plan of 94.3%). This is a continued improvement from 63.6% at the end of April 2025. Total patients waiting more than 6 weeks for a diagnostic test has reduced from 13,680 (April 2025) to 6,033 (February 2026).	**Main drivers are as previously identified:** • The main driver for non-compliance continues to be the Non-Obstetric Ultrasound (NOUS) backlog at UHNM, although the backlog continues to reduce. • There has been a significant increase in Dual-energy X-ray absorptiometry (DEXA) scan waits over 6 weeks at Midlands Partnership Trust (MPFT).	**Actions previously planned continue driving improvements:** 1. Backlog at UHNM for NOUS being reduced by increased capacity. Includes using capacity at Cannock Community Diagnostic Centre and increased 'in house' capacity at UHNM. 2. Increase in DEXA backlogs linked to capacity issues. Backlog expected to be cleared within a couple of months. The number of patients waiting over six weeks reduced from 191 at the end of December 2025 to 87 at the end of February 2026 (for all providers).
Community	Community Services Waiting List At the end of February 2026 there were 3 ICB patients on the Community Services Waiting List, that had been waiting over 52 weeks. All 3 patients were under Children and Young People services (all in Community Paediatrics Service)	**Main drivers are as previously identified:** • Growth in Attention-Deficit/Hyperactivity Disorder (AHDH) referrals. • Patients not being brought in for appointments. • Staff capacity affected by vacancies and sickness.	**Action as reported last month:** 1. Although capacity issues are largely resolved, there are patients still waiting over 52 weeks due to parents cancelling or not bringing their child in for appointment. To resolve this, MPFT have applied a 'Not brought in' policy.

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	Mar-26	66.3%	▲	78.0%	March 2026	-11.7%	78.0%	-11.7%	
	A&E Types 1 & 2 - more than 12 hours	%	UHNM	Mar-26	14.4%	▼	16.65%	2025/26	-2.2%	19.5%	-5.1%	
	Ambulance handover time (average)	Minutes	UHNM	Mar-26	01:08:06	▼	00:43:00	March 2026	00:25:06	00:43:00	00:25:06	
	Total Non-Electives spells	Number	UHNM	Feb-26	5,618	▼	n/a		-	7,011	-1,393	
	Non-elective average of Length of Stay	Bed days	UHNM	Feb-26	7.66	▲	n/a		-	7.20	0.46	
	General and Acute bed occupancy	%	UHNM	Mar-26	96.4%	▼	n/a		-	93.9%	2.5%	
	Average delay - bed days lost through discharge delays	Days	UHNM	Feb-26	3.4	▲	n/a		-	3.2	0.2	
	Virtual Ward Occupancy	%	ICB	Mar-26	64.3%	▼	n/a		-	85.0%	-20.7%	
	Urgent Community Response (UCR) referrals	Number	ICB	Feb-26	930	▼	n/a		-	750	180	
Urgent and Emergency Care (UEC) (Local Metrics)	Childrens A&E Type 1 - 4hr performance	%	UHNM	Mar-26	78.5%	▼	78.0%	March 2026	0.5%	-	-	
	Urgent community response (UCR) - patients seen within 2 hours	%	ICB	Feb-26	76.8%	▲	70.0%		6.8%	70.0%	6.8%	
	Ambulance Hours lost due to Handover delays > 15min (UHNM)	Minutes	ICB	Mar-26	5,019	▼	n/a		-	5,971	-952	
	Ambulance Compliance - % Handovers within 45 minutes	%	UHNM	Mar-26	67.2%	▲	100%	March 2026	-32.8%	-	-	
	Readmissions	Number	ICB	Feb-26	271	▼	n/a		-	385	-114	

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
Black	Not applicable / not available

Urgent and Emergency Care Metrics off Plan and Actions, 1 of 3

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 University Hospitals North Midlands (UHNM) 4-hour Performance at UHNM improved by 1.6% during March 2026 to 66.3%, which was 11.7% worse than plan for the month.	• Acuity of patients remained high with Resus patients representing 19.5% of Type 1 attendances at UHNM. • Bed Occupancy showed marginal improvement but remained high, constraining flow and restricting available capacity for timely admission.	1. Investment approved for Integrated Coordination Centre (ICC) in-hours delivery for 2026/2027 to support increase staffing and an enhanced clinical model 2. Agreed continuation of ICC Overnight for 2026/2027 with a longer-term strategy currently in development for sustained delivery 3. UHNM completed a Rapid Improvement Week (w/c 23rd March 2026) with outputs being collated to inform an internal 'lessons learnt' programme and inform revised UEC Improvement Plan workstreams aligned with Getting it Right First Time (GIRFT) recommendations.
	General & Acute (G&A) Beds Occupied (UHNM) Bed Occupancy at UHNM for March 2026 reduced to 96.4%, down 0.7% on the previous month. This was 2.5% worse than plan.	• Continued high levels of long stay patients during March 2026, with 22%% of occupied beds containing a patient that had been bedded for more than 14 days and 12% of beds containing a patient that had been bedded for more than 21 days. • Increased proportions of patients discharged via Pathway 1 resulting in increases in discharge delays.	1. Relaunch of the UEC Internal Improvement plan across UHNM. 2. 5 workstreams in place including Clinical Pathways, Bed, Site, Ward process, and Discharge which are Executive Sponsored with clinical leadership in situ. This aligns with GIRFT recommendations.
	Non-elective Average of Length of Stay (UHNM) Average Length of Stay for February 2026 increased by 0.6 days to 7.66 days, 0.46 days worse than plan.		

Urgent and Emergency Care Metrics off Plan and Actions, 2 of 3

Programme Area	Metric Name	Drivers for underperformance	Top 3 Planned actions provided by portfolio
Urgent and Emergency Care (UEC)	Percentage of patients discharged on discharge ready date (UHNM) The Percentage of patients discharged on their Discharge Ready Date during February 2026 was reported as 88.6%, 1.8% worse than plan.	• High levels of complex Medical patients requiring assessment and identification of required packages and placement. • Increased proportions of patients discharged via Pathway 1 resulting in increases in discharge delays.	1. Focus education/training of Discharge Facilitators to support further integration within the Integrated Discharge Hub. 2. Discharge to Assess (D2A) Productivity Workstream stocktake with system partners taking place in April 2026 to review progress to date and inform next steps of workstream for 2026/2027. 3. Relaunch of UHNM internal improvement plan for 2026/2027.
	Average Discharge delay - excluding 0 day delays (UHNM) The Average Delay for those not discharged on their Discharge Ready Date in February 2026 increased to 3.4 days, 0.2 days worse than plan.		

Urgent and Emergency Care Metrics off Plan and Actions, 3 of 3

Programme Area	Metric Name	Drivers for underperformance	Top 3 Planned actions provided by portfolio
Urgent and Emergency Care (UEC)	Average Ambulance Handover Time (average) - University Hospitals North Midlands (UHNM) Average Handover Time at UHNM during March 2026 was reported as 01:08:06, 00:25:06 worse than plan.	• Acuity of patients remained high with Resus patients representing 19.5% of Type 1 attendances at UHNM. • Bed Occupancy showed marginal improvement but remained high, constraining flow and restricting available capacity for timely admission.	1. Revised UEC Improvement programme relaunched with executive, corporate, care group and clinical leadership in place, 2. UHNM UEC Programme has 5 workstreams in place, aligned with GIRFT recommendations 3. Implement priority clinical pathways including implementation of Rockwood Frailty Score and falls/head injury pathways (subject to system approval).
	Ambulance Compliance - % Handovers within 45 minutes (UHNM) Handover compliance during March 2026 reported as 67.2%, a 3.5% improvement on the previous month.		
	Virtual Ward (VW) Occupancy - Staffordshire and Stoke-on-Trent ICB (SSoT) The last submission of March 2026 (made 3rd April 2026) reported an occupancy rate of 64.3%. This was down 7.1% on the final submission of February 2026 and 20.7% worse than plan. Capacity has remained at 140.	• North Wards continue to be above occupancy, however continued under-performance is due to Southeast and Southwest utilisation. • Inability to expand capacity is a result of clinical capacity to support appropriate governance.	1. Business Case being developed by UHNM to support expansion of capacity. 2. Acute Care at Home are working with University Hospitals Birmingham to support expanding pathways from Good Hope Hospital. 3. Review of Southwest provision, with ICB lead meeting with Walsall, to support patient pathways within this area of the system.

Provider Overview at Trust Site Level – Key Urgent and Emergency Care (UEC) Metrics for Out of ICB providers, March 2026

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]*	• March 2026 reported performance of 73.3%, an increase of 1% on February 2026 (72.3%).	• March 2026 was 79.2%, an increase of 0.6% on February 2026 (78.6%).
A&E Attendances Type 1 *[Site level]*	• 6,963 attendances during March 2026, a 15.6% increase against the previous month which equates to 10 patients more per day (in real terms) due to the longer month.	• 11,416 attendances during March 2026, an 8.6% increase against the previous month which equates to 7 patients less per day (in real terms) due to the longer month.
4-hour Performance (%) Type 1 Paediatrics *[Site level]*	• March 2026 reported performance of 89%, an improvement of 2.8% on the previous month (86.2%).	• March 2026 reported performance of 85.8%, an improvement of 0.4% on the previous month (85.4%).
12-hour Performance Type 1 & 2 (%) *[Provider level]*	• 11.3% of Type 1 & 2 attendances breached the 12-hour mark for 'Time in Department' in March 2026, down 3.6% on February 2026.	• 11.1% of Type 1 & 2 attendances breached the 12-hour mark for 'Time in Department' in March 2026, down 0.1% on February 2026.
Bed Occupancy (%) - General & Acute (G&A) *[Site level]*	• G&A Bed Occupancy decreased 1.3% during March 2026 to 94.5% from 95.8% the previous month.	• G&A Bed Occupancy decreased during March 2026 to 95.9% from 96% the previous month.
Virtual Wards *[Provider level]*	• UHDB – 41 occupancy out of 40 bed capacity (102%) for last submission in month (3rd April 2026).	• RWT – no submission was made for the last submission in month (3rd April 2026).
Average Ambulance Handover Time *[Site level]*	• West Midlands Ambulance Service (WMAS) and East Midlands Ambulance Service (EMAS) combined average handover time for March 2026 was 26 minutes 21 seconds, 5 minutes 46 second better than February 2026.	• WMAS average handover time for March 2026 was 51 minutes 47 seconds, down 4 minutes 31 seconds on February 2026.
Ambulance Compliance % Handovers within 45 minutes *[Site Level]*	• WMAS and EMAS combined handover compliance for March 2026 was 92.4%, up 5.1% on February 2026.	• WMAS handover compliance for March 2026 was 74.1%, up 6.5% on February 2026.
Time Lost due to handover delays > 15 mins *[Site level]*	• 30% decrease in time lost due to handover delays during March 2026, dropping to a combined total of 286 hours between WMAS and EMAS.	• Decrease of 0.8% during March 2026 in time lost, dropping the time lost by WMAS to 2,344 hours from 2,363 hours during February 2026.

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	Feb-26	554,740	▼	n/a	-	541,106	13,634	
	Unique patients seen by a NHS dentist - adult	% (quarterly)	ICB	Q3	43.1%	▼	n/a	-	43.2%	-0.1%	
	Unique patients seen by a NHS dentist - children	% (quarterly)	ICB	Q3	65.1%	▲	n/a	-	62.3%	2.8%	
	Units of Dental Activity delivered	% (quarterly)	ICB	Q3	78.8%	▼	n/a	-	82.2%	-3.4%	
	Urgent Dental Activity delivered	Number	ICB	Mar-26	5,328	▼	n/a	-	6,797	-1,469	
	Pharmacy First consultations	Number	ICB	Feb-26	16,205	▼	n/a	-	13,000	3,205	
Medicines Optimisation (Local Metrics)	Structured medication reviews (SMRs) conducted in general practice. (Year to Date Cumulative)	% (quarterly)	ICB	Q3	63.3%	▲	n/a	-	70.0%	-6.7%	

Key to arrows showing direction from previous month	
▲	Improved with a higher value than the previous month,
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▲	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	
Red	Negative impact / unwanted variation
Green	Positive impact / desired variation
Yellow	No change / equal
Black	Not applicable / not available

Notes on data:

- Unique patients seen by an NHS dentist (adults and children) not updated this month, as quarterly metrics.
- Structured medication reviews (SMRs) conducted: this is a quarterly measure, there is no update this month

Primary Care and Medicines Optimisation Metrics off Plan and Actions, 1 of 1

Programme Area	Metric	Drivers for underperformance	Top 3 Planned actions provided by portfolio
Dental	Units of Dental Activity (UDA) Quarter 3 2025/2026 : 373,306 UDAs were delivered against the plan of 473,516 (78.8%). For reference: January 2026 scheduled activity was 123.8% of contracted. February 2026 scheduled activity was 94.5%.	• December 2025 activity was affected by a technical issue relating to file transfers between WebEDI and Compass. • January 2026 activity is higher than normal because the missing December 2025 activity has been included in January 2026. Normal reporting resumed for February 2026.	**Actions planned previously continue to address performance issues:** 1. The ICB continues to deliver on the local dental plan (including redistribution of dental activity from hand backs and terminations, oral health and workforce initiatives). 2. The urgent dental communications campaign will continue to be shared in other healthcare settings e.g. GP practices, pharmacies, hospitals, A&E and via the internet. This will run throughout 2026 to support the changes to the dental contract and increase delivery in urgent appointments. 3. OWM continue to work with dental practices to ensure activity is reported correctly to support monitoring purposes, baselines and future planning of dental activity. 4. New Mandatory Requirements under the dental contract reform is that from 1st April 2026, NHS dental contractors are required to deliver a minimum level of 8.2% of their contract value as urgent/unscheduled activity.
	Urgent Dental Activity delivered March 2026: 5,328 units of urgent dental activity were delivered against the plan of 6,797 (78.4%). 2025/2026 (year-end): 66,430 units of urgent dental activity delivered against the plan of 80,090 (82.9%).	**Drivers identified previously remain:** • As previously highlighted to the National Team, concerns remain locally that there will be insufficient patient demand to deliver the ICB target. Lack of local urgent dental access is not supported by intelligence from local practices, the local Community Dental Services, Healthwatch etc. • 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, which is being addressed by the Office of the West Midlands working with individual practices to improve reporting.	

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	Mar-26	30	▼	n/a		-	4	26	
	Average length of stay for adult acute beds	Bed days	ICB	Jan-26	45	▲	41.1	2025/26	*3.9*	40.3	4.7	
	Number of people who are discharged having had at least 2 NHS talking therapy appointments	Number	ICB	Mar-26	1,167	▲	n/a		-	1,228	-61	
	Access to NHS talking therapies for anxiety and depression - reliable recovery	%	ICB	Mar-26	49.7%	▲	50.0%	March 2026	*-0.3%*	50.0%	-0.3%	
	Access to NHS talking therapies for anxiety and depression - reliable improvement	%	ICB	Mar-26	71.0%	▲	68.0%	2025/26	*3.0%*	68.0%	3.0%	
	Access to Specialist Community Perinatal Mental Health Services	Number, Rolling 12 months	ICB	Jan-26	1,415	▲	1,216	March 2026	*199*	1,209	206	
	Access to Children and Young People Mental Health Services	Number, Rolling 12 months	ICB	Jan-26	18,100	▲	17,273	March 2026	*827*	16,842	1,258	
	Access to Individual Placement Support	Number, Rolling 12 months	ICB	Jan-26	870	▲	891	March 2026	*-21*	977	-107	
Learning Disabilities & Autism (LD&A)	Learning disability registers, Annual health checks delivered by GPs	% (YTD)	ICB	Q4	83.58%	▲	n/a		-	77.01%	6.6%	
	Reliance on MH inpatient care for adults with a learning disability	Number (quarterly)	ICB	Q4	17	⇨	n/a		-	13	4	
	Reliance on MH inpatient care for autistic adults	Number (quarterly)	ICB	Q4	17	▲	n/a		-	6	11	
	Reliance on MH inpatient care for people with a learning disability and/or autism - children	Rate (quarterly)	ICB	Q4	0.0	▼	n/a		-	13.3	-13	
Learning Disabilities & Autism (LD&A) (Local Metrics)	Mean wait to complete autism assessment - Children and Young People (CYP) North	Weeks	ICB	Feb-26	118	▲	26	March 2026	*92*	26	92	
	Mean wait to complete autism assessment - Children and Young People (CYP) South	Weeks	ICB	Feb-26	118	▲	26	March 2026	*92*	26	92	
	Learning from Lives and Deaths Review (LeDeR) reviews within 6 months of notification of death.	%	ICB	Feb-26	100.0%	⇨	100%	2025/26	*0.0%*	100%	0.0%	
	Oliver McGowan training - Tier 1 (NHS staff)	%	ICB	Mar-26	32.1%	▲	30%	2025/26	*2.1%*	30%	2.1%	
	Oliver McGowan training - Tier 2 (NHS staff)	%	ICB	Mar-26	39.3%	▲	30%	2025/26	*9.3%*	30%	9.3%	

Key to arrows showing direction from previous month	
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n/a	not available

Key to variation Colour	
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Notes on data:

- Data is an up to date as is available upon refresh.

Mental Health and Learning Disabilities & Autism - Metrics off Plan and Actions, 1 of 4

Programme Area	Metric	Drivers for underperformance	Top 3 Planned actions provided by portfolio
Mental Health (MH)	Active inappropriate adult acute mental health Out of Area Placements (OAP) 30 OAP were active at the end of March 2026, down from 35 last month. 3 OAP reported by Midlands Partnership University NHS Foundation Trust (MPFT) (no change since last month) and 27 by North Staffordshire Combined Healthcare Trust (NSCHT), down 5 since last month.	**Drivers identified previously remain in place:** NSCHT: • Reduced Bed Availability: system-wide pressure continues due to a significantly reduced number of adult acute beds within NSCHT, linked to the mandatory implementation of Project Chrysalis. This has resulted in the lowest available bed stock since September 2020. • Clinically Ready for Discharge (CRfD) remain an issue across both Local Authorities. MPFT: • Demand for beds, the number of patients who are clinically ready for discharge blocking bed capacity and zero tolerance of mental health patients in Emergency Departments waiting for beds - meaning they need to be moved quickly. • Capacity within the market is extremely stretched, including residential and nursing homes with skills around mental health, supported living and supported accommodation.	**Current actions remaining in place:** 1. The ICB is in attendance at the weekly discharge calls to provide support and escalate actions. 2. Continued focused work on reducing the number of patients who are CRfD, working with colleagues across the system. 3. A root cause analysis from NSCHT has been reviewed by NHSE and is due to be presented at the Portfolio Board (due April 2026) to understand the increased demand and requirement for the increase in OAPs. **New action:** 1. Out of Area Project Implementation Document (PID) with specific actions around Cygnet contracting to be explored. 2. Trajectory for fall in OOA placements in line with performance submissions over medium term plans to NHSE.
	Average Length of Stay (LoS) for adult acute beds January 2026: 45 days. The first month since September 2025 to rise above target (40.3). The ICB continues to benchmark well against other ICBs in England and was 3rd lowest in January 2026.	**Drivers identified previously remain in place** • Patients who are Clinically Ready for Discharge (CRfD) are impacting on the average LoS. For NSCHT in particular, the number of patients who are CRfD in acute beds has remained around the 20% figure since September 2025. It has peaked at 25% and been as low as 15% during this time.	**Current actions remaining in place:** 1. Continue to closely monitor adult acute bed LoS, noting that no immediate actions are required at this stage due to acceptable benchmarking performance. 2. Actions noted above in OAP metric.

Mental Health and Learning Disabilities & Autism - Metrics off Plan and Actions, 2 of 4

Programme Area	Metric	Drivers for underperformance	Top 3 Planned actions provided by portfolio
Mental Health (MH)	Talking Therapy (TT) – reliable recovery Performance was 49.7% in March 2026, below the plan (of 50%) by 0.3%.	**Drivers identified previously remain in place:** • Recovery rates have been compromised by higher than ever levels of complexity seen both regionally and nationally. • In a couple of teams, Reliable Recovery has been impacted by the need to reallocate cases from staff being off sick long term – some of these clients have subsequently declined further treatment. • There is a natural variation with reliable recovery rates across teams' month-by-month, but also between treatment modalities and individual therapists.	**Current actions remaining in place:** 1. As part of the supported workforce plan, trainee and apprentice Psychological Wellbeing Practitioners (PWP) are now able to offer assessment and treatment. This will provide additional treatment capacity that will help to narrow this variance from target. Continued focus remains on teams and clinicians to focus on overall throughput and will be monitored through standard processes, for example, caseload management. 2. There is consistent on-going focus on strengthening the 'front door' to ensure the service accept suitable clients who are likely to benefit from treatment from TT, but the team are mindful that this may have a knock-on effect to demand on the wider system (secondary care) and/or result in a lack of services to some patients. 3. The team plan to develop an improvement plan to help understand the reasons for the variance across reliable recovery and proactively develop supported plans to improve this consistently across the whole service. This will be introduced at the teams next Managers Away morning in March 2026.

Mental Health and Learning Disabilities & Autism - Metrics off Plan and Actions, 3 of 4

Programme Area	Metric	Drivers for underperformance	Top 3 Planned actions provided by portfolio
Mental Health (MH)	Number of people who are discharged having had at least 2 NHS talking therapy appointments. March 2026 (1,167) is below the plan (1,228) by 61	• The portfolio has requested the drivers mirror those used for the reliable recovery metric on the previous slide (17).	1. The portfolio has requested the planned actions mirror those used for the reliable recovery metric on the previous slide (17).
	Access to Individual Placement Support (IPS) 870 in January 2026, an improved position on the previous month (860) and the 6th consecutive month showing improvement. 107 patients below trajectory; 145 below annual plan*. The rate of access varied between 62 and 84 patients per 100,000 population (6 sub ICBs). England rate = 83. In January 2026 (latest benchmarking data), the system benchmarked at position 27/42 amongst ICBs (in terms of percentage of YTD plan achieved – 89%). England = 102%; Midlands = 98%. * Please note: although NHS England published 'Fair Share' allocations in December 2025, they have confirmed that they require systems to continue to report against original Operational Plan targets.	**Drivers identified previously remain in place:** • Sickness and vacancies within the team continue to affect service delivery and hinder achievement of performance targets. • IPS grow submissions have identified some data quality issues and also some potential performance issues.	**Current actions remaining in place:** 1. Work continues regarding promotion of the service. There are service stands at depots and self-referral has been introduced, alongside a new website established. 2. Recruitment underway and mitigating actions are being put into place. 3. Quarterly steering group meetings moved to monthly for more oversight whilst workforce issues and access are discussed further and mitigations put in place.

Mental Health and Learning Disabilities & Autism - Metrics off Plan and Actions, 4 of 4

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

Learning Disabilities (LD) & Autism	Reliance on mental health inpatient care – adults with a learning disability and autistic adults
	
	In 2025/2026 quarter 4, there were 17 adults with a learning disability (4 over plan) and 17 autistic adults (11 over plan).
		• Q4 unprecedented issue with several types of required admissions mainly impacting autistic adults.
		  • 1x Ministry of Justice recall due to a breach.
		  • 1x Prison transfer
		  • 3x Autistic people with eating disorder
		  • 3x Autistic out of hours admissions
		  • Slippages with discharges due to capacity issues.
			1. Each case assessed to develop a robust plan for discharge
			2. Regular MDT meetings in place to track plans.

	Local Metrics: Autism assessment completion waits (Children and Young People, North & South) The average wait at North Staffordshire Combined Healthcare (NSCHT) was 118 weeks (up from 92 weeks last month). The average wait at Midlands Partnership University Foundation Trust (MPFT) was 118 weeks (up from 116 weeks last month).	**Drivers identified previously remain:** • Resource required to deal with increased activity from Right to Choose (RTC) providers. Two key factors are: a. the volume of new providers entering the market via other ICBs (with an uncertainty of the quality of due diligence done). b. the time required on an individual provider case that reaches our ICB via RTC.	**Actions from last month remain:** 1. In March 2026, Portfolio leads met with other Midlands ICBs and shared practice that is helping to try and manage situation. This work will be on-going in 2026/2027 as ICBs get to grips with the issue and seek to ensure the patients are at the centre of chosen approaches.

Notes on data:

- Narrative for drivers and actions provided by the portfolio. Drivers are very specific to individual patients due to the small cohort.

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	Feb-26	13	▼	n/a	-	14	-1	
	Epilepsy emergency admission (≤18)	Number	ICB	Feb-26	12	▼	n/a	-	8	4	
	Diabetes emergency admission (≤18)	Number	ICB	Feb-26	4	▼	n/a	-	7	-3	
Maternity and Neonates	Stillbirth rate	rate per 1,000	UHNM	Mar-26	10.2	▲	n/a	-	2.0	8.2	
	Neonate Mortality rate per 1000	rate per 1,000 (quarterly)	UHNM	Dec-25	2.2	▼	n/a	-	2.0	0.2	
	Brain injury rate per 1000	rate per 1,000 (quarterly)	UHNM	Dec-25	2.2	▲	n/a	-	2.0	0.2	
	The % of full - term babies admitted to a neonatal unit	rate per 1,000 (quarterly)	UHNM	Dec-25	5.9%	▲	n/a	-	0	0.0	

Key to arrows showing direction from previous month	
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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	
Red	Negative impact / unwanted variation
Green	Positive impact / desired variation
Yellow	No change / equal
Black	Not applicable / not available

Notes on data:

- Neonatal Maternity data is provided quarterly for Mortality, Brain Injuries and Neonatal admissions. Data is provided for the preceding months, each quarter. An update is not available this month but the data has been officially requested and chased.

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

Programme Area	Metric	Drivers for underperformance	Top 3 Planned actions provided by portfolio
Children and Young People (CYP)	**Local Metric:** Epilepsy Admissions An increase in admissions from 8 in February 2025 to 12 in February 2026. This is an increase of 4. Derived predominantly from an increase of 5 admissions in the 5-10 years age group.	• Lack of Epilepsy Specialist Nursing (ESN) posts has significant implications in terms of optimal management post diagnosis. This has resulted in significant wait times for appointments which is leading to unnecessary emergency care and admissions for people with epilepsy. • Ongoing management via non-specialists, meaning CYPs are not receiving specialist care they need, causing fragmented care pathways and a lack of co-ordinated care for this cohort of CYP.	1. Lack of ESN posts recorded within the risk register (score 16). This remains unchanged since it was added to the register in December 2024. 2. A business case for investment is under consideration to increase the number of ESNs to the recommended ratio levels.
Maternity and Neonatal (UHNM)	**Local Metric:** Stillbirth rate (per 1,000 births) A rate of 10.2 in March 2026, compared to a rate of 2.0 in March 2025. In real terms this represents an increase of 4 stillbirths (1 in March 2025, 5 in March 2026).	• A change in the birth count has impacted the stillbirth rate; 20 less births in March 2026 however the specific increase in stillbirths has driven the rate increase. • The stillbirth cases reported in March 2026 were reviewed through a rapid review process and presented at the Obstetric Risk Meeting. Learning points were identified and actioned to support safer care and reduce the risk of recurrence.	1. The ICB has reached out to UHNM for input as to why the value has increased and how the Provider will mitigate this increase and prevent further. The new in post Quality and Risk manager has provided: After-Action Review's are currently being arranged if appropriate and if further reflection is required. All cases will undergo a PMRT review to ensure comprehensive multidisciplinary learning and continued oversight of patient safety.

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

Programme Area	Metric	Drivers for underperformance	Top 3 Planned actions provided by portfolio
Maternity and Neonatal (UHNM)	**Local Metric:** Neonatal Mortality rate (per 1,000 births) A rate of 2.2 in December 2025 compared to a rate of 2.0 in December 2024. In real terms there is no change in the count of Neonatal deaths – 1 in each of the stated months.	• No change in the actual number of neonatal deaths between December 2025 (latest data) and the comparator month last year (December 2024). • The fluctuation in the rate is due to the small birth count, therefore the change is not statistically significant.	• None further actions planned as the change in the rate is not due to a change in the number of neonatal deaths. • Neonatal deaths are monitored through the local ICB dashboard, in the main Board meeting and the Quality, Safety and Oversight forum, each month.
	Local Metric: Brain injury (per 1,000 births) A rate of 2.2 in December 2025 compared to a rate of 2.0 in December 2024. In real terms there is no change in the count of cooled neonatal brain injuries – 1 in each of the stated months.	• No change in the actual number of cooled brain injuries between December 2025 (latest data) and the comparator month last year (December 2024). • The fluctuation in the rate is due to the small birth count, therefore the change is not statistically significant.	• None further actions as the change in the rate is not due to a change in the number of cooled brain injuries. • The number of cooled brain injuries are monitored through the local ICB dashboard, in the main Board meeting and the Quality, Safety and Oversight forum, each month.
	Local Metric: The % of full - term babies admitted to a neonatal unit 5.9% in December 2025 (27 babies admitted) compared to 4.2% in December 2024 (21 babies admitted). A total increase of 6 admissions between the current and comparator months.	• The acuity of the baby denotes the need to admit to the neonatal unit. • December 2025 was a very busy period with high acuity. UHNM have reviewed all cases and no themes or trends were identified • This metric reflects long-term improvement efforts and is not intended to drive reactive, month-by-month actions. Its sensitivity to monthly volatility limits the usefulness of short-term actions.	• The Local Maternity and Neonatal System (LMNS) and the Trust (UHNM) will continue to monitor the Avoidable Term Admissions into Neonatal Units to review trends, learning and themes to inform future quality improvement work. • No further planned actions at this stage.

Notes on data:
- The data and narrative on this slide **remain unchanged from last month** as an update to the data remains outstanding, but has been officially requested (April 2026).

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	Mar-26	0.9%	⇨	n/a	-	1.0%	-0.1%	
	Increase patients receiving all 8 care processes for Diabetes, receiving 3 treatment targets - Type 1 (Year to Date Cumulative)	%	ICB	Mar-26	57.7%	▲	n/a	-	53.4%	4.3%	
	Increase patients receiving all 8 care processes for Diabetes, receiving 3 treatment targets - Type 2 (Year to Date Cumulative)	%	ICB	Mar-26	64.8%	▲	n/a	-	62.5%	2.3%	
	Long-term conditions: Ensure referrals are made to the National Diabetic Prevention Programme – support for patients who are pre-diabetic	Number	ICB	Feb-26	570	▼	n/a	-	520	50	
	Urgent community response (LTC): Ensure patients commence on the National Diabetic Prevention Programme (NDPP) following referral	Number	ICB	Feb-26	365	▼	n/a	-	261	104	
	Reduction in number of conveyances for falls by WMAS	Number	ICB	Mar-26	743	▲	n/a	-	800	-57	
	Falls, Reduction in number of falls related emergency admissions - 65+	Number	ICB	Feb-26	150	▼	n/a	-	161	-11	
	Care Home, Reduction emergency admissions - 65+	Number	ICB	Feb-26	710	▼	n/a	-	713	-3	
	Reduction emergency admissions - all 65+	Number	ICB	Feb-26	5,722	▼	n/a	-	5,836	-114	

Key to arrows showing direction from previous month	
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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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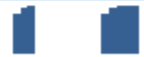
Yellow	No change / equal
Black	Not applicable / not available

Community Transformation Local Metrics off Plan and Actions

Programme Area	Metric	Drivers for underperformance	Top 3 Planned actions provided by portfolio
Community Transformation	**Local Metrics:** Prevalence rate of patients on palliative care registers to 1%.	**Driver identified previously remains:** • Palliative care identification across the ICB has plateaued to the expected level for the ICB population, with a slight seasonal dip over winter, suggesting the system may have reached a natural ceiling.	**Action reported previously remains:** 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.

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	Sep-25	89.5%	▲	n/a	-		-	
	Children and Young People Vaccination uptake - Pertussis maternal vaccination	%	ICB	Dec-25	78.9%	▼	n/a	-	76.1%	2.8%	
	Hypertension (CVDP007HYP): Patients treatment to recommended age specific thresholds	% (quarterly)	ICB	Sep-25	68.3%	▲	n/a	-	66.8%	1.5%	
	Cholesterol (CVDP003CHOL):Patients with QRISK 20% or more treated with lipid lowering therapy	% (quarterly)	ICB	Sep-25	65.7%	▲	n/a	-	64.1%	1.6%	
	Respiratory: Flu Vaccinations (65+years)	%	ICB	Feb-26	75.9%	⇨	n/a	-	76.3%	-	
	Respiratory: COVID Vaccinations (75+years)	%	ICB	Jan-26	65.7%	▲	n/a	-	64.4%	1.3%	

Key to arrows showing direction from previous month	
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Notes on data:
- No updates for this section this month
- Update from the Portfolio 9th December 2025; the criteria changed for COVID vaccinations - only 75+ year olds are now eligible.

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Staffordshire & Stoke on Trent ICS

Financial Position (March 26)

Finance & Performance Committee – 28th April 2026

Executive Summary

This report details the aggregate financial position as at month 12 with high level metrics shown on page 3.

Final outturn

At month 12, the system is reporting a £6.6m surplus breakeven position. (£4.9m adverse at month 11). This includes a deficit of £4.7m for UHNM, offset by a surplus of £7.1m at MPFT, and £3.4m at NSCHT and £0.7m for the ICB. The surplus was driven by the late receipt of additional deficit support funding released by NHSE.

Efficiency delivery

The reported system efficiency delivery YTD is £26.3m behind our submitted plan of £306.3m, this comprises of MPFT £0.3m and UHNM (£26.7m). As a system this equates to 91% delivery YTD.

Workforce

The system workforce numbers across providers and ICB (substantive + bank + agency) were 25,528 WTE in March 2026. This is an increase on month 11 of 255 WTE. Much of this increase can be attributed to an increase in bank staff at UHNM (121 WTE) and MPFT (65 WTE). Month 12 workforce numbers were 836 WTE above plan which was seen in 1,045 WTE above plan which was seen in substantive (737 WTE), bank (305 WTE), and agency (3 WTE).

Capital

The ICB met its capital forecast for the year.

Month 12 Position

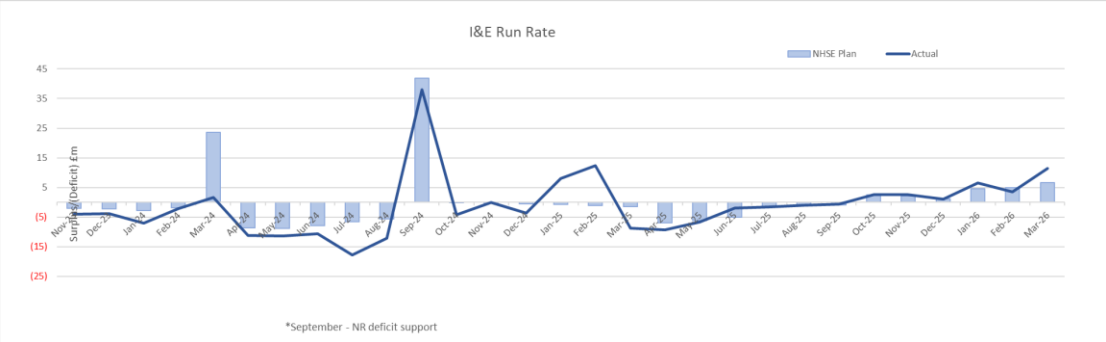
The System is reporting a YTD **favourable position to plan of £6.6m** against a planned breakeven position. The table below sets out the position for each of the system partners.

System	Month 12 £m Plan	YTD	Variance	Month 11 £m Plan	YTD	Variance
Income	5,613.0	5,688.9	75.8	5,049.8	5,062.9	13.2
Pay	(1,462.2)	(1,520.9)	(58.7)	(1,291.4)	(1,309.5)	(18.1)
Non Pay	(768.0)	(781.2)	(13.2)	(704.0)	(699.3)	4.7
Non Operating Items (exc gains on disposal)	(36.6)	(34.7)	1.9	(33.4)	(31.4)	2.0
ICB Expenditure	(3,346.2)	(3,345.5)	0.7	(3,027.6)	(3,027.6)	(0.0)
Total	(0.0)	6.6	6.6	(6.6)	(4.9)	1.8
			0.1%			0.0%

MPFT	Month 12 £m Plan	YTD	Variance	Month 11 £m Plan	YTD	Variance
Income	718.9	779.3	60.3	659.3	668.9	9.7
Pay	(520.7)	(558.5)	(37.9)	(476.9)	(479.3)	(2.4)
Non-Pay	(201.0)	(216.3)	(15.4)	(183.9)	(191.4)	(7.4)
Non Operating Items (exc gains on disposal)	2.7	2.7	0.0	2.6	2.8	0.2
TOTAL Provider Surplus/(Deficit)	0.0	7.1	7.1	1.0	1.0	0.0
			0.9%			0.0%

ICB	Month 12 £m Plan	YTD	Variance	Month 11 £m Plan	YTD	Variance
Allocation	3,346.2	3,346.2	0.0	3,022.5	3,022.5	0.0
Expenditure	(3,346.2)	(3,345.5)	0.7	(3,027.6)	(3,027.6)	(0.0)
TOTAL ICB Surplus/(Deficit)	(0.0)	0.7	0.7	(5.1)	(5.1)	(0.0)
			0.0%			0.0%

NSCHT	Month 12 £m Plan	YTD	Variance	Month 11 £m Plan	YTD	Variance
Income	186.8	187.9	1.1	164.9	164.3	(0.7)
Pay	(116.3)	(115.8)	0.5	(100.3)	(99.8)	0.5
Non-Pay	(69.6)	(67.5)	2.1	(63.9)	(62.2)	1.7
Non Operating Items (exc gains on disposal)	(0.9)	(1.2)	(0.3)	(0.8)	(1.1)	(0.3)
TOTAL Provider Surplus/(Deficit)	0.0	3.4	3.4	(0.1)	1.2	1.3
			-1.8%			-0.8%



UHNM	Month 12 £m Plan	YTD	Variance	Month 11 £m Plan	YTD	Variance
Income	1,361.1	1,375.5	14.4	1,203.1	1,207.2	4.2
Pay	(825.2)	(846.5)	(21.3)	(714.1)	(730.4)	(16.2)
Non-Pay	(497.5)	(497.4)	0.0	(456.2)	(445.8)	10.4
Non Operating Items (exc gains on disposal)	(38.4)	(36.3)	2.2	(35.2)	(33.1)	2.1
TOTAL Provider Surplus/(Deficit)	0.0	(4.7)	(4.7)	(2.4)	(2.0)	0.5
			-0.3%			0.0%

Key Performance Metrics

Position	Run Rate			System Net Risk		
	Income Extrapolated	Expenditure Extrapolated	Run rate difference to forecast	Planning Submission	Month 11	Month 12
Staffordshire and Stoke On Trent ICB				(11.7)	0.2	0.0
Midlands Partnership University NHS Foundation Trust	779.3	(772.1)	7.1	(0.7)	0.8	0.0
North Staffordshire Combined Healthcare NHS Trust	187.9	(184.5)	3.4	(30.0)	0.0	0.0
University Hospitals of North Midlands NHS Trust	1,375.5	(1,380.2)	(4.7)	(54.9)	0.1	0.0
Total	2,342.6	(2,336.8)	5.8	(97.3)	1.1	0.0

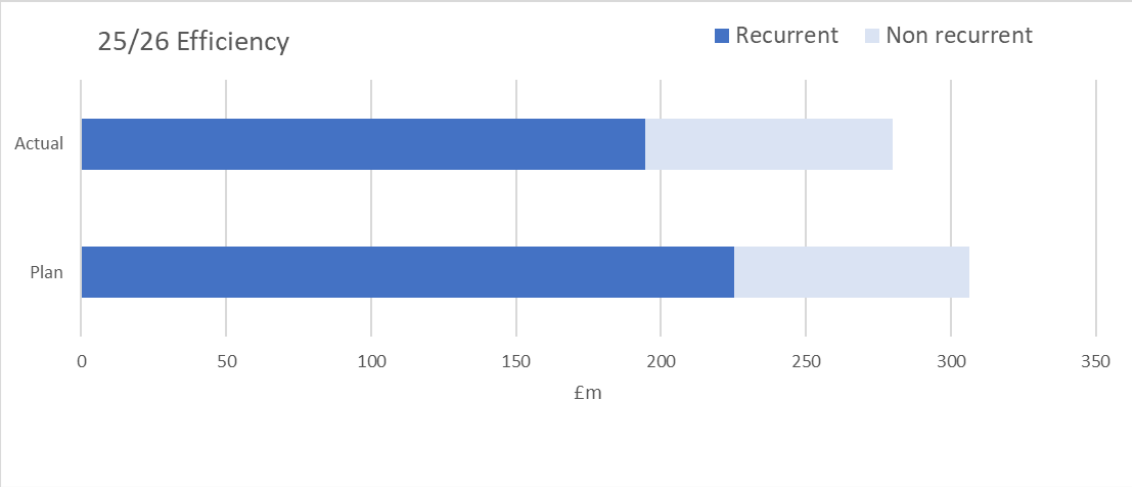
Efficiency	Efficiency			Efficiency FOT		
	YTD Actual	YTD Variance	YTD Variance %	Efficiency FOT	Forecast Variance	YTD as % of FOT
Staffordshire and Stoke On Trent ICB	169.9	(0.0)	(0%)	169.9	(0.0)	100%
Midlands Partnership University NHS Foundation Trust	54.5	0.3	1%	54.5	0.3	101%
North Staffordshire Combined Healthcare NHS Trust	7.4	0.0	1%	7.4	0.0	101%
University Hospitals of North Midlands NHS Trust	48.1	(26.7)	(36%)	48.1	(26.7)	64%
System	280.0	(26.3)	(9%)	280.0	(26.3)	91%

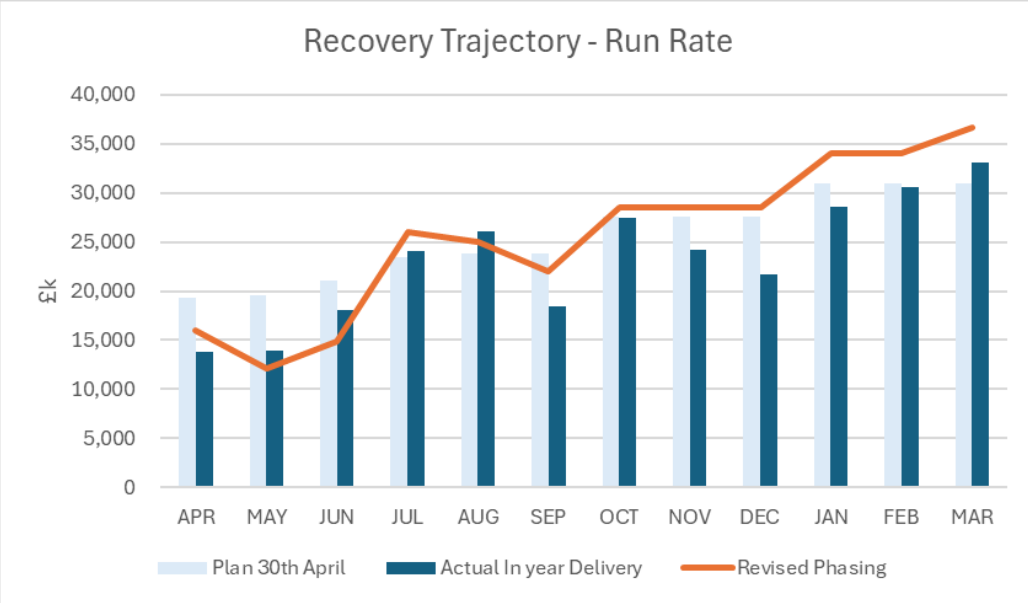
Workforce	Agency			Bank		
	YTD agency spend £m	FOT agency spend £m	YTD agency spend as % of FOT	YTD Bank spend £m	FOT Bank spend £m	YTD Bank spend as % of FOT
Staffordshire and Stoke On Trent ICB						
Midlands Partnership University NHS Foundation Trust	6.1	6.1	100%	23.9	23.9	100%
North Staffordshire Combined Healthcare NHS Trust	1.5	1.5	100%	6.3	6.3	100%
University Hospitals of North Midlands NHS Trust	13.5	13.5	100%	68.7	68.7	100%
System	21.2	21.2	100%	98.9	98.9	100%

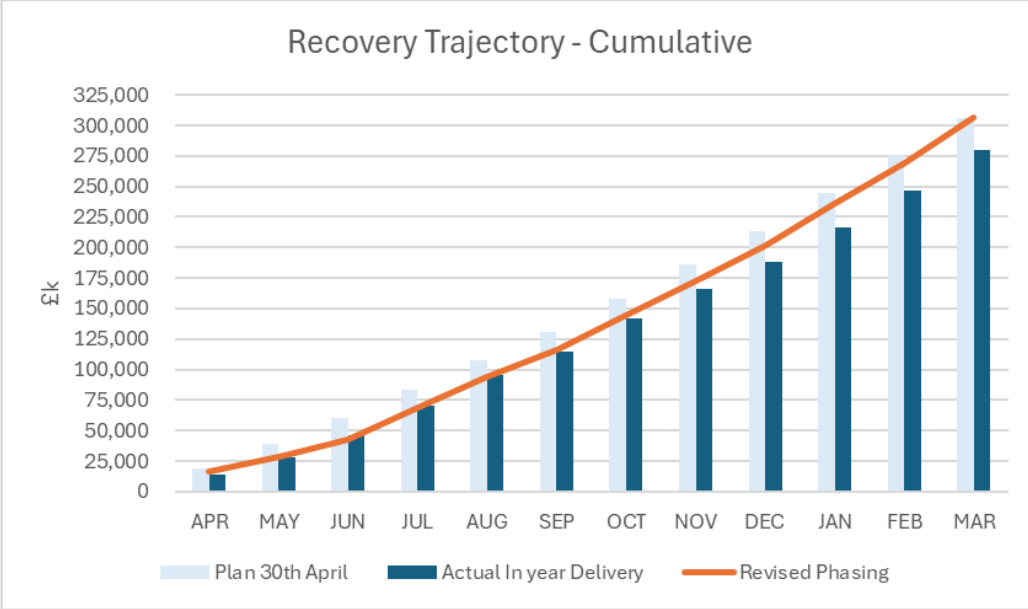
Efficiency

- The reported system efficiency delivery YTD is £26.3m behind our submitted plan of £306.3m, this comprises of the ICB (£0.0m), MPFT £0.3m, NSCHT (£0.0m) and UHNM (£26.7m)
- As a system this equates to 91% delivery at month 12

Total Efficiency Delivery	YTD (£'m)				
	ICB	UHNM	MPFT	NSCHT	ICS
Plan	169.9	74.8	54.2	7.4	306.3
Actual	169.9	48.1	54.5	7.4	280.0
Variance	(0.0)	(26.7)	0.3	0.0	(26.3)
% delivered	100%	64%	101%	101%	91%







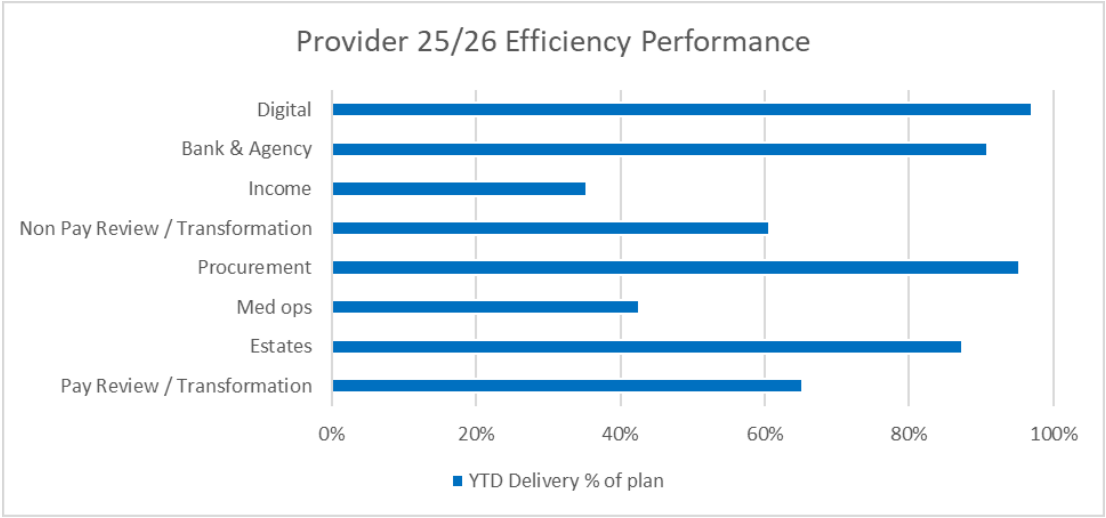
Efficiency Detail

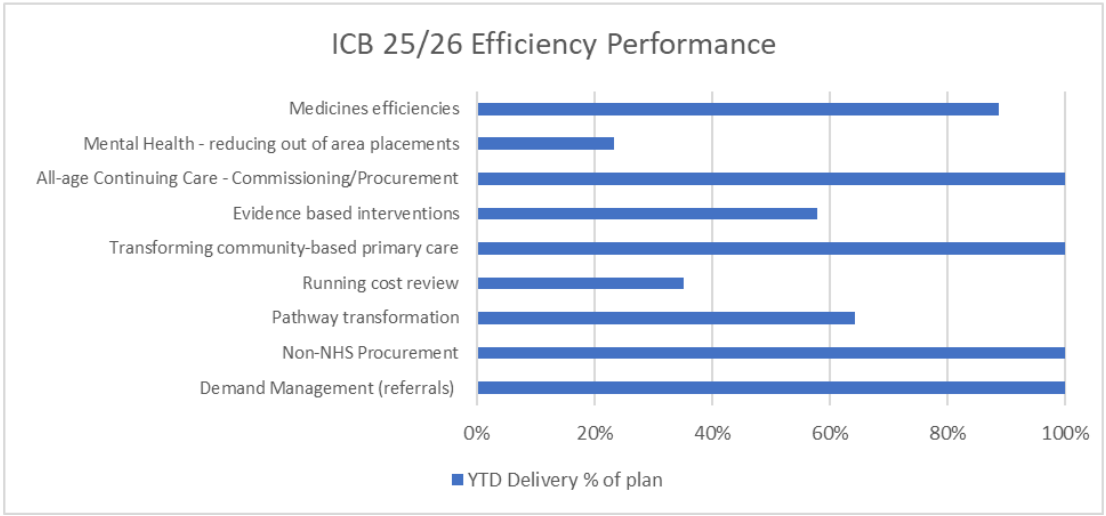
- The recurrent schemes are £30.5m adverse at month 12. Key challenges remain to deliver the 2026/27 efficiency programme to meet the agreed deficit and within this, ensure the recurrent efficiency is met to not deteriorate the underlying position.

Recurrent Efficiency Delivery	YTD (£'m)				
	ICB	UHNM	MPFT	NSCHT	SSOT
Plan	128.2	49.8	41.1	6.0	225.1
Actual	131.2	18.2	39.2	6.0	194.6
Variance	3.0	(31.6)	(1.9)	0.0	(30.5)

Non Recurrent Efficiency Delivery	YTD (£'m)				
	ICB	UHNM	MPFT	NSCHT	SSOT
Plan	41.7	25.0	13.1	1.4	81.2
Actual	38.8	29.9	15.3	1.4	85.4
Variance	(3.0)	4.9	2.2	0.0	4.2

Total Efficiency Delivery	YTD (£'m)				
	ICB	UHNM	MPFT	NSCHT	ICS
Plan	169.9	74.8	54.2	7.4	306.3
Actual	169.9	48.1	54.5	7.4	280.0
Variance	(0.0)	(26.7)	0.3	0.0	(26.3)
% delivered	100%	64%	101%	101%	91%

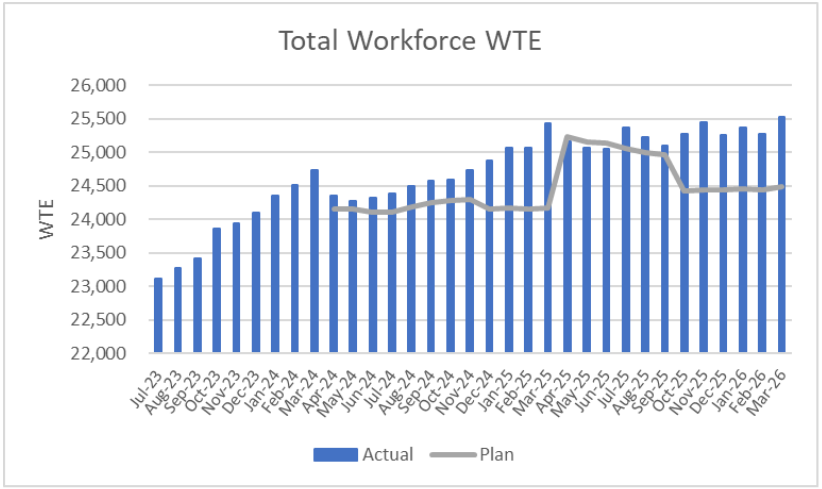


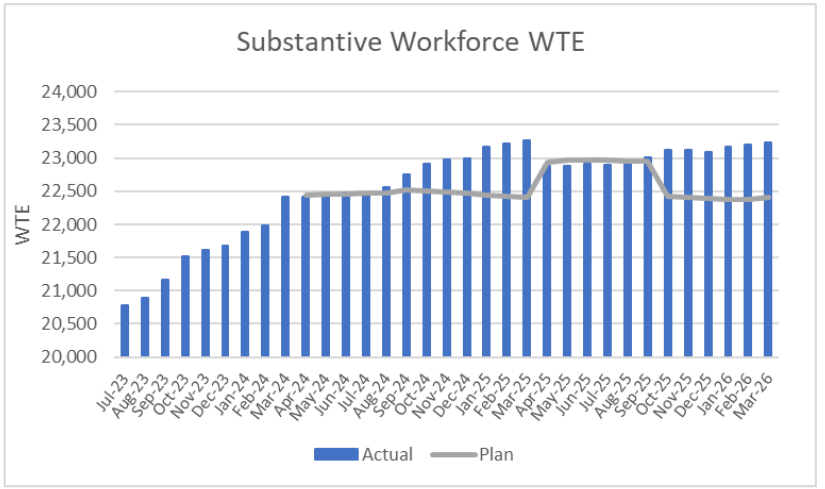


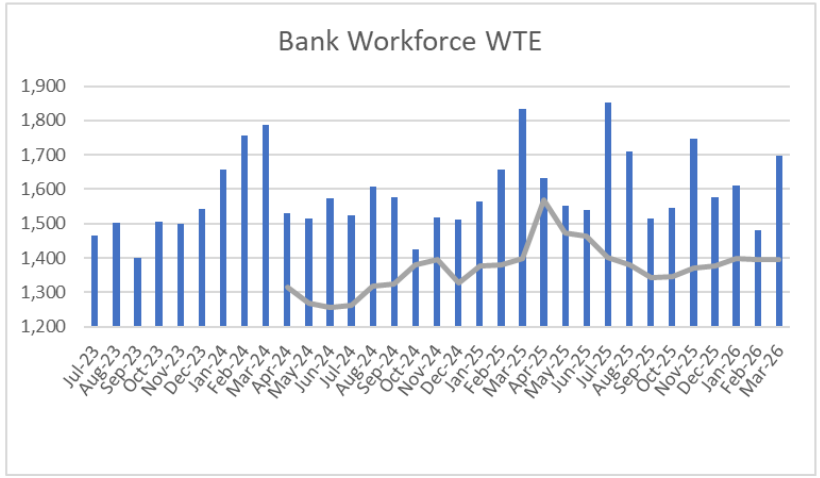
Workforce

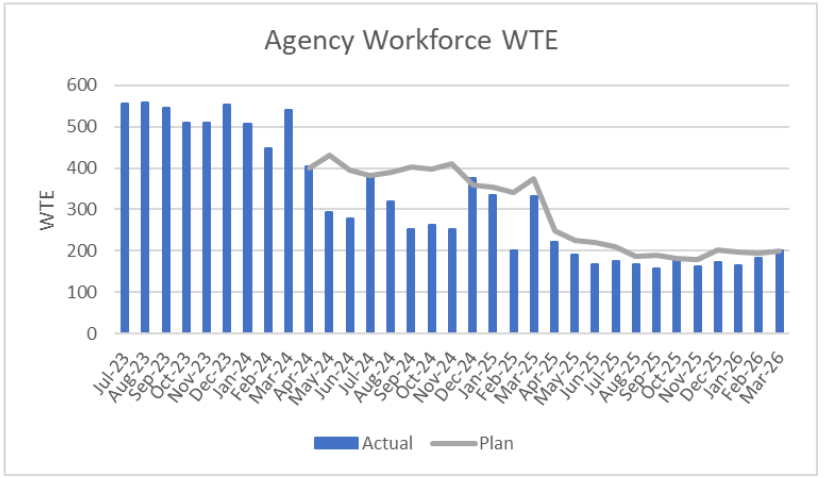
- The system workforce numbers across providers and ICB (substantive + bank + agency) were 25,528 WTE in March 2026. This is an increase on month 11 of 255 WTE. This is due to an increase in bank staff at UHNM 121 WTE and MPFT 65 WTE
- Month 12 workforce numbers were 1,045 WTE above plan which was seen in substantive (737 WTE), bank (305 WTE), and agency (3 WTE).

- As a system we were within our agency ceiling by 18.5% (£4.8m),
- Agency spend was 1.4% of total staff spend therefore (1.8%) under the 3.2% ceiling/target.









Capital

- For Month 12 expenditure actuals were £1.0m behind plan
- The majority of the under spend against plan relates to schemes where the plans are not approved or being deferred to 2026/27
- The capital pressures of IFRS16 and the deferral of the UHNM land sale have been mitigated through a combination of internal actions, additional regional support and system-wide working.

Category	YTD £000		
	Plan	Spend	Variance
Capital allocation	40,702	44,144	3,442
Return to Constitutional Standards	37,750	31,023	(6,727)
2025/26 Estates Safety	7,797	12,205	4,408
2025/26 Mental Health: Reducing Out of Area Placements	6,050	3,900	(2,150)
Total	**92,299**	**91,272**	(1,027)

By Organisation	YTD £000		
	Plan	Spend	Variance
MPFT	27,360	27,461	101
NSCHT	3,628	3,442	(186)
UHNM	61,311	60,369	(942)
System total	**92,299**	**91,272**	(1,027)

Board Assurance Committee
"Triple A" Escalations & Highlights Assurance Report

Report To:	ICB Boards in Common
Date:	30th April 2026
Reporting Committee:	Finance Committee in Common – Part 1 (ICB) & Part 2 (System)
Date of Meeting:	31st March 2026
Meeting Quorate Y/N?	Yes (both)
Presenter:	Mike Lawton, ICB Deputy Chair
Author:	Kelly Weatherill, Executive Assistant

Summary of Key Discussions & Decisions from the Committee Meeting

ALERT – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

There were no items to alert the ICB Board from the meeting.

ADVISE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

Finance Committee in Common Part 1 (ICB)

Financial Plan Update

The Committee were presented with an update on the changes made between the February 2026 financial plan submission and the March 2026 financial plan resubmission. Both ICBs reported no changes to the overall capital and revenue financial plan including the efficiency plan totals, underlying recurrent position. The only change related to contract value and efficiency development. Final confirmation that the capital and revenue for each ICB has been signed off is anticipated from NHS England.

ICB Finance Performance

SSOT Month 11 Finance Report

SSOT ICB reported a breakeven position against the £5.1m deficit plan at month 11 and is reporting a £0.8m surplus forecast position. For SSOT, capital was reported within the system element of the reporting.

SSOT 2025/26 Efficiency Report

The Committee received an update on the progress against the ICB's £169.9m efficiency programme. The level of plans implemented or fully developed by the ICB reflects a positive position (£150.3m/88%) however, a (£17.9m) risk of unidentified plans has remained throughout the financial year which has necessitated for the identification of mitigations, mostly non recurrent in nature.

STW Month 11 Finance Report

The Committee received an update on the latest position regarding STW ICB finance for revenue, efficiency and capital. The ICB is reporting a £0.2m surplus which is a £1.75m favourable variance compared to a £1.5m deficit plan due to prior year benefits and increased efficiency delivery. Efficiency delivery is ahead of plan by £6.3m at month 11 YTD due to prior year benefits and individual commissioning and is £6.1m ahead of plan by year end. The ICB is forecasting a £38k surplus by year end, £2m favourable variance compared to a £2m deficit plan, after deficit support funding of £38.6m.

CDEL BAU capital plans for 2025/26 are progressing in line with plan. All forecast expenditure remains within the available allocation. Bridgnorth Medical Practice and Woodside scheme under the Primary

Care Utilisation and Modernisation Fund (PCUMF) have been deferred to 2026/27, resulting in a £0.8m underspend in national programme capital this year (outside of CDEL).

Finance Committee in Common Part 2 (System)

Chief Finance Officer Update
The Committee received a verbal update from the Chief Finance Officer which covered the year-end position, 2026/27 plans, allocations and the availability of additional provider deficit support funding.

System Finance Performance

SSOT Month 11 System Finance Report
The system reported a £4.9m deficit, representing a £1.8m favourable variance against the planned £6.6 deficit (£3.2m favourable at month 10). Year-to-date, this includes deficits of £5.1m for the ICB, £2m at UHNM and offset by a surplus of £1m at MPFT and £1.2m at NSCHT.

While the overall position remains broadly on track, the key driver of variances continues to be lower than planned efficiency delivery, offset by several non-recurrent mitigations. The reported system efficiency delivery YTD is £28.5m behind the submitted plan of £275.4m, this comprises of ICB (£6.5m), MPFT (£0.6m), NSCHT (£0.2m) and UHNM (£21.1m). As a system this equates to 90% delivery YTD. The system is forecasting to meet the year-end financial plan of break even, after £95m deficit support funding.

The system workforce numbers across providers and the ICB (substantive + bank + agency) were 25,273 WTE in February 2026. This is a decrease on month 10 of 92.6 WTE. Month 11 numbers were 836 WTE above plan which consists of 758 WTE substantive and 90 WTE bank, offset by agency which is under plan by 12 WTE.

The system submitted a compliant capital forecast at month 11.

STW Month 11 System Finance Report
The system reported a £2.8m actual YTD System deficit v's £0.8m deficit plan, giving a £2m adverse variance at month 11, an improvement from £3.6m in month 10.

The system has delivered £94.7m of efficiency savings against a plan of £86.7m which is £8m favourable to plan. The 2025/26 expected forecast outturn is a surplus to the planned breakeven of £2.3m (after £83.8m deficit support funding).

Overall provider workforce expenditure YTD is adverse to plan by £16.6m, bank overspend YTD at £11.9m. WTE is above plan by 102 WTE (1%) with bank exceeding plan by 87 WTE (13%) but partially mitigated by agency which is 32 WTE (34%) below plan.

Month 11 is reporting a £30.5m capital underspend against plan, namely due to the profile of capital spend compared to plan this is expected to be recovered by year end.

ASSURE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

Finance Committee in Common Part 2 (System)

STW System Integration and Improvement Programme Update (SIIP)
The purpose of the paper was to assure the Committee that the STW system has met both the system and individual organisational deliverables for the SIIP in full. It was noted that the SIIP conditions has been met. It was also noted that the 2025/26 financial position post audit will not be available until June 2026 and the SATH data quality improvement plan remains ongoing.

STW Finance Committee – Annual Report

The Committee were presented with the Annual Report of the STW Finance Committee for the financial year 2025/26 to provide assurance that the Committee had fulfilled its responsibilities as outlined in its Terms of Reference (TOR). The Committee agreed that the STW Finance Committee had effectively discharged its responsibilities in line with its TOR and that it had provided appropriate oversight and assurance in all mandated areas during the reporting period.

Key Risks & Mitigations (ref. System Board Assurance Framework: SBAF)

The Committee were presented with the System Board Assurance Framework (SBAF) for Q4 2025-26 for oversight and assurance. The Committee were also presented with updates relating to the ICB and System Risk Registers.

Policies & Procedures 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 items for escalation originating from Part 1 or Part 2 of the Finance Committee.

Board Assurance Committee
Escalations & Highlights Assurance Report

Report To:	ICB Boards in Common
Date:	30.04.2026
Reporting Committee:	Quality and Performance Committee STW
Date of Meeting:	12.03.26
Meeting Quorate Y/N?	Yes
Presenter:	Cheryl Etches, Non-executive Director and Committee Chairperson
Author:	Vanessa Whatley, Chief Nursing officer, NHS STW

Summary of Key Discussions & Decisions from the Committee Meeting

ALERT – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

- The Urgent and Emergency Care system risk was reviewed. Ambulance handover and offload delays remain a patient safety risk. However, there is good assurance that the quality of care in the emergency departments is maintained and although performance data remains off-track for 4 hours and 12-hour waits, there is improvement, and harm monitoring confirms risk has reduced versus previous winters. The Committee reviewed the data and agreed reduce the risk from 20 to 16, reflecting the improvement.
- Several risks require pathways commissioning; all are currently in various stages of progress. These include ADHD (long waits, transition of comorbid cohort), TB (mitigation improving, recruitment underway). Shared care prescribing (variation in acceptance of referrals to primary care), Child protection medicals (service specification under review), Paediatric end-of-life care (partially commissioned and progressing).
- STW remains a High-dose opioid prescribing outlier in national data. Although numbers of patients on high dose opiates have reduced this is in line with national reductions. Furthermore, the national definition has been tightened from 120 mg to 90mg to be classed as high dose and we await full data on this definition once applied.
- Shropshire highest suicide rate in West Midlands, particularly among men; a system response is being escalated.

ADVISE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

- This Committee was the final one as STW. From May this will be replaced with a Quality and Performance Committees in Common across STW and SSOT.
- A developmental workshop has been held to progress terms of reference for the Committees in Common.
- The Committee remains focussed on improving the overall quality of assurance presented at the Committee

ASSURE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

- Quality and access across a number of priority services are improving and, in several areas, exceeding planned trajectories. Sustained improvements in mental health length of stay (49 days vs plan of 59.7), cancer diagnostics and treatment (Faster Diagnosis Standard (82.9% vs plan 76.5%), primary care access (appointment capacity and access remain within plan, with the 14-day access target achieved and improved same/next-day availability), maternity indicators, learning disability health checks (ahead of plan) and community waits demonstrate effective delivery of recovery actions and a positive impact on patient outcomes.
- Areas of underperformance and operational risk are identified, reported and subject to robust system oversight. These include urgent and emergency care flow, ambulance handover delays, >65wks waiters at RJAH, mental health out-of-area placements, diagnostics and neurodevelopmental waiting times are actively managed through agreed recovery plans, executive oversight, escalation frameworks and targeted mitigation actions to protect patient safety and service continuity.
- The Committee is reviewing system risks with risk owners to strengthen Board-level assurance going into 2026/27.

Key Risks & Mitigations (ref. System Board Assurance Framework: SBAF)

Policies & Procedures Approved

☑ The Committee approved the annual Special Education Needs and Disability (SEND) report for Health.

Decisions to be Escalated to ICB Board

☑ No Decisions to be escalated.

Board Assurance Committee
"Triple A" Escalations & Highlights Assurance Report

Report To:	Integrated Care Board in Common
Date:	30 April 2026
Reporting Committee:	Strategic Transformation & Commissioning Committee
Date of Meeting:	8 April 2026
Meeting Quorate Y/N?	
Presenter:	Trevor McMillan, Non Executive Director
Author:	Vanessa Ridout, Executive Assistant

Summary of Key Discussions & Decisions from the Committee Meeting

ALERT

There were no alerts to escalate to the Board.

ADVISE

Proposal: Phased Redesign of Strategic Commissioning Governance
The Committee received a paper that proposed a phased redesign of the governance arrangements supporting the Strategic Commissioning and Transformation Committee (SCTC) to allow the Committee to oversee a very broad agenda whilst simultaneously maintaining the high-level of scrutiny and assurance required of a Board sub-committee and partner engagement.

The proposal reflects three key developments:

- Increasing emphasis on place-based working and clustering arrangements
- The need for structured involvement of system partners
- The long-term ambition for greater delegation and accountability at place level

The model therefore proposes:

- Phase 1: Strengthened system governance with partner engagement through supporting working groups and structured place agenda segments.
- Phase 2: As Place Boards mature, oversight of place-based delivery moves to those boards, with system groups retaining oversight only of system-level strategy and programmes.

It is proposed that there would be four working groups to sit beneath the SCTC and undertake detailed development, scrutiny and coordination. These groups are:

- Commissiong Working group
- Population Health Improvement Group
- Transformation and Digital Group
- Primary Care Forum (SSoT) / Primary Care Commissioning Group (STW)

The Terms of Reference for the Committee are being reviewed and will be submitted to the Committee next month for further discussion and approval.

PCN Care Home Allocation
The Committee received a report relating to a Care Home Allocation within STW. The report had previously been submitted to the Primary Care Commissiong Group who approved the recommendations within the report. The SCTC approved the recommendations in the report.

ASSURE

5 Year Strategic Commissioning Plans – NHS Shropshire Telford & Wrekin ICB and NHS Staffordshire & Stoke-on-Trent
The Five-Year Strategic Commissioning Plans 2026/27–2030/31 for NHS Shropshire, Telford and Wrekin (STW) and Staffordshire and Stoke on Trent (SSoT) was presented to the Committee for information and assurance.

Key Risks & Mitigations (ref. System Board Assurance Framework: SBAF)

Year End 2025/26 Risk Report (STW/SSoT)
The year end risk report for both ICBs was submitted to the Committee for information and discussion.

The report set out all current system level risks, which are presented to the Strategic Commissioning and Transformation Committee Meeting in Common, for assurance and appropriate action. Full details for each risk, including current status, mitigation actions, and scoring history are provided as an attachment to the report.

The Committee approved the recommendations within the report and highlighted the need for the descriptions of mitigations to be high quality.

Policies & Procedures Approved

There were no policies or procedures for approval

Decisions to be Escalated to ICB Board

There were no decisions to be escalated to the ICB Board.

Board Assurance Committee
"Triple A" Escalations & Highlights Assurance Report

Report To:	ICB Boards in Common
Date:	24th April 2026
Reporting Committee:	SSOT People Culture and Inclusion Committee
Date of Meeting:	16th April 2026
Meeting Quorate Y/N?	Y
Presenter:	Mish Irvine, Shokat Lal
Author:	Gemma Treanor

Summary of Key Discussions & Decisions from the Committee Meeting

ALERT – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

1. Future Direction of PCI and System People Agenda

The Committee identified a material risk arising from loss of senior capacity and specialist expertise within the ICS People function and across partner organisations, impacting continuity, delivery pace and system leadership. Members also recognised the impact of the national direction for People and risks regarding the ability to continue collaborative work without the central infrastructure.

In view of the changes in national and local requirements for the system people agenda, members recommend that the System People Culture and Inclusion Committee structure in its current format is disestablished, and that it is redesigned to respond to the future requirements. Planning meetings are scheduled and the Board will be updated as the redesign work progresses. The ICB PCI Committee remains an integral, formal Committee in the Clustering ICB Board structure.

ADVISE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

1. System People, Culture and Inclusion Annual Report 2025/26

The Committee received an update on the achievements of the System People, Culture and Inclusion programmes over the past year, delivered within a highly challenging and evolving context. Despite this, the ICS People function and system partners have achieved nationally recognised impact, particularly in widening access and participation, workforce wellbeing and retention, and culture and inclusion. Members noted that dedicated system capacity and strong partnerships enabled scalable programmes and supported the system in securing national funding and demonstrator opportunities.

The Committee also recognised that the ICS People function has provided system-level coordination of people, culture and inclusion since 2018; however, NHS reform, financial pressures and organisational restructures have resulted in a significant loss of capacity and senior expertise across the ICB and providers, reducing specialist capability and continuity of people leadership.

ASSURE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

1. Future People Culture and Inclusion Committee structure and People agenda

As the ICB operating model transitions towards a strategic commissioning focus, the role of the ICB People function will become more targeted from a system perspective. The function will no longer deliver a comprehensive system-wide People Plan or assurance programme but will focus on workforce input to commissioning and contracting, targeted performance oversight, primary care support and enabling collaboration where appropriate.

Members recognised that this shift represents a change rather than an end to system working, but it does introduce risks, particularly in relation to culture, inclusion and workforce inequality, which will require continued Board visibility.

The Committee was updated on two important programmes which will form the core of ongoing delivery activity of the ICB People Team and System Partners:

- WorkWell: A three-year programme jointly funded by DWP and DHSC, focused on supporting people to remain in or return to work through prevention and health-aligned interventions, strongly linked to population health and socio-economic impact.
- Widening Access Demonstrator (WAD): A 12-month NHS England funded programme, commencing in April, building on established outreach foundations to support underserved communities into health and care employment.

Both programmes are strategically aligned to the ICB's population health and prevention agenda, will involve partners from multiple sectors and will require clear leadership and careful management of limited capacity. The Board will be kept informed and engaged in these programme as they are developed and mobilised.

2. Sexual Safety Charter

The Committee was assured that progress continues on embedding the Sexual Safety Charter across NHS Trusts, with all core organisations signed up. Recent legislative changes have strengthened organisational duties to prevent sexual harassment, reinforcing the importance of sustained system focus.

Support to primary care is developing, with variable progress acknowledged. A system Sexual Safety Working Group remains in place, providing governance, sharing good practice and supporting culturally sensitive responses to disclosures. Members noted that increased reporting may reflect improved confidence rather than deteriorating culture.

3. Anti-Racism, Antisemitism and Islamophobia Statement

The Committee acknowledged progress toward a joint Anti-Racism and Anti-Religious Hatred Statement, aligned to national NHS direction and reflective of increasing racial and religious tensions affecting staff experience.
System-wide anti-racism seminars continue, demonstrating strong senior leadership and partnership engagement. A risk was noted regarding the loss of dedicated Inclusion and Belonging capacity, creating potential gaps in system-level oversight and coordination. Sustained leadership focus will be required to maintain momentum and assurance.

Key Risks & Mitigations (ref. System Board Assurance Framework: SBAF)

The Committee received the 2025/26 People Risk Register closedown report for information and approval. Members recognised that the system and people landscape had changed significantly and further work was required as part of the overall PCI Planning work. People risks for 2026/27 are currently being considered and will form part of the overall risk register review.

Policies & Procedures Approved

None

Decisions to be Escalated to ICB Board

The Board is asked to:

- Note the impact delivered to date by the ICS People function and System partners, and the risks associated with reduced capacity and loss of key individuals as part of the ICB Blueprint and restructure.
- Endorse further work which will be undertaken by CPOs to define sustainable leadership and resourcing options for the System People agenda and programmes
- Recognise WorkWell and Widening Access Demonstrator as priority programmes requiring visible Board-level sponsorship and appropriate leadership capacity
- Request regular updates on workforce risk, programme delivery and capacity impact as the new operating model embeds.

Board Assurance Committee
"Triple A" Escalations & Highlights Assurance Report

Report To:	ICB Boards in Common
Date:	30th April 2026
Reporting Committee:	Staffordshire and Stoke on Trent Health and Care Senate
Date of Meeting:	12th March 2026
Meeting Quorate Y/N?	N
Presenter:	Dr Rachel Gallyot, Chief Medical Officer and H&C Senate Chair
Author:	Dr Rachel Gallyot, Chief Medical Officer and H&C Senate Chair

Summary of Key Discussions & Decisions from the Committee Meeting

ALERT – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

None.

ADVISE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

1. Excluded and Restricted Procedures (ERP) Policy including Evidence Based Interventions (EBI)

The Senate received a presentation which outlined the work that has been undertaken to update the ERP Policy and the amended wording and inclusions for Senate approval. The amendments reflect 4 key areas.

1) Minor word changes:

- Vaginal ring pessaries
- Overarching Trauma and Orthopaedic wording

2) Additions:

- Revision of previous cosmetic surgical procedures
- Health optimisation statement
- Mental Health Assessments
- Out of Area Mental Health Assessments
- Chronic Fatigue Syndrome and Myalgic Encephalomyelitis (CF/ME) residential treatment programmes

3) EBI Criteria:

- Surgical removal of kidney stones
- Cystoscopy for men with uncomplicated lower urinary tract symptoms
- Venous angioplasty for the treatment of multiple sclerosis
- Surgical treatment of uncomplicated varicose veins and reticular veins or telangiectasia
- MRI scan of the hip for diagnosis of OA
- Knee MRI when symptoms are suggestive of OA
- Knee MRI in the investigation of suspected meniscal tears
- Appendectomy without confirmation of appendicitis
- PSA Test

4) Interventions not recommended by NICE:

- Endoscopic laser foraminoplasty

In response to comments/questions from the Senate the following clarification points were provided: -

- The team are ensuring that the policy aligns with STW policy going forward.
- A QIA has been submitted and is awaiting sign off. The EBI Interventions have been through a national QIA process and it is just the local QIA process that has not been completed for those. It was confirmed that the Senate approval would be subject to QIA approval.

The Senate supported the inclusion of the interventions, which are already commissioned, the inclusion of the EBI interventions and the inclusion of interventions that are not recommended by NICE due to poor evidence base.

The Senate **clinically approved** the Excluded and Restricted Procedures (ERP) Policy V.2.3 subject to the approval of the Quality Impact Assessment (QIA). The meeting was not quorate as there was no representation from Adult Social Care. The approvals were subsequently sent to Ian Clarke, Interim Adult

2. Assisted Conception for Infertility Policy – Scheduled Review Update

The policy was due to be reviewed in December 2024 but delayed due to release of NICE guidance, which has still not been received. The policy has been reviewed and suggested amendments provide clarification to the policy, following queries from patients, providers, GPs and MPs about the policy, eligibility criteria and the treatments that are funded.

An EIA and QIA have been undertaken and approved at stage one.

The proposed amendments to the policy are as follows: -

- A definition for non-smoking is included in the policy. It is suggested that couples must be non-smoking for 6 months, which is in line with the policies of other ICBs.
- Staffordshire and Stoke-on-Trent (SSOT) Integrated Care Board (ICB) policy to include the same wording as Shropshire, Telford and Wrekin (STW) ICB, to clarify the clinically appropriate circumstances for cryopreservation of gametes and embryos.
- SSOT ICB to fund one cancelled Frozen Embryo Transfer (FET) for clinical reasons such as poor response / thin endometrium and one further FET attempt and it is suggested to use the same wording as NHS Devon.
- On the grounds of health inequity by gender, include in the policy, the clinical circumstances in which donor sperm for male infertility will be funded in line with STW ICB policy, in very specific circumstances where severe male infertility has been identified.
- Assisted conception treatment should be completed within 12 months of the initial referral, otherwise funding approval and eligibility checks will have to be re-requested.

In response to comments/questions from the Senate the following clarification points were provided: -

- Regarding donor sperm, it is difficult to ascertain the number of males that it would apply to but using some prevalence information it is estimated that it may be up to 10 men per annum. Whilst there may be a financial implication of funding donor sperm, and additional sperm freezes, it is estimated to be circa £10k and there is an underspend of £37k, so finance colleagues are happy with the proposal.
- Including the non-smoking definition was supported by the Senate as, whilst difficult to enforce, it was agreed it was a good stimulus to quit smoking.
- Whilst there is no evidence regarding the impact of vaping on fertility a lot of other ICB policies include vaping in their list of nicotine products.
- The definitions in the policy will support the team when dealing with complaints.
- A women's health page has been developed, which features advice about the pathway and wellbeing and lifestyle advice, that patients can follow, to help them conceive.
- The next review date is March 2027, to allow for ICB restructure and clustering arrangements to be completed, which will allow time for review of the policies, across both organisations, and any necessary public engagement.

The Senate **Clinically approved** the updates to the Assisted Conception for Fertility Policy.
ASSURE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions
None.

Key Risks & Mitigations (ref. System Board Assurance Framework: SBAF)

Policies & Procedures Approved
☑ Clinical approval of amendments to Excluded and Restricted Procedures (ERP) Policy V.2.3. ☑ Clinical approval of updates to the Assisted Conception for Fertility Policy.

Decisions to be Escalated to ICB Board
☑ Clinical approval of amendments to Excluded and Restricted Procedures (ERP) Policy V.2.3. ☑ Clinical approval of updates to the Assisted Conception for Fertility Policy.