



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

Shared Agenda for the meetings “in common” of:

**NHS Shropshire, Telford and Wrekin ICB
NHS Staffordshire and Stoke- on- Trent ICB
Thursday 29th January 2026 1.30pm – 4.00 pm**

**Newcastle Suite
Stafford Education & Enterprise Park, Weston Road
Stafford, ST18 0BF**

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

	Agenda Item	Lead	Purpose	Format	Time
OPENING MATTERS					
1.	Welcome and Apologies	Chair		Verbal	1.30pm
3.	Leadership Compact	Chair	A	Enc.01	
2.	Declarations of Interest: To declare any new interests or existing interests that conflict with an agenda item SSoT ICB Master COI Register January 2026 STW Register of Interests - NHS Shropshire Telford and Wrekin	Chair		Verbal	
3.	Minutes from the previous meetings held on: a) STW – 26 th November 2025 b) SSoT – 20 th November 2025	Chair	A	Enc 02 Enc 03	
4.	Matters arising and action list from previous meetings held on: a) STW – 26 th November 2025 b) SSoT – 20 th November 2025	Chair	D	Enc 04 Enc 05	
5.	Questions from Members of the Public: a) STW b) SSoT	Chair	I	Verbal	
STRATEGIC SYSTEM DEVELOPMENT AND OVERSIGHT					
6.	ICB Cluster Chair’s Report <ul style="list-style-type: none"> Urgent Decision Making – Betley GP Surgery 	Chair	R/S	Enc 06	1.40pm

7.	ICB Cluster Chief Executive (CEO) Report	S Whitehouse	I	Enc 07	1.45pm
8.	Residents/Community Story <ul style="list-style-type: none"> NHS Staffordshire, Stoke on Trent - End of Life Care 	H Johnstone	I/D	Enc 08	1.50pm
9.	SBAF a) STW – see links below https://www.shropshiretelfordandwrekin.nhs.uk/wp-content/uploads/09-Enc-09-Cover-Sheet-NHS-STW-Risk-Oversight-Report-Board-CiC-Jan-2026-002.pdf https://www.shropshiretelfordandwrekin.nhs.uk/wp-content/uploads/09A_Enc-9_NHS-STW-App-A-System-BAF-2025.26-Dec-25-Master-V13.pdf https://www.shropshiretelfordandwrekin.nhs.uk/wp-content/uploads/Copy-of-09B_Enc_9_NHS-STW-App-B-System-SORR-December-202526-risk-over-15.pdf https://www.shropshiretelfordandwrekin.nhs.uk/wp-content/uploads/09C-Enc_9_NHS-STW-App-C-ICB-SORR-202526-Dec-25-Risk-over-15.pdf https://www.shropshiretelfordandwrekin.nhs.uk/wp-content/uploads/09D_Enc-9_NHS-STW-App-D-Risk-Management-Matrix-SORR-202526-Master.pdf b) SSoT	M Irvine/ P Winter	S/D	Encs 09	2.00pm
10.	Short and Medium Term Planning	C Skidmore	D/S/A	Enc 10	2.10pm
11.	Winter Plan Delivery Update	P Smith	I	Enc 11	2.20pm
12.	NHS Reset – proposed governance changes	M Irvine/ P Winter	S/A	Enc 12	2.30pm
Break : Duration approximately 10 mins					
SYSTEM GOVERNANCE AND PERFORMANCE					
13.	a) STW Integrated Performance Report Board Committee Chair Reports: Quality and Performance Committee Finance Committee Strategic Commissioning Committee Strategy and Prevention Committee	C Skidmore V Whately D Bennett I Green C Purt	S/D S/I S/I S/I S/I	Enc 13 Enc 14 Enc 15 Encs 16 Enc 17	2.50pm

	Shropshire Integrated Place Partnership Committee Telford and Wrekin Integrated Place Partnership Committee System Transformation Group	T Miles D Sidway A Morgan	S/I S/I S/I	Enc 18 Enc 19 Enc 20	
14.	b) SSOT Finance and Performance Report Finance and Performance AAA Chair's Report Quality and Safety Report Quality and Safety AAA Chair's Report ICS People, Culture and Inclusion Committee People, Culture and Inclusion AAA Chairs Report SSOT Health and Care Senate AAA Chairs Report Remuneration Committee AAA Chairs Report Strategic Commissioning and Transformation Committee	C Skidmore M Lawton H Johnstone S Heafield M Irvine S Lal R Gallyot S Lal M Lawton	S/I S/I S/I S/I S/I S/I S/I S/I S/I	Enc 21 Enc 22 Enc 23 Enc 24 Enc 25 Enc 26 Enc 27 Enc 28 Enc 29	3:10pm
15.	STW and SSOT Committees in Common: Remuneration Committees Transition Committees	S Lal Chair	S/I S/I	Enc 30 Enc 31	3.30pm

ANY OTHER BUSINESS

16.	Any Other Business – items notified in advance to the Chair	Chair	D I	Verba I	3.40pm
17.	Review of new or amended risks following discussions in the board meetings			Verba I	3.45pm
18.	Meeting effectiveness	Chair	S	Verba I	3.55pm
	Date and time of next meeting: TBC				

RESOLVE: *To resolve that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (section 1(2) Public Bodies (Admission to Meetings) Act 1960.)*

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

ICS Partnership leadership compact



Trust

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



Courage

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



Openness and honesty

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



Leading by example

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



Respect

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



Kindness and compassion

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



System first

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



Looking forward

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

**NHS Shropshire, Telford and Wrekin
Integrated Care Board Meeting – Part 1**

Wednesday, 26 November 2025 at 2.00pm
Council Chambers, Guildhall, Frankwell Quay, Shrewsbury, SY3 8HQ

Present:

Ian Green OBE	Cluster Chair, (Meeting Chair)
Simon Whitehouse	Cluster Chief Executive Officer
Claire Skidmore	Deputy Chief Executive Officer and Chief Finance Officer, NHS STW
Cheryl Etches OBE	Non-Executive Director, NHS STW
Joanne Williams	Trust Partner Member and Chief Executive Officer, The Shrewsbury and Telford Hospital NHS Trust and Shropshire Community Health NHS Trust
Dr. Lorna Clarson	Chief Medical Officer, NHS STW
Dr. Ian Chan	GP Partner member
David Sidaway	Chief Executive Officer, Telford and Wrekin Council
Stacey Keegan	Trust Partner Member and Chief Executive Officer, The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Trevor McMillan OBE	Non-Executive Director, NHS STW (Virtually)
Dr Deborah Shepherd	GP Partner member
Roger Dunshea	Non-Executive Director, NHS STW
Dr Niti Pall	Non-Executive Director, NHS STW
Phil Smith	Interim Chief Delivery Officer, NHS SSOT

In Attendance:

Harry Turner	Chair, The Robert Jones and Agnes Hunt Orthopaedic Hospital
Nigel Lee	Chief Strategy Officer, NHS STW
Tanya Miles	Interim Chief Executive Officer, Shropshire Council
Pauline Gibson	Non-Executive Director, Midlands Partnership University NHS Foundation Trust
Alison Smith	Chief Business Officer, NHS STW
Terry Gee	Healthwatch, Telford and Wrekin
Sherilyn Ndhlovu	EDI Midwife, Shrewsbury and Telford Hospital NHS Trust
Cathy Riley	Deputy Director, Midlands Partnership University NHS Foundation Trust
Cllr Heather Kidd	Leader and Councillor, Shropshire Council
Nigel Lee	Chief Strategy Officer, NHS STW
Dr. Jessica Harvey	Joint Chair of GP Board
Andrew Morgan	Chair in Common, Shropshire Community Health NHS Trust and Shrewsbury & Telford Hospital NHS Trust
Richard Nuttall	Joint Chair, Telford and Wrekin Voluntary and Community Sector Assembly
Angie Porter	Governance Manager, NHS STW
Kay Johnson	Interim Board Secretary, NHS SSOT



Ambition



Compassion



Optimism



Focus

Apologies:

Vanessa Whatley	Chief Nursing Officer, NHS STW
Cathy Purt	Non-Executive Director, Shropshire Community Health NHS Trust
Jacqueline Small	Chair, Midlands Partnership University NHS Foundation Trust
Felicity Mercer	Executive Director, Telford and Wrekin Council
Tracey Shewan	Director, NHS SSOT
Rachel Robinson	Executive Director, Shropshire Council
Helen Onions	Director of Public Health, Telford and Wrekin Council
Jackie Jeffery	Vice Chair, Shropshire VCSA
Lynn Cawley	Chief Officer, Healthwatch Shropshire
Jan Suckling	Lead Engagement Officer, Healthwatch Telford and Wrekin
Simon Fogell	Chief Executive, Healthwatch, Telford and Wrekin
Cllr. Kelly Middleton	Cabinet Member for Public Health and Healthier Communities, Telford and Wrekin Council

Minute No. ICB-25-11.228 – Welcome & Apologies

- 226.1 Ian Green OBE, Chair opened the meeting and took the opportunity to thank Shropshire County Council for hosting the meeting.
- 226.2 Tanya Miles and Phil Smith were welcomed to their first STW Board meeting
- 226.3 Apologies recorded above were noted.

Minute No. ICB-25-11.229 – Members' Declarations of Interests

- 227.1 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 \(shropshiretelfordandwrekin.nhs.uk\)](https://shropshiretelfordandwrekin.nhs.uk)

- 227.2 Members were asked to confirm any new interests that needed declaring or any existing conflicts of interest that they had relating specifically to the agenda items. There were no further conflicts of interest declared.

Minute No. ICB-25-11.230 – Minutes of the previous meetings held on Wednesday 25 September 2025

- 228.1 Ian Green OBE presented the minutes from the previous NHS STW Integrated Care Board meetings held on the 25 September for approval. No issues were raised.

RESOLVE: The NHS Shropshire, Telford and Wrekin Integrated Care Board **APPROVED** the minutes of the previous meetings held on 25 September 2025.

Minute No. ICB 25-11.231– Matters arising and action list from previous meetings

- 229.1 NHS STW Integrated Care Board was asked to note the updates on the action list. There were no outstanding actions arising from previous meetings.

RESOLVE: The NHS Shropshire Telford and Wrekin Integrated Care Board **NOTED** the updates provided to the action list.

Minute No. ICB 25-11.232– Questions from Members of the Public



Ambition



Compassion



Optimism



Focus

- 230.1 The Chair noted that one question had been received from members of the public and would be answered in line with NHS STW policy. NHS STW Integrated Care Board was asked to note the questions received.

RESOLVE: The NHS Shropshire, Telford and Wrekin Integrated Care Board NOTED that one question had been received from the members of the public.

Minute No. ICB 25-11.233– Resident’s Experience – Engaging Families

- 231.1 Dr Lorna Clarson introduced Sherilyn Ndhlovu, who was in attendance to present the residents experience – engaging families. Dr Lorna Clarson highlighted to members that Sherilyn will be outlining some of the work she undertakes around improving inequality, diversion and inclusion and access to equitable care. Members were informed that Sherilyn has obtained an award for ‘BME Midwife of the Year’ nationally.
- 231.2 Sherilyn highlighted the importance of embedding the patient voice and service users within the communities that we serve, within the day-to-day work. Engagement is a priority with not only seldom herd communities, but with communities that have not had a consistent relationship, such as Muslim families.
- 231.3 Members were informed that a Muslim Women and Baby Group has been established and is supported by local organisations, in terms of education and training. In addition, there is an Afro Caribbean Mother and Baby Group, making sure that families are heard.
- 231.4. Sherilyn highlighted the ongoing visits to Traveller community sites to address health needs and provide opportunities for any questions they may have. Members were also informed that workforce education is continuing, with access to educational packages in addition to mandatory training.
- 231.5 Tanya Miles enquired what is the key learning that the ICB can take away in terms of how we work with individuals differently. Sherilyn responded to advise that engagement initiatives should be sustained so relationships are able to be continued and developed.
- 231.6 Simon Whitehouse asked ‘what next in terms of the work being undertaken and ‘what next’ in terms of what the Board needs to do over the next 12 months?
- 231.7 Members were informed that maternity services are focusing on neighbourhood-based working and re-engagement with the community, ensuring support is targeted to the areas with the greatest need. Sherilyn asked the Board for its full support to advance this work.
- 231.8 Dr Deborah Shepherd thanked Sherilyn for her enthusiasm and contributions and highlighted the importance of asking communities what they need, prior to work being undertaken.
- 231.9 Jo Williams took the opportunity to share how proud the Trust is of Sherilyn and the work that she has undertaken
- 231.10 Ian Green OBE thanked Sherilyn for the presentation and for the work being undertaken and congratulated her on her award.

RESOLVE: The NHS Shropshire, Telford and Wrekin Integrated Care Board NOTED the contents of the presentation.

Minute No. ICB 25-11.234 – Chair’s Report

- 232.1 Ian Green OBE presented the Chair’s Report, which was taken as read.
- 232.2 Ian green OBE introduced Simon Whitehouse as the Cluster Chief Executive.
- 232.3 Members were asked to note and consider item 2.4 within the report.
- 232.4 Pauline Gibson took the opportunity to congratulate Simon Whitehouse on his appointment.



Ambition



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Optimism



Focus

- 232.5 Pauline Gibson enquired what health and wellbeing support was in place to support staff during the transition.
- 232.6 Simon Whitehouse explained that a range of support is available, including various external offers, internal one-to-one conversations and staff support networks. NHSE at regional level has also provided access to additional support. Staff wellbeing services from Staffordshire and Stoke-on-Trent (SSOT) colleagues are available across the cluster, with clear signposting. He added that the SSOT recruitment and workforce teams are now operating across the cluster to help with future role development and job support. Simon Whitehouse emphasised the ongoing commitment to continued dialogue and to working with individuals to meet their support needs.
- 232.7 Ian Green OBE informed the Board that a Joint Transition Committee meeting had been held during which staff support was a major focus. He provided further assurance that appropriate support measures are being put in place.

RESOLVE: The NHS Shropshire, Telford and Wrekin Integrated Care Board: NOTED the contents of the report.

Minute No. ICB 25-11.235 – Chief Executive Officer (CEO) Report

- 241.1 Simon Whitehouse presented the report, which was taken as read. Members were advised that, regarding Diabetes, the ongoing progress and system-wide clinical priority for large-scale improvement will be revisited, with an updated report to be brought to a future Board meeting.
- 242.2 Members were advised of progress relating to the organisation's ability to meet Emergency Preparedness, Resilience and Response (EPRR) requirements. The organisation is assessed annually by NHSE to ensure it can fulfil its responsibilities as a category one responder. Simon Whitehouse reported that year-on-year progress has been made, with provider partners also showing continued improvement.
- 242.3 Members were advised of the update in terms of the neighbourhood programme, which is a focus in the 10-year plan.
- 242.4 Simon Whitehouse took the opportunity to thank colleagues in the 'Prescription Order Direct Service' recognising this service is being decommissioned.
- 242.5 Members were advised of the work being carried out from a digital perspective.
- 242.6 Simon Whitehouse advised the Board that there are two decisions that have been requested to the proposed amendment to the Constitution and amendment to the Remuneration Committee.
- 242.7 Simon Whitehouse highlighted to members that the ICB has received formal notification to exit the Recovery Support Programme, which is NHSE highest level of oversight.
- 242.8 Members were advised that this is a positive step as a system and for the ICB. However, it was noted that this is a stepping stone with a focus on ensuring that SaTH follow and also are able to exit RSP at the earliest opportunity.
- 242.9 Ian Green OBE emphasised the importance of supporting system colleagues, to provide the best possible care to the population of STW and acknowledged the work undertaken by the range of staff across the ICB and the system.

RESOLVE: The NHS Shropshire, Telford and Wrekin Integrated Care Board NOTED and APPROVED the contents of the report and the amendments to NHS STW Constitution and Governance Handbook.

Minute No. ICB 25-11.236 – System Board Assurance Framework and System Operational Risk Register (SBAF & SORR)

- 243.1 Alison Smith presented the report and advised members of the changes that are required to be made to the Board Assurance Framework and the Strategic Risk Registers for the ICB and the system.
- 243.2 Ian Green OBE enquired around the proposed alignment with the risk processes for STW and SSOT, as we cluster and obtain a shared understanding of risks.
- 243.3 Alison Smith responded to advise that discussions have taken place in Board development sessions around refreshing the current Board Assurance Framework and risk registers, which is in progress. Tentative discussions have taken place with STW and SSOT governance teams around how we move forward into a clustering model to bring together risk management approaches. The plan is to align policies in order to implement same ways of working and undertake staff training at a later date.
- 243.4 Alison Smith recommended a further update be presented to the Transition Committee.
- 243.5 Ian Green OBE outlined concerns around risk appetite and the potential of more risks.
- 234.6 Ian Green OBE highlighted the need to create more space and time as we transition to the ICB cluster to consider risks that are common and distinct and different based on our Board Assurance Framework and suggested to hold conversations on risk appetite.
- 234.7 Trevor McMillan highlighted that there a number of risks where there are no 'owners' identified and no completion dates.
- 234.8 Alison Smith advised that these will be raised with risk owners for them to update.

ACTION: Alison Smith to highlight to risk owners where information is missing or needs updating.

RESOLVE: **The NHS Shropshire, Telford and Wrekin Integrated Care Board:**

- **NOTED** the report and accompanying appendices.
- **REVIEWED** the populated System Board Assurance Framework (SBAF) to affirm that sufficient levels of controls and assurances are in place in relation to the organisation's strategic risks, and the risks to the system's strategic objectives, are being properly managed.
- **REVIEWED** the current risks from both Strategic Operational Risk Registers (SORRs) that score above 15 for severity and likelihood and considered:
 - **If there are any additional assurances are necessary; and**
 - **if any additional risks or amendments to risks are required following discussions in this Board meeting or in other forums i.e. recent committee or group meetings.**
- **Were Assured** that the SBAF and SORR provide oversight of the strategic risks to the system meeting the strategic objectives.

[Minute No. ICB 25-11.237 – Short and Medium Term Planning](#)

- 235.1 Claire Skidmore advised members that planning for the system is an all-year-round process. Members were advised that STW are now in receipt of key guidance to enable the organisation to draft plans. The paper presented provides a summary of the guidance received.
- 235.3 Claire Skidmore advised that since the paper was presented the organisation has received indicative allocations for both revenue and capital.
- 235.4 Members were informed that a commitment was made to a 'system first approach' by all partners in the ICS.
- 235.5 Claire Skidmore highlighted that collaborating on our planning pays off when it comes to triangulating plans, ensuring we present a consistent narrative regarding our ambitions for performance, workforce, and finance.

- 235.6 Members were advised that early headlines have been shared with the System Finance Committee, in readiness for a draft submission to NHSE prior to Christmas.
- 235.7 Claire Skidmore reminded members that board assurance is more important than ever, as NHSE is seeking confirmation that our Boards—both individually and collectively—are committed to delivering the plans we submit. She stressed the need for thorough oversight of these plans before signing off any statements, highlighting two key considerations: first, to review what is being submitted to ensure the organisation is confident in the narrative and information as it stands; and second, to think ahead about what additional work or detail will be required before final plans are submitted in February 2026.
- 235.8 Members were informed that some guidance has been issued later than expected, creating a significant workload to review and incorporate into the process.
- 235.9 Ian Green OBE asked whether the organisation has a solid understanding of the process and whether the necessary governance arrangements are in place, with coordinated steps that allow providers to sign off their parts of the plan and also offer a collective perspective. He noted that further guidance may still be issued and highlighted the tight timescales.
- 239.10 Members were advised that the System Planning Group is working together to ensure that calendars and diaries are aligned. An Extraordinary System Board is yet to be put in place however this is in progress.
- 239.11 Simon Whitehouse advised members that the challenge as a Board, is to make sure we create the time to maximise on the opportunity around setting this as a 3-year plan
- 239.12 Andrew Morgan emphasised the importance of the narrative as part of the process.
- 239.13 Simon Whitehouse suggested that a Board Development Session to be held prior to the submission date to pull everything together and to articulate our ambitions.
- 239.14 David Sidaway asked whether the assumptions made for 2026/2027 and subsequent years, particularly regarding closing the gap within the three-year period have been significantly impacted by the information received to date.
- 239.15 Claire Skidmore explained that there are some fundamental differences in the planning guidance compared with the assumptions used when the medium-term finance plan was set in June 2025. These differences relate both to expected performance targets and to financial allocations. Members were informed that the central team has reviewed the allocations and shifted more funding locally to provide greater flexibility in delivering improved outcomes. Work is underway to assess what, if anything, has fundamentally changed since the original assumptions, as this will affect the gap that needs to be closed. Initial analysis suggests that, although there are variations across different areas, the overall position still appears achievable from a high-level perspective.
- 239.16 Members were advised that there are changes to the deficit support regime. The changes provide the time to deliver that aspect of financial recovery with a clear steer of how much activity we can by next year.
- 239.17 Claire Skidmore highlighted to members that the 2-year finances will be submitted prior to Christmas, with the 3-year finances and a 5-year narrative submitted in February 2026.
- 239.18 Dr Niti Pall enquired if there was any extra funding and are there any targets, we should be aware of and is there a sense of where we will be pushed to spend our money.
- 239.19 Claire Skidmore responded to advise that there are clear signals that fall out of the 10-year plan that are a thread through into the planning framework with a steer of how we allocate the additional allocation that we receive. We continue to receive service development funding which would be targeted to specific areas. There is also a national capital fund for Digital that teams are working on presently to have business cases ready for the bidding process. All of this supports the 'left shift'.
- 239.20 Simon Whitehouse advised members that within the planning guidance there is an increasing push in terms of deconstructing block contracts. Members were informed that this is how we support the shift from hospital to community in the right way. Simon



Ambition



Compassion



Optimism



Focus

Whitehouse highlighted that there is a structure with a group model with our approach towards neighbourhoods and with our Place Boards, providing an opportunity to think about that in the right way.

- 239.21 Simon Whitehouse recommended that Tanya Miles and David Sidaway assist with narratives going forward with two Place Boards having an informed conversations around what our ambition should look like.
- 239.22 Terry Gee highlighted that colleagues in SSOT have a well-developed VCSE infrastructure model, which creates a risk of an equal community voice and intelligence across the cluster. Terry Gee enquired how this will be balanced, to ensure the residents voice is consistent.
- 239.23 Claire Skidmore responded to clarify that STW and SSOT remain two statutory organisations with any work within STW focussing on the existing community.
- 239.24 Simon Whitehouse noted Terry Gee's comment and responded to highlight that we need to understand what this will look like going forward and learn from the two organisations and the two system in terms of what works, what's positive.
- 239.25 Niti Pall enquired around access to diagnostics and requested to keep in mind in relation to elective recovery and how we look at some positive disruption in the diagnostic pathways, especially on point of care testing.
- 239.26 Jo Williams responded to advise members that as of the end of October the Trust is one of the most improved in the Country for electives. In terms of the number of patients waiting over 52 weeks, it has gone from 7% to 0.2 and it is now close to being cleared, which is years ahead of where it needs to be. Members were advised that in terms of 62-day cancer the Trust has had its best month, with 28-day faster diagnostic, best on record, with diagnostics having the best performance in five and half years.
- 239.27 Phil Smith took the opportunity to highlight demand management, making sure pathways are working correctly, as we see higher than expected levels of referrals for certain diagnostics.
- 239.28 Ian Green OBE thanked colleagues for the discussions held. He summarised that there is a timetable that needs to be adhered to and the need to make sure that we are clear in terms of the decision-making processes, both in terms of for our providers and also in terms of the system. He reinforced that this be built in as soon as possible. This provides an opportunity for the system to be innovative, be creative and to start to articulate what our ambition is for our population, followed through with very clear plans and actions.

RESOLVE: The NHS Shropshire, Telford and Wrekin Integrated Care Board:

- **NOTED the headline information from the national medium term planning framework including the requirement for the board assurance statements**
- **NOTE progress with the planning process to date**

Minute No. ICB 25-11.238 – System EDI Update

- 240.1 Ian Green OBE presented the report on behalf of Vanessa Whatley and took the report as read.
- 240.2 Simon Whitehouse informed members that system EDI has been a Board priority and emphasised the importance of addressing how we continue to get EDI embedded in business as usual and core business that is front and central. Members were informed that receiving regular updates to the Board helped to enforce this and highlighted that regular updates are being received by Provider Boards. These updates demonstrate the work that is taking place across this important agenda.
- 240.3 Discussions took place around race related incidents, particularly around how we support staff to report of race related incidents and how we support managers to know



Ambition



Compassion



Optimism



Focus

how to respond.

ACTION: Vanessa Whatley to work with colleagues and partners across the ICS provide a clear statement and narrative.

RESOLVE: The NHS Shropshire, Telford and Wrekin Integrated Care Board:

- **NOTED** the report and progress in addressing EDI as a system
- **SUPPORTED** further development of EDI collectively

Minute No. ICB 25-11.239 – GP Patient Survey

- 241.1 Dr Lorna Clarson took the paper as read and provided key findings of the report to members.
- 241.2 Discussions took place around supporting local Practices to improve practice flow, the practice level support scheme, peer ambassadors, digital inclusion and the approach being adopted to support more challenged practices.
- 241.3 Councillor Heather Kidd raised concerns around community pharmacies in rural areas and improvement around access. Councillor Heather Kidd highlighted issues around digital access in rural areas.
- 241.4 Discussions took place around deprived areas, health inequalities and the most social disadvantaged.
- 241.5 Ian Green OBE enquired how the key findings of the report are taken forward.
- 241.6 Dr Lorna Clarson responded to confirm that the actions within the report are owned by the Primary Care Commissioning Group, which then feeds up to the Strategic Commissioning Committee and subsequently feed into the Board.

ACTION: Dr Lorna Clarson to provide an updated report to the board in terms of any specific actions with the focus of the six low performing practices identified.

RESOLVE: The NHS Shropshire, Telford and Wrekin Integrated Care Board:

- **NOTED** the findings of the 2025 GP Patient Survey
- **ACKNOWLEDGE** the work undertaken by the Primary Care Team, PCNs and practices
- **SUPPORTED** the continued use of GPPS insight and GP dashboard performance metrics
- **RECOGNISED** the local approach

Minute No. ICB 25-11.240 – GP Out of Hours Update

- 242.1 Dr Lorna Clarson presented the report which was taken as read.
- 242.2 Members were content within the report around mobilisation period.
- 242.3 Discussion took place around lessons learnt and taken away for future procurement and changes of providers.
- 242.4 Simon Whitehouse advised members that there is a commitment to be transparent to enable the public to have full visibility of the report.

RESOLVE: The NHS Shropshire, Telford and Wrekin Integrated Care Board:

- **NOTED** the challenges faced and action undertaken
- **NOTED** the early impacts of the service post the 1st October 2025
- **NOTED** the move to Business as Usual



Ambition



Compassion



Optimism



Focus

Minute No. ICB 25-11.241 – Shropshire Integrated Place Partnership Committee Chairs Report (SHIPP)

- 243.1 Tanya Miles presented the report which was taken as read.
- 243.2 Members were informed that the last meeting held on the 16th October 2025 was well attended. Tanya Miles outlined that there was an introduction to the National Neighbourhood Health Programme, along with an update on the Shropshire Partnership Prevention Fund and the Shropshire Telford and Wrekin Healthy Aging Strategy. Members were informed of the Vaccination Improvement Plan and the introduction of the Out of Hours GP Service.
- 243.3 Members were informed that there were no risks raised at the meeting.
- 243.4 Nigel Lee took the opportunity to share with members that Naomi Roach from Shropshire Council has been extraordinary in the work that she has carried out on this agenda.

RESOLVE: The NHS Shropshire, Telford and Wrekin Integrated Care Board:

- NOTED the briefing report
- Were ASSURED by the report presented.

Minute No. ICB 25-11.242 –Telford and Wrekin Integrated Place Partnership (TWIPP) Committee Chair's Report

- 244.1 David Sidaway presented the report, which was taken as read.
- 244.2 Members were provided with a summary of the report and David Sidaway took the opportunity to thank the ICB for the support in relation to the ICB funded prevention work and shared that all the schemes are progressing well.

RESOLVE: The NHS Shropshire, Telford and Wrekin Integrated Care Board:

- NOTED the contents of the report
- Were ASSURED

Minute No. ICB 25-11.243 – Integrated Performance Report

- 245.1 Claire Skidmore presented the report.
- 245.2 Members were informed that there are no material shifts and nothing to highlight from the last report to the Board.
- 245.3 Members were informed of the continued progress that's been made in elective recovery and in our non-elective delivery, although there remains challenges with ambulance hand over delays and work is underway to progress on the challenges.
- 245.4 Claire Skidmore highlighted that for month 7, finance remains slightly ahead of plan. However, there is a small element of 'net risk' which is being reported as around £3 million. Members were informed that this is being proactively managed, with a commitment to still deliver the plan.
- 245.5 Members were advised that for month 8, finance is a critical month, which is the last staging post for the release of this year's deficit support funding. There are two tasks to fulfil for the last piece of funding to be released.
- 245.6 Claire Skidmore informed members that the organisation needs to hit the year-to-date position. Results so far do not show any indication that this will not be achieved. Members were informed that the organisation needs to assure NHSE that we are confident in delivering the outturn position.
- 245.7 Phil Smith informed members that at the last board meeting on the 24th September 2025, the Winter Plan was approved and submitted to NHSE with board assurance statement provided to NHSE. Members were informed that deploying the Winter Plan and ensuring it remains effective as we go through winter is important. Phil Smith



Ambition



Compassion



Optimism



Focus

shared that tracking with UK HAS data takes place around prevalence, particularly around respiratory conditions. Members were informed that Flu A, B and Covid are all on the rise. Phil Smith advised that there is good mobilisation of schemes.

- 245.8 Jo Williams informed members that at RSH a reconfiguration of the acute medical floor took place. On the 1st December 2025, 56 beds will be handed over, with a phased move on the 8th December 2025, 22nd December 2025 and also on the 29th December 2025. A discharge lounge has been opened with 16 spaces. Further investment of £1.7 million had been made, with another 40 assessment and inpatient beds which will be in place on the 15th December 2025 and 22nd December 2025. Members were informed that a frailty unit will be in place on the 1st December 2025. There will be extended community service response in place seven days a week, with rapid access for bridging domiciliary care in place on the 1st December 2025, with practitioners at the front doors across PRH and RSH that went live two weeks ago.
- 245.9 Jo Williams went on to thank Harriet Hopkins in the ICB Communications and Engagement Team who has designed and led a very successful communications Winter Campaign across the system. Ms Williams also highlighted that whilst we will deliver the plan that we set ourselves, it's acknowledged how far away we are from the national target.
- 245.10 Phil Smith highlighted the importance of vaccinations in terms of both the workforce and members of the public who are eligible.

RESOLVE: The NHS Shropshire, Telford and Wrekin Integrated Care Board:
• NOTED and ASSURED by the report presented

[Minute No. ICB-25-11.244 – Maternity and Neonatal Annual Position Statement](#)

- 246.1 Dr Lorna Clarson presented the report on behalf of Vanessa Whatley who is the SIRO for LMS programme.
- 247.2 Members were informed that the 10-year plan for England gives renewed commitment to quality and has committed to a further review of maternity and neonatal care, leading to a new national action plan that will be overseen by a task group chaired by the Secretary of State.
- 247.3 Members were informed that the Secretary of State for Health and Social Care also announced a rapid national learning review into NHS Maternity and Neonatal Services.
- 247.4 In terms of assurance that the LMNS delivers, the LMNS Programme Board meets on a quarterly basis with the Perinatal Quality Surveillance Group meeting monthly.
- 247.5 In terms of independent maternity review that was undertaken at SaTH, 210 actions were allocated, with 192 now been completed. There are 11 that remain, which are all on track for delivery shortly. Members were advised that we are compliant on all six elements of the 'Saving Babies Lives Programme' which is a set of evidence-based recommendations and guidelines.
- 247.6 Dr Lorna Clarson advised that close monitoring of Embrace UK Data takes place, which shows that STW data is improving across all three measures, which are still birth, neonatal mortality and a combined aggregate measure of both. Members were informed that SaTH maternity services are rated as 'good' by CQC as well as Children and Young People Services being rated as 'good'.
- 247.7 Dr Lorna Clarson shared that we are a single provider LMNS system with on maternity provider that is SaTH and it was recommended as part of the Ockenden review that this was not best practice and we should be looking to other system to learn from. Subsequently we have formed a bimonthly learning collaborative forum with SSOT.
- 247.8 Members were advised that two insight visits have taken place, from national NHSE leads where the feedback was overwhelmingly positive. Dr Lorna Clarson advised that we have taken part in the Maternity Neonatal Independent Senior Advocate Pilot (MNISA) pilot, which is a scheme running across 16 ICBs in the Country including STW.



Ambition



Compassion



Optimism



Focus

Feedback received from families has been positive. The pilot is due to end in March 2026. A decision on the future of the role from NHSE has been postponed from October 2025 to rest with the National Maternity Investigation and/or Taskforce decisions. Due to a gap between post holders providing some unspent project funds NHS STW has taken the decision to extend the role until October 2026.

- 247.9 Members were informed that there has been positive work undertaken by the Maternity and Neonatal Voices Partnership (MNVP) Services, with recruitment of a permanent MNVP Lead to strengthen engagement and inclusivity. Active recruitment of further MNVP volunteers is taking place. Members were informed that a perinatal equity analysis has been undertaken in collaboration with our Public Health colleagues to guide our planning around preconception services and maternity services planning. A review of the inequality action plan has taken place and been updated as part of the review.
- 247.10 Dr Lorna Clarson shared that an external grant has been secured, supporting improved early booking and antenatal screening and to support a preconception education pilot.
- 247.11 Jo Williams recognised that there are families that have been let down. There has been a commitment to write to all the families There is a plan to meet with families in January 2026.
- 247.12 Ian Green OBE stated that this is important and recognised by the system and not just the provider.

RESOLVE: The NHS Shropshire, Telford and Wrekin Integrated Care Board:

- Were **ASSURED** and **ACCEPTED** the report presented.

[Minute No. ICB 25-11.245 – Governance Handbook Polices \(Conflicts of Interest/Petitions Policy\)](#)

- 228.1 The report presented was taken as read.

RESOLVE: The NHS Shropshire, Telford and Wrekin Integrated Care Board:

- **APPROVED** the amendments to the Conflicts of Interest Policy section of the Governance Handbook
- **APPROVED** the updated version of NHS Shropshire, Telford and Wrekin Integrated Care Board Petions Policy

[Minute No. ICB 25-11.246 – System Finance Committee Chairs Report](#)

- 229.1 The report presented was taken as read.

RESOLVE: The NHS Shropshire, Telford and Wrekin Integrated Care Board:

- **NOTED** the content of this paper.

[Minute No. ICB 25-11.247 – System Quality and Performance Committee Chairs Report](#)

- 230.1 The report presented was taken as read. Members were asked to note the recommendations of the polices and documents that were approved on behalf of the board, issues around diabetes and TB were escalated.

RESOLVE: The NHS Shropshire, Telford and Wrekin Integrated Care Board:

- **NOTED** the content of the report

[Minute No. ICB-25-11.248 – Strategic Commissioning and Productivity Committee Chairs Report](#)



231.1 The report presented was taken as read.

- RESOLVE:** The NHS Shropshire, Telford and Wrekin Integrated Care Board:
- NOTED and APPROVED the content of the report

[Minute No. ICB-25-11.249 – System Transformation and Digital Group Chairs Report](#)

232.1 The report presented was taken as read. Members were informed that a further two meetings have since taken place since the report was presented to the board.

- RESOLVE:** The NHS Shropshire, Telford and Wrekin Integrated Care Board:
- NOTED the contents of the report

[Minute No. ICB 25-11.250 – Audit Committee Chairs Report](#)

233.1 The report presented was taken as read. Members were informed that communications around audit arrangements with SSOT going forward are taking place.

- RESOLVE:** The NHS Shropshire, Telford and Wrekin Integrated Care Board:
- Were ASSURED by the report presented

[Minute No. ICB-25-11.251 –System Strategy and Prevention Committee Chairs Report](#)

234.1 The report presented was taken as read. Members were informed that close work takes place with Health and Wellbeing Boards and there is a focus on the prevention angle at the meetings held.

- RESOLVE:** The NHS Shropshire, Telford and Wrekin Integrated Care Board
- NOTED the report presented
 - NOTED the importance that the Committee continue to place on Prevention activity

[Minute No. ICB 25-11.252 – System People, Culture and Inclusion Committee Chairs Report](#)

235.1 The report presented was taken as read.

- RESOLVE:** The NHS Shropshire, Telford and Wrekin Integrated Care Board:
- AGREED scheduling a presentation on the Partnership Launch of Telford College and Keele University at a future Board meeting

[Minute No. ICB 25-11.253 – Remuneration Committee Chairs Report](#)

236.1 The report presented was taken as read.

- RESOLVE:** The NHS Shropshire, Telford and Wrekin Integrated Care Board
- NOTED the report presented and the decisions that were made at the meeting on 19th and 30th September 2025.

[Minute No. ICB-25-11.254- Transition Committee](#)

237.1 The report presented was taken as read. Ian Green OBE highlighted that the first joint meeting in common took has taken place.



Ambition



Compassion



Optimism



Focus

RESOLVE: The NHS Shropshire, Telford and Wrekin Integrated Care Board:
• NOTED and ASSURED by the report presented

Minute No. ICB-25-11.255 – Review and Reflection of new or amended risks following discussions at Board meeting

238.1 Ian Green OBE thanked colleagues at Shropshire Council for hosting the STW Board meeting.

Minute No. ICB-25-11.256 – Any Other Business notified in Advance

239.1 Ian Green OBE informed members that the next meeting scheduled on the 26 January 2026 may change as STW and SSOT are considering holding a meeting in common.

239.2 Ian Green OBE informed members that this was Dr Deborah Shepherd last STW Board Meeting and took the opportunity to thank her for her services as a clinician and her commitment to system leadership

239.3 Simon Whitehouse informed members that it was also Alison Smith's and Nigel Lee's last STW Board meeting and thanked them for their work and commitment supporting the STW Board.

239.4 Ian Green OBE thanked the members of the public for their attendance.

16.41 – Meeting Closed

Date and Time of Next Meeting

Date: Wednesday 28th January 2025 - TBC

Time: 14:00

Location: Meeting Room 1, Wellington Civic Offices, Larkin Way, Tan Bank, Wellington, TF1 1LX



Ambition



Compassion



Optimism



Focus



**Staffordshire and Stoke-on-Trent
Integrated Care Board
HELD IN PUBLIC**

Thursday 20th November 2025 1.00pm – 3.30pm

**Staffordshire County Council Chamber, County Buildings, Martin Street,
Stafford, ST16 2DH**

Members:	Quoracy	15/05/2025	17/07/2025	18/09/2025	20/11/2025	15/01/2026	19/03/2026
Ian Green (IG) Cluster Chair (commenced in post as from 1 st November 2025)					Y		
Simon Whitehouse (SW) Cluster Chief Executive (commenced in post as from 1 st October 2025)					Y		
David Pearson (DP) Chair Staffordshire & Stoke-on-Trent ICB (left 31 st October 2025)	Over 50% of the quantum (nine out of seventeen members) with there being an equitable balance to represent that of a Unitary Board, split between proportions of Executive, Non-Executive and Partner Members, including: • the Chief Executive plus one other Executive Director (from CFO, CTO, CDO) • either the Medical Director (MDO) or the Director of Nursing & Therapies (DNTO) • three Independent Members: i.e. Chair plus two Non-Executive Members • three Partner Members, with ideally at least one from each of the three cohorts	Y	Y	Y			
Dr Paul Edmondson-Jones (PEJ) Deputy Chief Executive Officer, Staffordshire & Stoke-on-Trent ICB		Y	Y	Y	Y		
Claire Finn (CF), Chief Finance Officer, Staffordshire & Stoke-on-Trent ICB (commenced in post as from 1 st June 2025)		Y	Y	Y	Y		
Phil Smith (PS) Chief Delivery Officer, Staffordshire & Stoke-on-Trent ICB		Y	Y	Y	Y		
Heather Johnstone (HJ) Chief Nursing and Therapies Officer, Staffordshire & Stoke-on-Trent ICB		X	Y	Y	A		
Dr Rachel Gallyot (RG) Interim Chief Medical Officer, Staffordshire & Stoke-on-Trent ICB (Interim Chief Medical Officer as from 15 th July 2025)			Y	Y	Y		
Elizabeth Disney (ED) Chief Transformation Officer, Staffordshire & Stoke-on-Trent ICB		Y	Y	Y	Y		
Julie Houlder (JH) Non-Executive Member, Staffordshire & Stoke-on-Trent ICB		Y	Y	Y	A		
Shokat Lal (SL) Non-Executive Member, Staffordshire & Stoke-on-Trent ICB		Y	Y	A	Y		
Josephine Spencer (JS) Non-Executive Member, Staffordshire & Stoke-on-Trent ICB (left 31 st October 2025)		Y	Y	A			
Mike Lawton (ML) Non-Executive Member, Staffordshire & Stoke on Trent ICB		X	Y	Y	Y		
Siobhan Heafield (SH) Non-Executive Member, Staffordshire & Stoke on Trent ICB (commenced in post as from 7 th July 2025)			Y	Y	Y		
Jon Rouse (JR) Chief Executive, City of Stoke-on-Trent Council		Y	Y	A	A		
Patrick Flaherty (PF) Chief Executive, Staffordshire County Council		X	X	X	A		
Dr Simon Constable (SC) Chief Executive Officer, University Hospitals of North Midlands NHS Trust		X	Y	Y	A		
Neil Carr (NC) Chief Executive, Midlands Partnership NHS University Foundation Trust		Y	X	A	A		
Dr Buki Adeyemo (BA) Chief Executive, North Staffordshire Combined Healthcare NHS Trust		Y	Y	Y	Y		
Participant Members:							
Simon Fogell (SF) Stoke-on-Trent Healthwatch		X	X	Y	A		
Anna Mather (AM) Healthwatch Support Staffordshire		Y	Y	Y	A		
Tracey Shewan (TS) Director of Communications, Staffordshire & Stoke-on-Trent ICB		Y	Y	Y	A		
Mish Irvine (MI) Chief People Officer, Staffordshire & Stoke-on-Trent ICB		Y	X	Y	Y		
Chris Ibell (CI) Chief Digital Officer, Staffordshire & Stoke-on-Trent ICB		Y	Y	A	Y		

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Paul Winter (PW) Associate Director of Corporate Governance & DPO, Staffordshire & Stoke-on-Trent ICB		Y	Y	Y	Y		
Dr N Tony Ahmed (TA) Dental Participant Board Member		Y	Y	Y	Y		
Dr J Chan (JC) Primary Care Service Parter Member		Y	Y	Y	Y		
In attendance:							
Lynn Tolley (LT) Director of Nursing – Maternity and Safeguarding					Y		
Sharuna Reddy (SR) Senior Medicines Optimisations Pharmacist					Y		
Renee Larsen (RL) Medicines Optimisation Pharmacist/Project Lead for SLA)					Y		
Helen Ashley (HA) Deputy Chief Executive, UHNM					Y		
Lisa Ellis (LE) Executive Support Officer, Staffordshire and Stoke on Trent ICB (minutes)		Y	Y	A	Y		

		Action
1.	Welcome and Introductions	
	<p>IG welcomed attendees to the ICB Public Board meeting and advised that it was a meeting being held in public to allow the business of the Board to be observed and members of the public could ask questions on the matters discussed at the end of the meeting.</p> <p>The meeting is being recorded and will be available on the ICB website after the meeting.</p>	
	Apologies	
	<p>Apologies were received from:</p> <p>Heather Johnstone – represented by Lynn Tolley Julie Houlder Jon Rouse Simon Constable – represented by Helen Ashley Patrick Flaherty Neil Carr Tracey Shewan Anna Mather Simon Fogell</p>	
	Confirm Quoracy	
	IG confirmed that the meeting was quorate.	
2.	Leadership Compact	
	IG reminded members of the importance of the Leadership Compact document which was used in all the meetings transacted by the ICB and guides the way business is conducted.	
3.	Conflicts of Interest	
	Members confirmed there were no conflicts of interest in relation to items on the agenda other than those listed on the register.	
4.	Minutes of the Meeting held on 18th September 2025	
	<p>The minutes of the meeting held on 18th September 2025 were AGREED as an accurate record of the meeting and were therefore APPROVED.</p> <p>Note one accuracy change, page 8 should state David Fuller case (not David Forward case).</p>	

5.	Action log	
	Action log reviewed and updated accordingly.	
6.	Questions submitted by members of the public in advance of the meeting	
	<p><u>Question one - Mr Ian Syme</u> <u>UEC</u> I have over several years repeatedly questioned both UHNM and the ICB at their respective Board Meetings about protracted Ambulance Handover Delays at UHNMs RSUH ED. I have also questioned WMAS about such and obtained substantial ambulance handover data all of which is verified data.</p> <p><i>In September 2025 Enforcement Undertakings were agreed between NHSE and UHNM regarding UEC provision including rectification action regarding Ambulance Handover delays. A “robust UEC Improvement plan” is required of UHNM jointly developed with the ICB WMAS and other partners which is to be monitored on quality and other factors. That ‘robust’ plan was presented to UHNM Public Board meeting in October 2025.</i></p> <p><i>The national UEC Plan 2025/26 is explicit that Ambulance Handovers at EDs must NOT exceed 45minutes.</i> <i>Up to 31st October 2025 58% of Ambulance Handovers at RSUH were within the 45minutes standard and thus 42% of handovers exceeded the 45 minutes standard.</i></p> <p><i>I note from today’s ICB Performance & Finance Report that due to “challenges” at ED portals Ambulance Handovers Delays in September 2025 had drifted back up to 1hr 23 mins on average. Such challenges are not unique to our ICB and those challenges certainly exist throughout the West Midlands.</i></p> <p><i>The October Ambulance Handover Delay for RSUH ED is 2hrs 5mins 38secs average Ambulance Handover. That data is verified.</i></p> <p><i>For this year April 1st to end of October 2025 (WMAS data) there have been 30070 ambulance conveyances to RSUH ED. There have been (same time period) 322578 Ambulance Conveyances to ALL West Midlands EDs. Thus 9.3% of ALL Ambulance conveyance in the West Midlands are to RSUH ED.</i></p> <p><i>83294 Ambulance handovers at West Midlands EDs exceeded the 45 mins standard this year to end of October that’s throughout the ENTIRE West Midlands. At RSUH ED 12775 Ambulance handovers exceeded 45mins. 15.3% of ALL handovers at West Midlands EDs that exceeded the 45mins Maximum were at RSUH ED with 9.1% of all’s Ambulance Conveyance in the region being to RSUH ED.</i></p> <p><i>At the November 10th 2025 Staffordshire CC OSC mention was made of ambulance “inappropriate conveyance”.</i></p> <p><i>Checking through UHNM Board Papers over the last 2 years that phrase “inappropriate conveyance” first appeared in January 2025 UHNM Board papers (page 127) in response to the review in December of UHNMs UEC Service. The phrasing was ‘collating evidence of ‘inappropriate conveyance’.’ The phrase ‘inappropriate conveyance’ is singularly absent from UHNMs “Robust UEC Improvement Plan’ required under the agreed ‘Enforcement of Undertakings’ as described earlier an UEC Improvement Plan that the ICB have jointly developed.</i></p> <p>a. How is inappropriate ambulance conveyance to an ED being defined? b. Considering that collating evidence of ‘Inappropriate conveyance’ is first mentioned in public papers in January 2025, some 10months ago, would the ICB please now quantify numbers of evidenced inappropriate ambulance conveyances to RSUH since January 2025.</p>	

c. Of the 30070 ambulance conveyances to RSUH ED since April 1st, 2025, date how many of those conveyances have been deemed 'inappropriate'?

PS confirmed that ambulance handover delays at Royal Stoke had worsened since September, with 58% of handovers exceeding the 45-minute standard and average times rising to one hour and 23 minutes and acknowledged the situation is unacceptable and committed to ensure improvement.

PS advised that there is no fixed definition of inappropriate ambulance conveyance and stated that weekly clinically led multidisciplinary team review individual cases to determine if alternative pathways could have been used and confirmed that learning indicates that most inappropriate conveyances did not use the single point of access.

PS confirmed that a system-wide winter plan is being deployed, with governance structures in place to oversee urgent emergency care.

The Board emphasised the need for all care professionals to use the single point of access and highlighted ongoing partnership work with all Provides, including West Midlands Ambulance Service.

Question Two – Mr Ian Syme

Quality and Safety Report:

Looked After Children Review Health Assessment (RHA)

RHAs are still behind target as stated in the above.

What is that Target and what is the present situation of numbers and waiting times re RHAs for Looked after children?

IG confirmed that this will be covered under the Quality and Safety Report.

Question three – Mr Ian Syme

Quality and Safety Committee Report

Mention is made of delay in the publication of "Right Care Right Person Report."

When was that report supposed to be published and when will it now be published?

IG confirmed that this will be covered under the Quality and Safety Report.

Question four – Mr Ian Syme

ICB Clustering

It's a cluster or it's a merger? Whichever!

For our new expanded 'patch' what will define success of this dramatic change and how will success or otherwise be objectively reported publicly?

SW explained that the current arrangement is a cluster of two ICBs with a shared management team, not a merger and confirmed that any future merger would require a separate Board decision and NHSE/DHSC approval. He added that success for the cluster is defined by improved population outcomes, delivery of the 10-year plan ambitions, the development of high-quality sustainable NHS providers supported by strong community and neighbourhood health and care delivery.

7. Community Story – Reducing Harm from Inappropriate Prescribing of Opioids : Patient Story (role of peer group support in managing chronic pain)

RG introduced the Team, Sharuna Reddy (SR) and Renee Larson (RL) who presented a community story on reducing harm from inappropriate opioid prescribing, highlighting the role of peer support groups and pilot projects in East Staffordshire.

	<p>It was highlighted that the ICB is the fifth highest prescriber of opioids for pain, with limited local alternatives, leading to long-term prescribing and national priorities and NICE guidance now discourage opioid use for chronic non-cancer pain.</p> <p>SR advised that a pilot peer support group, developed with East Staffordshire PCN and Burton Albion Community Trust, provided biopsychosocial interventions for pain management, empowering patients to self-manage and reduce reliance on opioids.</p> <p>A patient shared their journey through the pilot, describing improved confidence, increased activity, and reduced dependence on painkillers, demonstrating the effectiveness of peer support in pain management.</p> <p>Board members welcomed the briefing and were grateful to receive such a powerful patient story and emphasised the importance of redirecting resources from low-impact interventions toward more effective, community-based support.</p> <p>ML highlighted that this approach places the patient at the centre of care and expressed interest in understanding the funding arrangements and strategies for engaging the voluntary sector. RG confirmed that this will be embedded within neighbourhood initiatives to drive better outcomes through self-empowerment and also highlighted the need for active implementation and strong collaboration with voluntary sector partners.</p> <p>The ICB Board:</p> <p>Noted the patient story and video illustrating the impact of peer support on deprescribing outcomes.</p> <p>Recognised the identified gap in community-based peer support for people living with pain. Strongly recommend the development of a Pain Café peer-support model as a community offer alongside the existing opioid deprescribing SLA and other commissioned services.</p> <p>Supported the need to identify opportunities to integrate this into strategic planning for a community peer led offer in chronic pain to fund in targeted localities, with evaluation to inform wider rollout as part of the ICS Prevention 10-Year Plan.</p>	
8.	<p>ICB Cluster Chair and Chief Executive Report</p>	
	<p>IG formally expressed his appreciation to David Pearson MBE for his support throughout the transition period.</p> <p>SW advised that, going forward, the Chair and Chief Executive will provide separate reports to the Board and echoed IG's comments, extending his thanks to David Pearson and thanked PEJ for his support during this time of change.</p> <p>SW acknowledged that this is an exceptionally unsettling period for staff and commended their leadership and professionalism during a significant change process. He noted that changes will continue to evolve as the organisation moves forward. He confirmed that Executive appointments have now been made, with postholders due to commence on the 1st December.</p> <p>PW highlighted that, following the recruitment of the Executive Team, the ICB Constitution will require minor amendments and requested the Boards agreement for these changes to be submitted to NHS England for approval.</p> <p>The ICB Board:</p> <ul style="list-style-type: none"> • Received the report and be assured the leadership are working on each topic as raised. • Approved the submission of ICB Constitution changes to be submitted to NHS England. 	

9.	<p>System Winter Assurance</p>	
<p>PS presented the report and advised that a detailed plan was presented at the September Board and subsequently Board Assurance Statements have been submitted to NHS England.</p> <p>IG asked to what extent Provider colleagues had been involved in the development of the winter plan and whether any emerging risks were not reflected within the plan. PS confirmed that the plan was developed collaboratively with all system Providers, including West Midlands Ambulance Service and has been approved by the relevant Boards and Committees. He added that the plan covers 13 pillars, ranging from vaccination to hospital discharge, and includes governance arrangements for ongoing review. He added that following the September Board discussion, several aspects of the plan remain under development and subject to further clarification, including three key elements.</p> <ul style="list-style-type: none"> • Demand modelling assumptions • Quality Impact Assessments • Elements of funding linked to winter capacity <p>PS confirmed that all outstanding elements of the winter plan have now been clarified and that the System Finance and Performance Committee formally approved the plan on the 7th October and requested ratification from the Board. He advised that the plan includes detailed governance arrangements to ensure continuous data review and responsive adjustments. He reported a significant increase in respiratory illnesses during late September and October, resulting in parts of the winter plan being deployed ahead of schedule, placing the system approximately four weeks ahead of the usual seasonal curve. He also added that both Staffordshire and Stoke-on-Trent Overview and Scrutiny Committees have been briefed. He confirmed that that short-term staff absences and reduced uptake of bank shifts have contributed to increased community illness, prompting changes in bank rates and Providers are focusing on substantive recruitment and staff well-being initiatives, with agency usage remaining low.</p> <p>SW noted that, as a system Board, it is important to acknowledge the dedication of frontline health and care staff and the vital work they deliver every day in managing services and providing care across Staffordshire and Stoke-on-Trent. He emphasised that this commitment would continue throughout the winter period.</p> <p>ML welcomed the report and acknowledged the strength of the plans but expressed concern regarding the practical challenges of implementation and highlighted a point on page five of the report noting significant staffing pressures, including short-term absences and lower-than-expected uptake of bank shifts and requested further clarification on the underlying causes and the measures being taken to mitigate these issues. PS reported that recent staffing pressures are linked to the rise in respiratory cases within the community, which has also impacted staff absence. MI added that some Providers have recently adjusted their bank rates and alongside increased sickness levels, this has contributed to reduced staffing availability in certain areas. She added that despite these challenges, agency usage remains at its lowest level since 2019 and while concerns around staffing availability persist, the system is not currently moving towards increased agency reliance.</p> <p>MI suggested that it would be helpful to hear from individual Providers on how they plan to mitigate these challenges. HA reported that, from a UHNM perspective, staff are working extremely hard and day-to-day pressures remain relentless. She added that UHNM have implemented changes to bank rates, however, given the current pressures, staff are not always inclined to take on additional shifts. She confirmed that UHNM has a strong recruitment pipeline and emphasised the importance of securing substantive staff to reduce reliance on bank shifts. She confirmed that full recruitment for winter capacity is underway, and mitigation measures are being applied across both hospital sites and well-being initiatives and vaccination programmes are in place to support staff during this period.</p> <p>SH referred to previous Board discussions on staff surveys and suggested using tools such as SurveyMonkey to gather quick feedback and questioned whether more could be done to understand staff concerns. She referred to feedback from the recent Quality and Safety Committee regarding targeted bank rate increases and the need for further creative approaches. She expressed concern</p>		

	<p>that agency staffing uptake remains low, which, while a last resort, may become necessary if winter pressures escalate and emphasised the importance of identifying actionable themes through rapid surveys to ensure staff feel heard. HA confirmed that the staff survey remains open and highlighted the importance of ward managers obtaining real-time feedback. MI acknowledged the current position and advised that each organisation has a clear staff plan, with responsibility for safety sitting with Providers, who should escalate concerns to the ICB and work collectively to redirect resources where required.</p> <p>PS emphasised the importance of eligible individuals (public and staff) to obtain their flu vaccination.</p> <p>The ICB Board:</p> <ul style="list-style-type: none"> • Noted that following the additional assurance discussions with NHS England’s and approval at Finance & Performance Committee and formally ratified the SSOT Winter Plan. 	
10.	2026/2027 Planning	
	<p>CF and ED provided an update on the planning submission, confirming that the initial submission is due in December, with the final submission scheduled for February and advised that the plan will include commissioning intentions, alignment of governance and proposals for eliminating deficit support funding, with a clear focus on delivering the three strategic shifts.</p> <p>CF advised that there is an intention to phase out deficit support funding over the next five years.</p> <p>The Board emphasised the importance of co-creating commissioning intentions with Providers, ensuring alignment between the two ICBs and securing Provider Board sign-off and Local Authority support for the strategic plan.</p> <p>SW noted that, from an NHS planning cycle perspective, the system is in a strong position but stressed the need to ensure opportunities are not missed given the scale of change across the ICBs.</p> <p>CF confirmed adherence to the required timescales and advised that significant work has been undertaken to enable timely submission. ED added that engagement across the system continues, acknowledging the scale of the task and confirming that colleagues are clear on the requirements.</p> <p>The ICB Board:</p> <ul style="list-style-type: none"> • Noted the publication and requirements of the Medium-Term Planning Framework - delivering change together 2026/27 to 2028 2029. • Noted the updates provided on progress. • Noted the draft commissioning intentions. 	
11.	Quality and Safety Report	
	<p>LT presented the report and referred to Home to Host Commissioner and advised this this had previously been reported to the Board in 2021 and advised that following the closure of an independent hospital, the ICB worked closely with both the National and Regional teams to strengthen the guidance, and we have actively participated in the pilot programme. She reported that, North Staffordshire Combined and MPFT have been fully engaged in this process, completing self-assessments with highly positive outcomes.</p> <p>LT advised that Cygnet Hospital in Kidsgrove opened in May, a new 31-bed women’s mental health facility, offering both acute and rehabilitation services. It was noted that a system-wide quality assurance visit was conducted in October 2025 to enhance understanding of the service’s evidence-based, least restrictive care model and to strengthen collaborative oversight among system partners and routine annual visits to The Moorlands Neurological Centre and St Augustine’s in September 2025 resulted in minor recommendations to support continuous improvement.</p>	

LT referred to the Learning from the Lives and Deaths of People with a Learning Disability and Autistic People (LeDeR) Programme and advised that significant improvement has been made and the ICB is now ranked second nationally. She emphasised that the focus is not only on performance but on learning from reviews to improve education and ensure this education is delivered effectively to patients and advised that significant work has been undertaken, including face-to-face dysphagia and epilepsy training, development of cancer awareness videos for breast and bowel cancer.

LT referred to the ongoing work on quality improvement and highlighted the significant joint initiatives between STW and SSOT ICBs, which reflects a strong commitment to embedding continuous quality improvement across the system. She added that NHS England has invested in roles at Bands 6 to 8, which is a highly positive development, which highlights continuous quality improvement, which is not solely the responsibility of individuals or leaders, it is a collective approach that involves everyone across organisations.

LT advised that health assessments are carried out for children under the age of five are carried out every six months and for those children over the age of five and over the are carried out every twelve months. She addressed the earlier question raised by Mr Syme regard the low rate of review health assessments for looked after children and advised that health assessments are at 15%, well below the 85% target and added that the backlog has reduced from six months to six weeks and advised that there are ongoing monthly monitoring and it is also overseen by the Corporate Parenting Board.

LT provided additional assurance regarding risk management for children and stated that for any child exceeding the statutory timeframe, a harm review is undertaken and advised that in addition, health assessments are prioritised for children approaching 18 years and leaving care, those being considered for adoption, and those with identified health conditions. It was noted that there are currently 277 children within the waiting period.

LT referred to the Quality Impact Assessments and noted that feedback from NHS England, previously reported to the Board, has been received and stated that this work is closely aligned with the principles of continuous quality improvement, supported through collaborative workshops and stakeholder engagement. She added that questionnaires have been distributed to gather insights, reinforcing our commitment to embedding continuous quality improvement across the system.

LT highlighted the focus on quality and safety during the transition period and confirmed that a monthly meeting is held between STW and SSOT, chaired by the Chief Nursing Officer, to ensure statutory duties are maintained throughout the transition process.

LT addressed the second question raised by Mr Syme regarding the publication timeline for the 'Right Care, Right Person' report and confirmed that there has not been a delay, explaining that the original intention was to present the report to the Quality and Safety Committee last month. However, as the report involves contributions from four partner organisations, each requiring completion of their respective governance processes, the timeline was extended and the report was presented to the Quality and Safety Committee this week and a summary update will be provided to the Board in January.

IG referred to health assessments and queried the 15% performance figure and asked what actions are being taken to address this. LT explained that there is currently a six-week backlog due to several contributing factors and provided assurance that improvements are underway, including investment in the workforce and changes to processes, with local providers working to ensure that any child exceeding statutory timeframes undergoes a harm review. She advised that no harm has been identified to date and the trajectory shows month-on-month improvement. She stated that the backlog is partly due to the time required for local authorities to obtain consent and collate necessary documentation before a health assessment can take place and added that oversight is provided by the Corporate Parenting Board.

It was agreed that an action should be taken to provide an update at the next meeting, including a clear trajectory and action plan outlining specific steps the system and partners will take to achieve a more acceptable performance level. While harm has not been identified, the current position falls

	<p>short of the 85% target, and plans must be in place to deliver improvement. The Board will be kept informed of progress.</p> <p>The ICB Board:</p> <ul style="list-style-type: none"> • Noted the report. • Were assured that key quality assurance and patient safety activity undertaken in respect of matters relevant to all parts of the Integrated Care System is carried out. • That a summary update will be provided to the Board in January on the Right Care, Right Person review 	<p>HJ/LT</p>
<p>Quality and Safety AAA Chairs Report</p>		
	<p>SH presented the report and provided an update on the perinatal quality surveillance visit, which was scheduled for last week but stood down due to industrial action. She assured the Board that actions taken as part of previous work provide a level of assurance despite the postponement.</p> <p>SH noted that the SEND Alternative Provision Strategy has been approved by the Quality and Safety Committee and now requires ratification by the Board.</p> <p>SH highlighted the 'Right Care, Right Person' initiative as an excellent piece of work and added that learning from this will be shared widely and the NHS England representative on the Quality and Safety Committee has requested that it be presented at the Regional Quality Committee, which will be undertaken without including any patient-identifiable information.</p> <p>SH advised that the Quality and Safety Committee has reviewed risks on the risk register and colleagues have been asked to reassess the scores for two risks where mitigation measures may be having an impact.</p> <p>IG queried whether the SEND and Alternative Provision Strategy 2026–29 had previously been presented to the Board. SH agreed to confirm this.</p> <p>The ICB Board:</p> <ul style="list-style-type: none"> • Received and noted the report. • Noted that the Quality & Safety Committee approved the Staffordshire SEND & Alternative Provision Strategy 2026-29 and ratified the Strategy, subject to clarification that it has previously been presented to the Board. 	<p>SH</p>
<p>12.</p>	<p>Staffordshire and Stoke-on-Trent Health and Care Senate AAA Chairs Report – September and October 2025</p>	
	<p>RG presented the report and confirmed that the Senate has approved several key initiatives, including the self-care toolkit for care homes, homely remedies guidance, pain management guidance and the infertility pathway and implementation support is being provided to ensure these initiatives are effectively embedded, particularly within care home settings.</p> <p>RG advised that the Senate agreed to retain Mounjaro as a 'red drug' in line with the national directive, as it continues to be administered via specialist hubs.</p> <p>It was noted that the Senate has clinically approved the Winter Plan.</p> <p>RG further reported that IMOG approvals have been received for NICE Technology Appraisals relating to specialised NHS-funded drugs, which will now be added to the formulary and advised that the report includes decisions on treatment for Crohn's disease, pain management guidance (clinically approved) and the minor hand service specification, which has also been approved.</p>	

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

	<p>JC referred to the self-care toolkit and homely remedies for care homes, noting the importance of implementation and asked what systems are being put in place to support care homes. RG confirmed that work is underway with the Medicines Optimisation Team, with active implementation being driven through the Senate and IMOG approvals process.</p> <p>The ICB received and noted the report.</p>	
13.	ICS Finance and Performance Report	
	<p>CF presented the finance section of the report and advised that the ICB reported a favourable position at Month 7, with unmitigated risk reduced from £94 million to £13 million through collaborative recovery planning with providers. CF noted that efficiency delivery remains behind plan and the underlying deficit stands at £139 million.</p> <p>IG acknowledged the significant work undertaken to reduce financial risk and reiterated the expectation that plans are submitted and delivered. CF confirmed that approximately £94 million of unmitigated risk remains and that work continues with partners to implement actions aimed at reducing this to zero.</p> <p>ML also acknowledged the considerable effort being made by colleagues and teams across the system.</p> <p>PS presented the performance section of the report and advised that planned care performance is slightly off track for 52-week waits, with work underway to ensure all first appointments are scheduled by January. He added that cancer performance is below plan, primarily due to an increase in skin cancer referrals and provided assurance that additional capacity is being deployed and a series of cancer awareness and prevention campaigns are ongoing, which remain a key priority.</p> <p>ML raised concerns regarding the low completion rates for Oliver McGowan training. It was agreed that further information and benchmarking data would be provided and that a review of statutory and mandatory training compliance would be taken through the Finance and Performance Committee.</p> <p>SW requested that the Finance and Performance Committee focus on the top three actions linked to the drivers of underperformance, ensuring targeted and effective responses.</p> <p>The ICB Board:</p> <ul style="list-style-type: none"> • Acknowledged the performance overview. • Acknowledged the financial position. • Requested that the Finance and Performance Committee focus on the top three actions linked to the drivers of underperformance, ensuring targeted and effective responses 	CF
	Finance and Performance Committee AAA Chairs Report - 7th October and 29th October	
	<p>There are no alerts requiring the Board's attention.</p> <p>The ICB Board received and noted the report.</p>	
14.	ICS People, Culture and Inclusion Committee Assurance and Performance Report	
	<p>MI presented the report and advised that the system is currently 182 staff over plan at month 6, which is primarily due to high levels of bank usage. This is despite changes to payment rates and stated that efforts to manage vacancies and sickness continue and agency usage is now at its lowest level since 2019. She provided assurance that Regional meetings are being held to support with high bank usage.</p>	

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

	<p>IG queried whether the ICB is assured that appropriate actions are being taken within provider organisations. MI confirmed that workforce reduction targets are ambitious and closely linked to financial plans and stated that providers are working with external consultants to strengthen controls and alternative plans are being developed where reductions are not achieved. SL noted that while there is a good understanding of the data, the targets remain ambitious and further work is required, aligning with the wider transformation agenda. HA acknowledged that more can be done and confirmed that Deloitte colleagues have been engaged for support, noting that workforce planning has been driven by financial objectives, reducing pay bills requires corresponding workforce reductions.</p> <p>Colleagues discussed the need to integrate workforce, finance, and productivity data, with agreement that productivity metrics will be included as a regular agenda item at the Finance and Performance Committee.</p> <p>The ICB Board:</p> <ul style="list-style-type: none"> • Received and note the contents of the report. 	
15.	<p>Staffordshire and Stoke-on-Trent ICB Audit Committee AAA Chairs Report – October 2025</p>	
	<p>IG presented the report.</p> <p>CF provided an update on the implementation of the new ledger system (ISFE2), noting that significant progress has been made and expressing thanks to members of the Finance Team and all colleagues involved in the work.</p> <p>ML highlighted the alert and potential risks outlined in the report relating to the NHS Reset and confirmed that these will be discussed further during the Closed session of the Board.</p> <p>The ICB Board:</p> <ul style="list-style-type: none"> • Received and noted the report. 	
16.	<p>Staffordshire and Stoke-on-Trent ICB Remuneration Committee AAA Chairs Report</p>	
	<p>SL presented the report and confirmed that there were no alerts for the Boards attention.</p> <p>The ICB Board:</p> <ul style="list-style-type: none"> • Received and noted report. 	
17.	<p>Staffordshire and Stoke-on-Trent ICB Strategic Commissioning and Transformation Committee AAA Report– September, October and November</p>	
	<p>ML presented the report and highlighted one alert for the Board’s attention regarding challenges in children and young people’s access to services and stated that follow-up actions have been assigned to the Children and Young People’s Portfolio Board. IG queried the next steps for the alert. ED confirmed that it will be managed by the Children and Young People’s Portfolio Board, which reports to the SCTC, and will be escalated to the Board as required.</p> <p>ED referred to Section 75 Agreements update, which was omitted from the report and advised that the Committee recommends Board ratification of these agreements with Local Authorities and confirmed that information will be circulated to Board members for formal approval.</p> <p>The ICB Board:</p> <ul style="list-style-type: none"> • Received and noted the report. 	<p>ED</p>

	<p>ICBs Commercial Sponsorship Policy</p>	
	<p>PW presented the report, confirming that the full version of the policy is available on the website and requested Board ratification.</p> <p>SL queried how declarations of interest are audited. PW explained that an annual review is undertaken by Counter Fraud, with declarations tested against Companies House records. He added that Counter Fraud Specialists use team briefs and staff communications as evidence and, in collaboration with the Governance Team, will deliver a 'lunch and learn' session for staff, when required.</p> <p>RG welcomed the policy and highlighted the importance of sharing it with primary care colleagues to ensure understanding and engagement. PW agreed that collaboration is essential to ensure the policy is communicated effectively to all primary care providers.</p> <p>ML noted that the ICBs approach is consistent with other ICBs and questioned whether a single national process could be adopted. IG confirmed that the Board has an obligation to approve the policy.</p> <p>The ICB Board are requested to:</p> <ul style="list-style-type: none"> • Received and ratified the policy. 	
<p>18.</p>	<p>Items notified in advance to the Chair</p>	
	<p>SW provided an update on the ICB Reset and Change Programme, noting that part of the process includes the appointment of the cluster executive team, subject to NHS England approval and advised that further changes will follow as the programme progresses.</p> <p>SW acknowledged that this is the final Board meeting for several colleagues - PEJ, CI, ED, TS, and CF and expressed thanks for their contributions. He recognised the significant changes introduced by government policy and the turbulence experienced during this period, which the Board collectively acknowledged.</p> <p>IG expressed gratitude to colleagues for their warm welcome and ongoing support to the teams.</p>	
<p>17.</p>	<p>Questions from the floor relating to the discussions at the meeting</p>	
	<p>Mr Ian Syme expressed gratitude to everyone who has served the public through the ICB and acknowledged that it's a sad day and stated that members of the public he speaks to are confused about what's happening and added that despite this uncertainty, he praised members of the sterling work that has laid strong foundations for the future. SW thanked Mr Syme for his comments and for recognising the efforts from the public gallery. He acknowledged that Mr Syme's experience and observations in the system go back much further than most of the current colleagues and assured that his remarks would be appreciated by everyone present.</p> <p>Mr Ian Syme raised a question regarding the commissioning of dentistry and its position within the new system. SW highlighted the importance of using precise and consistent terminology when referring to 'primary care' and stated that primary care encompasses more than general practice and includes dentistry, community pharmacy, and community optometry. He added in discussions on neighbourhood health and delivery of the three shifts, dentistry must be recognised as a core component of primary care and will continue to be commissioned strategically and will remain integral to neighbourhood health, ensuring strong community-based dental services, clear pathways to specialist care, and services aligned to population needs. TA confirmed that dentistry will remain a core element of the primary care offer and will continue to be commissioned by the ICB. He also advised that discussions are ongoing about the future structure and commissioning responsibilities and highlighted the importance of the wider primary care team, including doctors, dentists, pharmacists, optometrists and the essential contribution of administrative and back-office staff who support service delivery. Concerns were expressed about potential changes that may impact</p>	

	<p>established relationships and team structures, which have been built over time and TA provided assurance that a commitment remains to continue serving patients across Stoke on Trent and Staffordshire.</p> <p>Mr Syme highlighted concerns regarding the nationally reported mistreatment of ICB and wider NHS staff by national bodies as referenced in recent media coverage, noting his agreement with the editor’s observations (although this was not specially directed at NHS SSoT). He emphasised the significant scale of change currently taking place within the system and expressed concern for individuals who have served the ICB with dedication to public service yet now face abrupt career disruption. He questioned how such circumstances can be effectively managed, warning that this situation risks demoralising staff and, in turn, negatively impacting service delivery to the public. He further stressed the importance of back-office staff, noting a perceived misunderstanding at national level of their critical role in developing plans and strategies that enable frontline services to operate effectively.</p> <p>SW thanked Mr Syme for his question and acknowledged the exceptional difficulty and challenge of the current situation and recognised that many staff do feel disenfranchised and that the changes have had a significant negative impact on individuals’ sense of security about their future. He stated that this reality would not be hidden or minimised and emphasised the need for a clear focus on defining what it means to become a strategic commissioner across the system footprint and building a structure that is fit for purpose to deliver this effectively. He added that central to this approach is the responsibility to commission services that improve outcomes for residents across Shropshire, Telford & Wrekin, Staffordshire, and Stoke-on-Trent and all decisions must remain anchored to this core principle.</p> <p>SW noted that the organisations will undergo several phases of a change programme and acknowledged the leadership challenge of ensuring appropriate support is in place throughout for our staff. The strong engagement of ICB staff is a central tenant of this work. He emphasised that moving towards an affordable organisational structure within the £19 per head allocation will result in a significantly smaller workforce than currently employed across the two ICBs and these changes will follow organisational policies and best HR practice with support offers provided wherever possible.</p> <p>SW reiterated that the impact of these changes cannot be understated and will affect staff and the work being delivered. Against this backdrop, staff are being asked to deliver the medium-term financial plan and future strategies while facing uncertainty about their roles. He committed to working through the change programme transparently and supportively, on a day-by-day, week-by-week basis, to minimise negative impacts where possible. Mr Syme thanked SW for the response and stressed the importance of acting with transparency and openness, treating people with dignity and respect, and providing support throughout the process. He also placed on record his appreciation for ICB staff who have faced prolonged uncertainty about their future.</p>	
<p>18.</p>	<p>Meeting Effectiveness</p>	
	<p>The Chair confirmed that the meeting followed the Leadership Compact.</p> <p>CF stressed that the Board must ensure continued progress on all agenda items in parallel with the NHS Reset, maintaining alignment with strategic objectives.</p> <p>IG noted that not all key representatives were not present at the meeting, particularly Local Authority representatives and stressed the importance of encouraging their participation, as many of the initiatives being discussed cannot be delivered without the support of Local Authority partners.</p> <p>SW suggested reflecting on this when considering how the agenda flows and acknowledged that, as the organisation moves towards new governance arrangements, there will be changes to how meetings are conducted over the coming months.</p>	

19.	Close	
	There being no further business, the Chair closed the meeting.	
20.	Date and time of Next Meeting	
	Date and Time of Next Meeting Thursday 15 th January 2026, 1.00pm – 3.30pm, Trust Headquarters Boardroom, Mellor House, St George's Hospital, Corporation Street, Stafford, ST16 3SR.	

NHS Shropshire Telford and Wrekin Integrated Care Board Actions Arising from previous Board Meetings

Agenda item: Minute No. ICB 25-09.214 – LeDeR Annual Report 2024/25 including Learning Disability Mortality Review Annual Report

Action Required: Explore a system-wide response to the issue around aspirational pneumonia for individuals who live with a learning disability and/or autism and bring an update to a future Board meeting.

Owner: Vanessa Whatley

By When:

Update/Date: **Confirmed that an update will be included within the Annual Report for 25/26 - 23/10/2025**

Agenda item: Minute No. ICB 25-11.236– System Board Assurance Framework and System Operational Risk Register (SBAF & SORR)

Action Required: Alison Smith to highlight to risk owners where information is missing or needs updating.

Owner: Alison Smith

By When:

Update/Date: **Completed**

Agenda item: Minute No. ICB 25-11.238– Minute No. ICB 25-11.238 – System EDI Update

Action Required: Vanessa Whatley to work with colleagues and partners across the ICS provide a clear statement and narrative.

Owner: Vanessa Whatley

By When:

Update/Date: updated to be provided



Ambition



Compassion



Optimism



Focus

ACTION STATUS KEY
ACTION DUE
ACTION PENDING
ACTION COMPLETE

Staffordshire and Stoke-on-Trent ICB Board Meeting
HELD IN PUBLIC

Meeting Date	Agenda Item	Action	Due Date	Responsible Officer	Outcome/update
20/11/2025	Quality and Safety Report	It was agreed that an action should be taken to provide an update at the next meeting, including a clear trajectory and action plan outlining specific steps the system and partners will take to achieve a more acceptable performance level. While harm has not been identified, the current position falls short of the 85% target, and plans must be in place to deliver improvement. The Board will be kept informed of progress.	29/01/2026	HJ/LT	Update – An update summary will be provided at the next board meeting. Colleagues confirmed SQG & QSC will have oversight of the detail. RECOMMENDATION TO CLOSE ACTION
20/11/2025	SCTC AAA Report	ED referred to Section 75 Agreements update, which was omitted from the report and advised that the Committee recommends Board ratification of these agreements with Local Authorities and confirmed that information will be circulated to Board members for formal approval.	29/01/2026	ED/PW	Discussion to be held at the Extra-Ordinary Board meeting on the 9th December 2025 RECOMMENDATION TO CLOSE ACTION
20/11/2025	Quality and Safety AAA Report	IG queried whether the SEND and Alternative Provision Strategy 2026–29 had previously been presented to the Board.	29/01/2026	SH	In line with ICB policies the full SEND strategy was presented to Board for ratification only of the decision to approve made by Quality and Safety Committee where a comprehensive review was undertaken by all members of the Committee. As this is normal practice ICB Board Members should have been aware that the strategy could be made available if anyone wanted to review further. A discussion has taken place with Governance to ensure both clarity and consistency in future. RECOMMENDATION TO CLOSE ACTION

Report to:	Integrated Care Board				
Date:	29 January 2026				
Title:	Betley Surgery – Urgent Decision Notification				
Presenting Officer:	Ian Green OBE, ICB Cluster Chair				
Author(s):	Paul Winter, Associate Director of Corporate Governance				
Document Type:	Report				
Action Required (select):	Information (I)	<input type="checkbox"/>	Discussion (D)	<input type="checkbox"/>	Assurance (S) <input checked="" type="checkbox"/>
	Approval (A)	<input type="checkbox"/>	Ratification (R)	<input checked="" type="checkbox"/>	(check as necessary)
Is the decision within SOFD powers & limits	Yes / No	YES			
Any potential / actual Conflict of Interest?	Yes / No	YES <i>If Y, the mitigation recommendations –</i> The Provider Partner Member from North Staffs Combined NHST is conflicted owing to the provider managing other local GP Contracts – Member to stay in the room but not decide on this paper			
Any financial impacts: ICB or ICS?	Yes / No	NO			
Any impacts on ICB Undertakings?	Yes / No	NO			
Appendices:	NONE				

(1) Purpose of the Paper:

The Primary Care Team requested Cluster Chair’s invoking of the Urgent Decisions clause, from the ICB Constitution (Standing Orders). In order to mitigate unavoidable timescale pressures arising from holding our first ‘In-Common’ Board meeting on 29th January. Originally, the SSOT-only date of 15th January allowed for on-the-day SSOT Board discussion of an urgent Primary Care Commissioning Options Appraisal for Betley Surgery, where the GP Partners handed back their GMS contract on 12th October 2025, with 6 months’ notice. Meaning the contract will come to an end on 31st March 2026.

Urgent mitigating actions for potential Practice List dispersal or competitive tender for a new contract have to be taken this month, owing to national procurement & contract management rules. An Options Appraisal went to SSOT’s Primary Care Forum (PCF) on 13th January 2026, for it to recommend its preferred choice to the lead committee for formal approval: the Strategic Transformation & Commissioning Committee (SCTC), held on 14th January 2026.

SCTC’s approval was escalated to the ICB Chair on 15th January 2026.

The Chair was asked if he could permit use of the ‘Urgent Decisions’ route for interim ratifying of the SCTC-approved option under powers reserved to ICB Chair. This was deemed the best decision-making option in the circumstances. Exercise of those powers is now being reported in full, to the next available Board meeting; and Members asked for formal ratification of the Chair’s interim verbal ratification of 15th January. It will also be verbally updated to the ICB’s Audit Committee for their oversight on 22nd January.

(2) History of the Paper & Whether for I-D-S-A-R (as above):	Date
Primary Care Forum (D)	13 January 2026
Strategic Commissioning & Transformation Committee (A)	14 January 2026

(3) Implications:	
Legal or Regulatory	GMS Primary Care Manual / ICB Constitution
CQC or Patient Safety	n/a
Financial (CFO-assured)	n/a
Sustainability	n/a
Workforce or Training	n/a
Equality & Diversity	Primary Care Team have worked extensively with local communities
Due Regard: Inequalities	Impact Assessments have been produced / discussed to support the option
Due Regard: wider effect	Impact Assessments have been produced / discussed to support the option

(4) Statutory Dependencies & Impact Assessments:			
Assessment	Completed?	If No / N/A – Rationale	If Yes – Outcome & Date Reported / Signed off
DPIA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A	No Personal Data used	
EIA	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A	Click or tap here to enter text.	<i>Outcome and date of completion:</i> 19th December 2025 – the QIA has comprehensively identified and mitigated potential risks to patients including access, experience, and outcomes.
QIA	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<i>(enter rationale, per ICB QIA Policy, that it does not impact on quality of services)</i>	<i>SRO sign-off, outcome & date of completion:</i> 30/12/2025 Full Assessment Completed / Submitted
Has there been Public / Patient Involvement?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		A patient engagement exercise was undertaken during November 2025 via in person drop in events at the practice and a survey.

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

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

To provide SCTC / Board with an overview of the options available to the ICB regarding the future commissioning arrangements of Betley Surgery. The GP Partners handed back their GMS contract on 12th October 2025 with 6 months' notice, the contract will come to an end of 31st March 2026. The full SCTC paper provided two options for future provision: (1) List Dispersal (2) Competitive Tender for a new APMS contract.

Two further options were explored by GP Partners prior to handing back the contract: to bring a new partner onto the contract and to look at a merger with a nearby practice.

Neither of these were viable due to estate and financial constraints. The paper set out the advantages, risks and mitigations for both options and following a QIA / EHIA process and recommended to disperse the list.

(7) Recommendations to Board:

Board is asked to **RATIFY** the prior Urgent Decision taken by Cluster Chair on 15th January; and **BE ASSURED** that all ICB Governance has been properly followed in doing this.

Enclosure No: 7.

Report to:	Integrated Care Board					
Date:	29 January 2026					
Title:	Chief Executive Officer Report					
Presenting Officer:	Simon Whitehouse, CEO					
Author(s):	Simon Whitehouse, CEO					
Document Type:	Report	If Other: Click or tap here to enter text.				
Action Required (select):	Information (I)	<input checked="" type="checkbox"/>	Discussion (D)	<input type="checkbox"/>	Assurance (S)	<input type="checkbox"/>
	Approval (A)	<input type="checkbox"/>	Ratification (R)	<input type="checkbox"/>	<i>(check as necessary)</i>	
Is the decision within SOFD powers & limits	Yes / No	Choose an item.				
Any potential / actual Conflict of Interest?	Yes / No	NO <i>If Y, the mitigation recommendations –</i> Click or tap here to enter text.				
Any financial impacts: ICB or ICS?	Yes / No	NO <i>If Y, are those signed off by and date:</i> Click or tap here to enter text.				
Any impacts on ICB Undertakings?	Yes / No	NO <i>If Y, are those signed off by and date:</i> Click or tap here to enter text.				
Appendices:	Click or tap here to enter text.					

(1) Purpose of the Paper:

This report provides a strategic overview and update on national and local matters, relevant to the Staffordshire and Stoke on-Trent and Shropshire, Telford and Wrekin 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 key areas and enabling functions across NHS Staffordshire and Stoke-on-Trent and NHS Shropshire, Telford and Wrekin.

Updates on the below areas are included:

- General
- Primary Care
- Urgent and Emergency Care
- Planned Care and Cancer
- Mental Health
- Provider Collaborative
- Medicine Management Optimisation
- Quality and Safety

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

N/A

Date

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

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

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

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

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

1.0 General

1.1 NHS Government Reset Programme

The ICB's continue to work through their responses to the national NHS Reset programme. The focus remains one of how to evolve into the strategic commissioner across the wider system that both ICBs cover.

Work continues to develop the ICB Cluster Operating Model and the leadership structure that will be put in place to discharge the Statutory functions. This management structure needs to be affordable within the significantly reduced running cost allowance of £19.40 per head of population.

A local voluntary redundancy scheme for staff across NHS Shropshire, Telford and Wrekin Integrated Care Board (ICB) and NHS Staffordshire and Stoke-on-Trent Integrated Care Board (ICB) launched on 1 December and closed on 22 December 2025. Staff who have submitted applications for voluntary redundancy will be informed of decisions in late January 2026. This continues to be an unsettling period for staff, and all colleagues are working hard to ensure that we are compassionate in our approach and supporting colleagues to navigate this period. It is important that I thank all staff across both ICB's for their continued work and efforts during this period of change.

The next stage of finalising the leadership team across the cluster has now commenced. A formal Management of Change consultation opened in early January 2026, which will include Senior Leadership Teams (Bands 8C to 9 + VSM2) from across the wider cluster. This process will follow the agreed organisational policies and has had active involvement with our Trade Union colleagues. The ICB Cluster Chair and I met with TU colleagues in December as part of this process and our commitment to strong / continued engagement.

Work on the Clinical Leadership Management of Change will soon commence and teams are advancing the TUPE transfer of NHS Midlands and Lancashire Commissioning Support Unit (MLCSU) colleagues.

The ICB Cluster Transition Committee has met on several occasions since the last Board meetings. This committee continues to have oversight of the wider change and reform programme, and a more detailed update is included in the Board papers.

1.2 NHSE Checkpoint

On 12 January 2026, I met with NHSE colleagues, accompanied by Paul Edmondson-Jones and Mish Irvine, for our first NHS Reset Checkpoint Meeting. We presented an update on our Management of Change progress, process and timeline, our Organisation Form, our Transition Governance and the work we are doing to ensure we can safely and effectively deliver all the functions set out in the Model ICB Blueprint (as modified and updated since by NHSE) and all our statutory functions within the £19.40 per head of population running costs. Main issues raised as actions for the next checkpoint were a greater understanding of our "glide path" to the full and steady delivery of those running costs, a paper/presentation setting out our operating model and more detail on the indicative size, functions and capabilities of our future directorates and teams, cross-referenced to our statutory duties and the Model ICB Blueprint.

1.3 Board Assurance Statement

NHSE has requested that the ICB Boards submit a Board Assurance Statement by 30 January 2026. It is recognised that this will be a statement about our progress rather than about a final position. They have asked that it confirms that the Board:

- has considered and understands the functions for which it is accountable under current legislation, under formal delegation from NHSE, and as described in the Model ICB Blueprint, with specific regard to:
 - the current national position on functions identified as ‘review for transfer’
 - the good practice guides shared on Continuing Healthcare, Infection Prevention and Control, Safeguarding, Special Educational Needs, and Medicines Optimisation
- is confident that the proposed ‘To Be’ structure enables the effective and efficient discharge of these functions within the £19.40 per head running cost allowance
- has fully assessed the risks linked to the running cost reduction and has identified clear, tangible mitigations for any changes to how the ICB’s functions will be delivered.

This was considered by the Transition Committee at its last meeting.

1.4 Staffordshire and Stoke-on-Trent CEO session at Keele University

In December, I chaired a meeting of Health and Care leaders from the Staffordshire and Stoke-on-Trent system. This included Health and Local Authority CEOs and Primary Care leaders from across the system. The meeting in December, and a further one planned at the end of January, are an opportunity to bring together partners to develop our approach to the provision and commissioning of Health and Care. All partners are committed to developing a shared plan that enables Staffordshire and Stoke-on-Trent to further strengthen its approach to collaboration at scale, community shift and neighbourhood teams.

1.5 Royal Shrewsbury Hospital Expansion – Topping Out Ceremony

I was pleased to attend the topping out ceremony for the Royal Shrewsbury Hospital expansion on 17 December. This marked a significant milestone in the progress of the new four-story development, which will provide an expanded Emergency Department, improved front of house facilities, and modern clinical spaces designed to enhance patient care and staff experience.

The project remains on track for completion in 2028 and will bring acute medical, women and children’s, and critical care services together on the same site as the upgraded Emergency Department, supporting faster clinical decision-making and improved patient flow. This is supported by further improvements and developments to services at the Princess Royal Hospital in Telford with a significant increase in diagnostic and elective activity taking place from that site. All of these physical changes are underpinned by work to enhance and mobilise the model of care across both primary and secondary care.

Having been part of the team that worked tirelessly to secure the national funding approval for this, it is fantastic to see this translate into reality. It will genuinely make a positive difference to the way that care is delivered for resident across Shropshire, Telford and Wrekin.

1.6 Chief Medical Officer Sir Chris Whitty Visit to Shropshire

Professor Sir Chris Whitty visited Shropshire on 26 November to discuss rural health challenges, including access, transport, digital exclusion and workforce pressures, and to recognise the strong local partnerships delivering initiatives such as Family and Community Hubs. He described the visit as highly valuable in understanding Shropshire's unique needs, with leaders hopeful it will help shape national policy and support for rural areas.

1.7 Regional Feedback on Health Inequalities Programme

Dr Paul Edmondson-Jones, Transition Director, received positive feedback from the West Midlands Regional Health Inequalities Team on the Staffordshire and Stoke-on-Trent ICB's Health Inequalities Programme. Feedback highlighted strong system leadership, a clear Health Inequalities Strategy, and effective multi-agency governance through the Improving Population Health Board. The programme was recognised for progress against Core20Plus5 priorities, including the use of Population Health Management data, targeted service development, and community outreach activity.

1.8 Gill Boast awarded MBE

Gill Boast, Senior Nurse and Primary Care Nursing Lead in Staffordshire, has been awarded an MBE in the King's New Year Honours List for services to primary care nursing. Gill has had a long career in nursing, including many years in general practice, and has made a significant contribution to patient care, education, and workforce development. Her work includes establishing the General Practice Nursing Foundation School to support training and development within the primary care nursing workforce.

1.9 Dr Jess Harvey recognised nationally for contribution to Primary Care

Local GP, Clinical Director for the South-East Shropshire Primary Care Network and Co-Chair of the GP Board, Dr Jess Harvey, has been recognised nationally at the 2025 General Practice Awards for her outstanding leadership and innovation. Jess's work continues to raise the profile of General Practice both locally and regionally, including regular contributions to national and local media and advocacy for key NHS campaigns. Her leadership across programmes such as the Dementia MDT and Highley Medical Centre has contributed significantly to improved patient care and strengthened primary care services across Shropshire, Telford and Wrekin.

1.10 Clinical Strategy

In January 2026, NHS Shropshire, Telford and Wrekin will be publishing a draft Clinical Strategy and inviting patients and residents to share their views.

The strategy responds to key challenges including an ageing population, a large rural geography, health inequalities and rising demand for services. It focuses on prevention, stronger neighbourhood-based community support, tackling inequalities and better use of digital tools across five life stages.

This aligns closely with the Government's 10 Year Plan and emphasises clinical leadership, data-driven decision-making and collaboration across partner services. The engagement period will run for three weeks, concluding Friday 30 January.

2.0 Primary Care

2.1 Locally Commissioned Services (LCS) Review

In December 2025, NHS Shropshire, Telford and Wrekin ICB began a comprehensive review of Locally Commissioned Services (LCS) in General Practice to ensure investment is fair, sustainable, and aligned with local population needs.

The review is being undertaken with full involvement from the Local Medical Committee and GP Board Chairs, with a revised service model planned for implementation from April 2026. The review aims to reduce variation across the county, improve equity of access for patients and outcomes, align services with national best practice and the NHS 10 Year Plan, and ensure local services remain financially sustainable within the refreshed three-year financial strategy.

2.2 The Deck Project

Newcastle Central Primary Care Network (PCN) in Staffordshire and Stoke-on-Trent, has secured £44,000 from the Health Innovation West Midlands Innovation Fund 2025/26 for The Deck project. The Deck is a trauma-informed, holistic model supporting children, young people and families facing adversity, with a focus on reducing health inequalities across Core20 communities. Funding will enable implementation from 1 December 2025, establishing a coordinated, multi-agency pathway across primary care, education, social care, and the voluntary sector.

2.3 Men's Health Event

Newcastle Central PCN in Staffordshire and Stoke-on-Trent, hosted a Men's Health evening event on 12 November 2025, which exceeded expected attendance levels. The event featured three guest speakers addressing key men's health topics and provided opportunities for engagement with local services. Attendees were supported to access information and signposted to further support, including GP services and Andy's Man Club. The event highlighted the impact of targeted engagement in improving awareness, reducing barriers to access, and supporting early intervention in men's health.

2.4 IT Hardware Donation

The Staffordshire and Stoke-on-Trent ICB Digital Team partnered with local voluntary and community sector organisations to donate 189 laptops no longer suitable for NHS use. The equipment was repurposed to support digital literacy and improve accessibility across the region, distributed to VAST, YMCA, Free IT Stafford, and Donate IT.

The laptops have enabled young people in YMCA's YES programme to access training and employment preparation, supported online learning and work experience, assisted with CSCS test preparation, provided digital access for children outside mainstream education, supported cadets' training, helped individuals navigate housing and benefit claims, and

reduced social isolation among older people. These donations demonstrate the value and impact of collaborative initiatives.

2.5 Mitigating Digital Exclusion across Shropshire, Telford and Wrekin

Shropshire, Telford and Wrekin ICB Health Inequalities Team has developed a system plan for Mitigating Digital Exclusion in partnership with Primary Care, NHS Providers and Local Authority leads. This has made progress in delivering coordinated action across four priority areas: strengthened leadership, accountability and governance, improving digital exclusion intelligence, increasing access to devices and data, and expanding digital inclusion champion networks.

Digital exclusion considerations are now fully incorporated into the ICB's revised Integrated Impact Assessment (IIA) process, ensuring that potential barriers, and appropriate mitigations, are systematically addressed within all service and policy change proposals.

Work is also underway to map local schemes offering free devices and data, alongside improving referral and signposting routes to ensure people can access support. Multiple local services are registered with the National Databank and are providing free SIM cards to local communities most at-risk of digital exclusion. Additional Primary Care Networks and secondary care services aligned to Core20PLUS5 populations have expressed interest in joining. Alongside this, a pilot device recycling and re-use scheme is being explored by Telford & Wrekin Council, in collaboration with local partners from the NHS, Shropshire Council and VCSE, with the aim of increasing access to refurbished devices for those who need them.

2.6 Urgent Dental Care Incentive Scheme

The Urgent Dental Care Incentive Scheme supports the delivery of 700,000 additional urgent care appointments and runs from 25 September 2025 to 31 March 2026. Dental practices can sign up to deliver an increase of 25% in urgent care courses of treatment. The aim is to boost the additional urgent dental appointment capacity already commissioned by both ICBs and to provide a comprehensive safety net for patients with urgent dental needs. Across Staffordshire and Stoke-on-Trent, 80 of the 111 eligible dental practices have signed up, representing a participation rate of 72%, demonstrating strong engagement with the scheme. For Shropshire, Telford and Wrekin, this is 32 of the 63 eligible dental practices, which is a 51% uptake rate. Although lower than the West Midlands average (64%) there is sufficient capacity in STW practices to manage the demand for appointments.

3.0 People and Workforce

3.1 The People Team

The Staffordshire and Stoke-on-Trent ICS People, Culture and Inclusion Committee met in December and received assurance on significant system wide workforce challenges. Partners reported sustained seasonal pressures, industrial action impacts, and the need to progress workforce cost reduction. With workforce levels currently above the 2025/26 plan, providers are building mitigations into the medium-term planning process which bridge the position into FY26-27 delivery. Partners continue to monitor key people metrics, including

persistently high sickness, and provide support to staff during significant system change. They also maintain strong momentum on the Inclusion agenda, reflected in data, engagement, events, and programmes.

4.0 Urgent and Emergency Care (UEC)

4.1 UEC Improvement

In Shropshire, Telford and Wrekin, significant progress continues to be made against the system Urgent and Emergency Care (UEC) improvement programme, with a particular focus on increasing acute capacity, improving patient flow, and strengthening alternatives to admission.

At Royal Shrewsbury Hospital (RSH), two new modular wards are now operational, providing an additional 56 inpatient beds to support gastroenterology and surgical services. This additional capacity is contributing to improved flow through the acute pathway, increased resilience during periods of peak demand, and enabling further planned reconfiguration of medical bed capacity as part of wider UEC improvements.

At Princess Royal Hospital (PRH), investment in acute assessment capacity has delivered 40 new assessment spaces, which became operational in December. These facilities are supporting more timely assessment, decision-making, and streaming at the front door, helping to reduce congestion in the Emergency Department and support more appropriate admission and discharge decisions.

These developments form part of a broader, system-wide programme focused on improving urgent and emergency care performance, reducing avoidable pressure on emergency departments, and improving patient experience across Shropshire, Telford and Wrekin.

4.2 UEC Demand

In Staffordshire and Stoke-on-Trent, in December 2025 continued to see increased demand for Urgent and Emergency Care (UEC) services across the system, and consequently, December's performance remained challenged, with several key metrics off plan. Further periods of industrial action, Infection Prevention and Control (IPC) challenges, and a Critical Incident also impacted operational delivery. Focus remains on recovery of core metrics against the plan, with contributions from system partners.

The system winter plan continues to be mobilised, with oversight provided by the UEC Governance structure. The system collaborated on a 'Home for Christmas' plan, aiming to achieve 80% occupancy at University Hospitals of North Midlands (UHNM) prior to the festive period. The plan achieved just below 80% occupancy, demonstrating success through joint system working. The Integrated Care Coordination (ICC) and Community Rapid Intervention Service (CRIS) continued to see increasing referral numbers, with record referrals during the festive period, supporting positive outcomes for the population by reducing ambulance conveyances and attendances at Acute Hospital sites.

4.3 Winter Pressures

I would like to take this opportunity to personally thank all colleagues across the health and care system for their exceptional hard work and commitment throughout the winter period and especially across the Christmas and New Year period. Their professionalism, resilience and compassion during an exceptionally challenging time are deeply appreciated.

The Shropshire, Telford and Wrekin system continues to work hard to mitigate winter pressures (including an early rise in flu cases, high number of respiratory-related emergency department (ED) attendances, and high overall demand. Efforts are focused on improving patient flow, enhancing community care and promoting preventative measures like vaccinations. These interventions are helping to reduce unnecessary hospital admissions and speed up discharge processes.

Key initiatives include the Shrewsbury PCN's Winter Wellness Clinic, the expansion of the Urgent Community Response (UCR) teams, British Red Cross ED Support Service, as well as encouraging the public to support discharge if loved ones are ready to go home and 'Think Which Service'. The 'Think Which Service' campaign aims to help residents choose the right care at the right time.

4.4 Vaccination Programme Update: Flu, COVID-19 and RSV

4.4.1 Shropshire, Telford and Wrekin

Across Shropshire, Telford and Wrekin, vaccination uptake continues to perform strongly, with the system consistently ahead of national averages in many key areas.

Flu Vaccination

- Shropshire, Telford and Wrekin (STW) are performing above the England average in almost all cohorts, and above the West Midlands average in every cohort.
- Uptake has improved overall compared to last year, with notable increases in most groups.
- Healthcare worker uptake has now exceeded the ambition, reflecting strong engagement from local providers.
- STW remains one of the highest performing- systems in the region, currently ranked 4th overall.
- Work continues to ensure equitable access, with targeted support in communities where uptake is traditionally lower.

RSV Vaccination

- STW uptake is higher than both England and West Midlands averages across all three eligible groups, showing strong early delivery of this new programme.

COVID-19 Vaccination

- Uptake across STW is ahead of England in all priority cohorts, including care home residents, those aged 75+, and the immunosuppressed.
- The system continues to work closely with partners to maintain high coverage and adapt delivery models as the programme evolves.

4.4.2 Staffordshire and Stoke-on-Trent

Across Staffordshire and Stoke-on-Trent, vaccination uptake continues to perform well, with the system showing improvements across key cohorts.

Flu Vaccination

- Overall uptake is 55.2%, up 0.8% from the same period last year, with over 360,000 doses administered.
- Higher uptake among those aged 65+ (75.9%) and care home residents (74.8%), with improvements for pregnant women, at-risk under 65s, immunosuppressed individuals, and children.
- Vaccinations continue via GP practices, pharmacies, and walk-in clinics until March 2026.
- Staff vaccinations: 50.3% of front-line staff have been vaccinated across North Midlands NHS Trust (UHNM), North Staffordshire Combined Healthcare NHS Trust (NSCHT), and Midlands Partnership NHS Foundation Trust (MPFT). This is an increase of 8.4% compared with the same period last year. UHNM and NSCHT have exceeded their stretch targets by 5 percentage points, while MPFT is very close to its target, just 0.6 percentage points below.

RSV Vaccination

- Uptake at 68.6% for 75–79-year-olds and 43.4% for those 75+.
- Primary care prioritising invitations for individuals turning 75 to ensure protection through the remainder of winter.

COVID-19 Vaccination

- Over 95,000 doses have been administered this campaign, with 59.2% of all eligible individuals vaccinated. Uptake has improved among over-75s, older adult care home residents, and immunosuppressed individuals compared with Spring 2025.
- Partners continue to maintain coverage and adapt delivery models as the programme evolves.

5.0 Planned Care and Cancer

5.1 Lung Cancer Screening Programme

On 1 December, the Lung Cancer Screening (LCS) Programme was launched in Shropshire, Telford and Wrekin.

The programme aims to detect lung cancer earlier, improving outcomes and reducing mortality. Initially focusing on areas with the highest deprivation, smoking rates and lung cancer prevalence, there will be a phased rollout across the system over the next four years.

It forms part of the national NHS Lung Cancer Screening Programme, which aims for full coverage across England by 2030. Alliance Medical, working with Xyla Elective Care and Telemedicine Clinic, has been appointed to deliver the service.

Approximately 62,000 local people aged 55–74 who have ever smoked are eligible. Participants will be offered a Lung Health Check, followed by low-dose CT scanning for those identified as high risk, alongside referral to stop smoking services where appropriate. Mobile CT units will be used to maximise accessibility and reduce health inequalities.

5.2 Elective Care Strategy (2025–2030)

Staffordshire and Stoke-on-Trent ICB has worked collaboratively with system partners, including providers, local government, NHS England and patient representatives, to develop an Elective Care Strategy for Staffordshire and Stoke-on-Trent (2025–2030). The shared vision is: ‘A health and care system where people get the care they need, in the right place, at the right time; where care is joined up, delivered by teams working together, and shaped by what matters most to patients and communities.’ This strategy provides a collective framework to guide system delivery plans and ensure alignment across partners. It reflects the ambitions of the NHS 10 Year Plan and focuses on the three national shifts, alongside productivity and sustainability:

1. Sickness to Prevention
2. Analogue to Digital
3. Acute to Community
4. Productivity
5. Resilience and Sustainability

The full strategy is available on the ICS website: [Elective care - The full strategy is available on the ICS website: Elective care - Staffordshire and Stoke-on-Trent, ICS](#)

6.0 Mental Health

6.1 Child and Adolescent Mental Health Services (CAMHS) mobilisation

Mobilisation of the new children and young people’s emotional wellbeing, mental health and neurodevelopmental service continues to progress well in Shropshire, Telford and Wrekin. The ICB, MPFT and our local authority partners are working closely together to ensure the redesigned service remains on track to go live on 1 April 2026.

Work is also underway to develop a new name and brand for the service, shaped by children, young people, families and professionals ready for launch in April. The three-year transformation programme will continue to build on this foundation, with a strong focus on early help, prevention and improved access.

6.2 All-age Autism and ADHD Services review

In March 2025, NHS Shropshire, Telford and Wrekin ICB agreed to undertake a comprehensive whole-system review of all-age autism and ADHD services and pathways.

The findings of this review are intended to help shape and inform any future redesign and commissioning of services, ensuring that provision is needs-led, safe, efficient, and delivers the greatest impact and value for money.

This evaluation considered national policy and regulatory frameworks and extensive local data and intelligence.

The review has been informed by wide-ranging engagement with professionals and over 1,000 local residents and stakeholders, identifying good practice and gaps in current provision to inform recommendations to improve access, integration and outcomes for people.

6.3 Enhanced Autism Support and Empowerment (EASE) service

Staffordshire and Stoke-on-Trent have secured funding from Toucan, the West Midlands Provider CAMHS Collaborative, for an Enhanced Autism Support and Empowerment (EASE) service delivered by MPFT. The service will support children open to the Intensive

Support Team (IST) with diagnosed or suspected ASC, including those awaiting assessment. Service features include:

- Family peer support and enhanced support for young people
- Increased training to strengthen system-wide knowledge and capacity for working with autistic children and young people
- Supporting Diagnosis in the Community - exploring ways to speed up autism assessments outside hospital, recognising crisis is not the ideal time for diagnosis
- Personalised Care: Dedicated care teams to improve continuity and reduce disruption from shift-based systems.
- Joined-Up Care: Coordinated support across Autism Care Teams (ASC), Key Worker Service, and IST.

This offer will also use the value of third-sector services, subject to a planned and successful procurement.

6.4 24/7 Mental Health Text Support

Free 24/7 mental health support text services are now available across Shropshire, Telford and Wrekin and Staffordshire and Stoke-on-Trent, commissioned by the ICBs and delivered locally by MPFT and SHOUT (in Shropshire, Telford and Wrekin), and MPFT and NSCHT in Staffordshire and Stoke-on-Trent. These services enable people of all ages to access compassionate, tailored mental health support by text at any time of day or night, providing an accessible option for those who may find speaking on the phone difficult or need discreet help when they need it most. The text services complement existing crisis pathways and can help connect individuals with further support where needed.

7.0 Provider Collaborative

The Staffordshire and Stoke-on-Trent Health and Care Collaborative continues to make progress across a number of priority areas. These include:

- Corporate Services in conjunction with wider cluster partners
- Urgent and Community Care Transformation
- The development of Neighbourhood teams

As part of responding to the ten-year plan, the Collaborative continue to work closely and positively with wider system partners. In particular, focussing on the role collaborative partners can play in successful delivery of the system priorities.

8.0 Medicine Optimisation Team

8.1 Supporting World Antimicrobial Awareness Week

Both Staffordshire and Stoke-on-Trent Integrated Care Board (ICB) and Shropshire, Telford and Wrekin ICB supported World Antimicrobial Awareness Week (WAAW) across the Integrated Care System, joining the global call to action. WAAW is an international campaign aimed at improving awareness and understanding of antimicrobial resistance (AMR) and promoting best practices to reduce its spread. The week ran from 18 - 24 November, with activity focused on reinforcing key messages around the responsible use of

antibiotics and the shared responsibility of individuals, communities, and healthcare professionals in tackling antimicrobial resistance.

8.2 Reducing Harm from Inappropriate Opioid Prescribing - National Conference Presentation

The Staffordshire and Stoke-on-Trent ICB Medicines Optimisation team continues to lead a programme addressing harm from inappropriate opioid prescribing for chronic pain. In November, the team showcased the programme at the Clinical Pharmacy Congress in Manchester. The national event brought together healthcare and pharmacy professionals, and this work has demonstrated improvements in safer prescribing practices and patient outcomes, highlighting the ICB's innovative, patient-centred approach.

8.3 Oral Nutritional Supplements

In January 2025, Staffordshire and Stoke-on-Trent ICB introduced a system-wide policy to ensure appropriate prescribing of Oral Nutritional Supplements (ONS) and promote a food first approach in the treatment of malnutrition. Staffordshire and Stoke-on-Trent ICB was the highest national prescriber in terms of spend and items, with a projected spend of £11.7m in 2025/26, despite evidence indicating that ONS do not contain anything more than food can provide (Cochrane 2021). The Clinical Value and Medicines Team, working collaboratively across the Chief Medical Officer (CMO) directorate and with system partners, applied evidence-based behaviour change techniques to support clinicians in changing long-standing and cultural prescribing practices.

October 2025 data highlight an improved position for Staffordshire and Stoke-on-Trent ICB, ranking 4th highest for ONS prescribing spend and 11th out of 42 ICBs for items prescribed from a position of 1/42. Forecast savings for 2025/26 are £2m, alongside significant cost avoidance from rising prices.

9.0 Quality and Safety

9.1 Biannual ICS Patient Safety Learning Conference

The fourth Biannual Staffordshire and Stoke-on-Trent ICS Patient Safety Learning Conference took place on 12 January at St George's Hospital. Developed and facilitated by Quality colleagues from Staffordshire and Stoke-on-Trent and Shropshire, Telford and Wrekin ICB's, it was attended by NHS and independent providers, Healthwatch, Local Authorities, and Health Innovation West Midlands. Highlights included a patient story on the importance of communication with families, Q&A sessions with specialist panels on patient safety and medical examiner processes, and updates on learning from suicide, 'Right Care Right Person' processes, and deterioration. Initial feedback was very positive, with the next event scheduled for 29 July 2026.

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

January 2026

Report to:	Integrated Care Board				
Date:	29 January 2026				
Title:	Palliative Care: Sue's story				
Presenting Officer:	Heather Johnstone, Interim Chief Nursing Officer				
Author(s):	Heather Johnstone, Interim Chief Nursing Officer				
Document Type:	Other	If Other: Video Clip			
Action Required (select):	Information (I)	<input checked="" type="checkbox"/>	Discussion (D)	<input checked="" type="checkbox"/>	Assurance (S) <input type="checkbox"/>
	Approval (A)	<input type="checkbox"/>	Ratification (R)	<input type="checkbox"/>	<i>(check as necessary)</i>
Is the decision within SOFD powers & limits	Yes / No	Choose an item.			
Any potential / actual Conflict of Interest?	Yes / No	NO <i>If Y, the mitigation recommendations –</i> Click or tap here to enter text.			
Any financial impacts: ICB or ICS?	Yes / No	NO <i>If Y, are those signed off by and date:</i> Click or tap here to enter text.			
Any impacts on ICB Undertakings?	Yes / No	NO <i>If Y, are those signed off by and date:</i> Click or tap here to enter text.			
Appendices:	Click or tap here to enter text.				

(1) Purpose of the Paper:
To share Sue's story, as told by her husband Mike, and her experiences of End of Life care in Staffordshire and Stoke-on-Trent.

(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	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A	Click or tap here to enter text.	Reported to IG Committee: Click or tap to enter a date.
EIA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A	Click or tap here to enter text.	Outcome and date of completion: Click or tap here to enter text.
QIA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A	<i>(enter rationale, per ICB QIA Policy, that it does not impact on quality of services)</i> 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?		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Click or tap here to enter text.

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

(6) Executive Summary, incl. expansion on any of the preceding sections:
<p>The Staffordshire and Stoke on Trent Mortality Forum recently received a patient story which was presented by the Palliative Care forum. This story, kindly shared by the husband of Sue, a local patient, focussed on the challenges of multiple ward/attendances and lack of joined up care prior to her death.</p> <p>Mike, the patient's husband, is keen that this is shared and used to support learning and improvement. Mike is attending the Patient Safety Learning Conference, organised by Staffordshire and Stoke on Trent ICB which is taking place on January 12th. He will be supported by Katherine House Hospice director of care and MPFT's Service Development and Transformation Lead for Frailty.</p> <p>The animation is very focussed on continuity and system sharing and whilst brief, summarises clearly the impact on patients when care is not joined up. The potential for learning from this experience spans far beyond palliative care patients and if adequately considered would not only streamline and improve the patient journey but may also present opportunities for improvements in efficiency.</p>

(7) Recommendations to Board / Committee:
Members of the Board are asked to watch the short video which Mike has produced and to consider the impact that the lack of joined up care can have. Members are also asked to consider the learning from this experience when making decisions and planning future changes to services.

Report to:	Integrated Care Board					
Date:	29 January 2026					
Title:	Q3 2025/26 System Board Assurance Framework (SBAF) Update					
Presenting Officer:	Paul Winter, Associate Director of Corporate Governance					
Author(s):	Lia Pitarokoili, Head of Governance					
Document Type:	Report	If Other: Click or tap here to enter text.				
Action Required (select):	Information (I)	<input type="checkbox"/>	Discussion (D)	<input checked="" type="checkbox"/>	Assurance (S)	<input checked="" type="checkbox"/>
	Approval (A)	<input type="checkbox"/>	Ratification (R)	<input type="checkbox"/>	<i>(check as necessary)</i>	
Is the decision within SOFD powers & limits	Yes / No	NO				
Any potential / actual Conflict of Interest?	Yes / No	NO <i>If Y, the mitigation recommendations –</i> Click or tap here to enter text.				
Any financial impacts: ICB or ICS?	Yes / No	NO <i>If Y, are those signed off by and date:</i> Click or tap here to enter text.				
Any impacts on ICB Undertakings?	Yes / No	NO <i>If Y, are those signed off by and date:</i> Click or tap here to enter text.				
Appendices:	SBAF Q3 2025/26 report					

(1) Purpose of the Paper:

The enclosed report sets out a high level summary of the updated System Board Assurance Framework (SBAF) for Quarter 3 2025-26 and is submitted to ICB Board for oversight and assurance. The SBAF has been presented to or circulated offline in full among all SSOT ICB Committees during December - January.

(2) History of the Paper & Whether for I-D-S-A-R (as above):	Date
ICB Board Assurance Committees (D-S)	December 2025 – January 2026




(3) Implications:

Legal or Regulatory	UK Corporate Governance Codes and Controls Assurance Audits. SBAF completion is a key component of the ICB's Risk Management Strategy.
CQC or Patient Safety	There are no implications for CQC or other regulators
Financial (CFO-assured)	Managing financial risks will help mitigate Financial Management Concerns
Sustainability	Managing 'Greener NHS' risks will help mitigate Sustainability Concerns
Workforce or Training	Mitigation of workforce risks to meet the requirements of NHS Long Term Workforce Plan. There are no training implications resulting from this paper
Equality & Diversity	N/A

Due Regard: Inequalities	N/A
Due Regard: wider effect	N/A

(4) Statutory Dependencies & Impact Assessments:			
Assessment	Completed?	If No / N/A – Rationale	If Yes – Outcome & Date Reported / Signed off
DPIA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A	N/A in relation to this report	Reported to IG Committee: Click or tap to enter a date.
EIA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A	N/A in relation to this report	Outcome and date of completion: Click or tap here to enter text.
QIA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A	(enter rationale, per ICB QIA Policy, that it does not impact on quality of services) N/A in relation to this report	SRO sign-off, outcome & date of completion: Click or tap here to enter text.
Has there been Public / Patient Involvement?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A		Click or tap here to enter text.

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

(6) Executive Summary, incl. expansion on any of the preceding sections:	
<p>The System Board Assurance Framework (SBAF) sets out the principal risks to the achievement of the ICB's Strategic Ambitions and provides a structured means through which Committees can assess delivery against those. It is also a key source of evidence in demonstrating how the ICB discharges its responsibility for internal control. The SBAF sets out the key controls in place to manage these risks, the assurances available on their effectiveness, any gaps in control or assurance, and the actions to further reduce each risk to our Strategic Ambitions.</p> <p>The attached SBAF provides the Board with the Q3 update for 2025/26. During Q3, objective owners reviewed the rationale for each risk level and assessed the progress made during the quarter, including mitigating actions undertaken. They evaluated the key controls framework, considered sources of planned assurance, and identified any gaps in control or assurance. While the full report presented to ICB Assurance Committees also included reflections on Q2 actions and progress made in the quarter, the high-level summary focuses on summarising a future actions plan aimed at improving assurance and further reducing risk levels.</p> <p>The SBAF includes eight Strategic Risks which provide coverage of the four Strategic Ambitions. The Strategic Framework is set out in Section 2 of the appended report.</p>	
	Seven Strategic Risks continue to be assessed as High this quarter, reflecting the ongoing complexity and system-wide challenges. SBAF 6: Sustainable Finances is assessed as Moderate .
	Risk levels across the seven Strategic Objectives have remained unchanged since Q2 2025/26. The only movement this quarter is a reduction in the risk level for SBAF 6: Sustainable Finances .
	SBAF 5: High Quality, Safe Care Outcomes has the highest number of linked operational risks (19) while SBAF 2: Responsive Patient Care (Non UEC Care) has the lowest number of linked operational risks (8).

	<p>Strategic Ambition 2: <i>Address inequalities in access, experience and outcomes from health and care services</i> and Strategic Ambition 3: <i>Achieve a sustainable and resilient Integrated Care System</i> remain the 'most threatened', each with 5 Strategic Risks posing a threat.</p>
	<p>The majority of Strategic Risks (6 out of 8) are currently rated as having 'Partial Assurance', indicating that while some controls are in place, further work is required to fully mitigate risks.</p>
	<p>SBAF 5: High Quality, Safe Care Outcomes and SBAF 8: Sustainable Workforce are the only strategic risks with 'Acceptable Assurance' at this time.</p>

(7) Recommendations to Board / Committee:

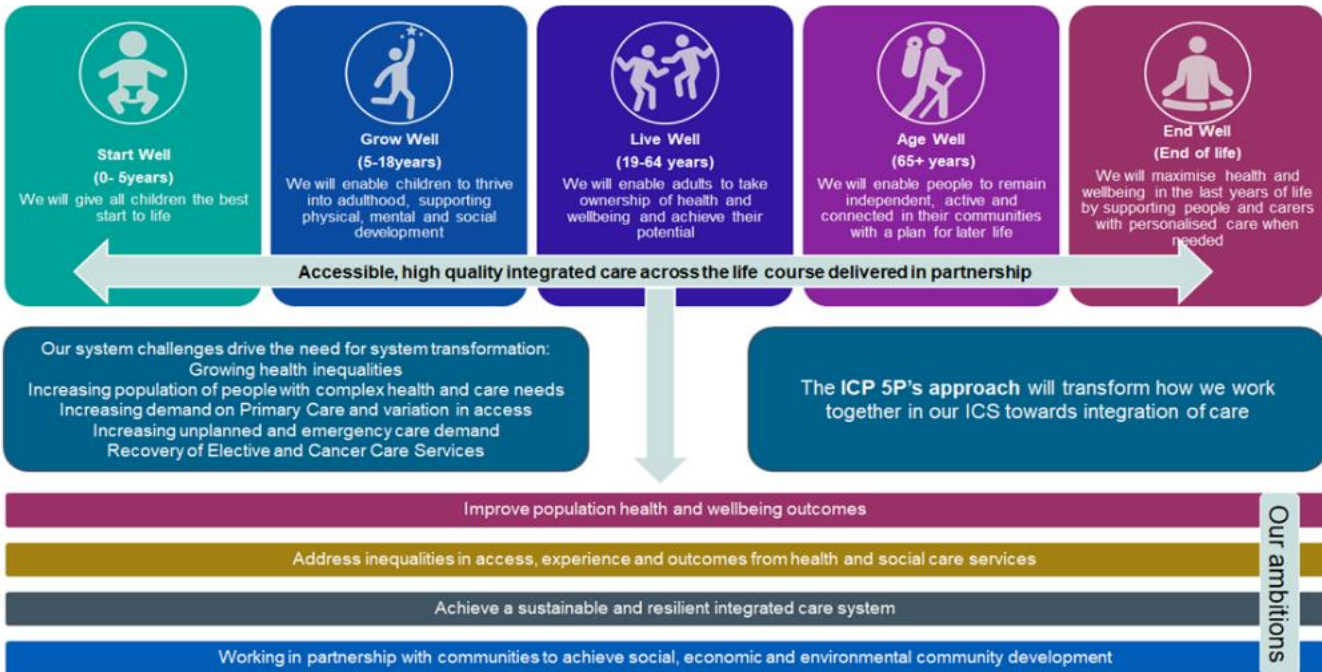
The ICB Board is asked to consider whether risk levels and assurance assessments are an accurate reflection of the position and discuss and confirm the adequacy of those controls and assessments.

System Board Assurance Framework (SBAF) Quarter 3 2025/26

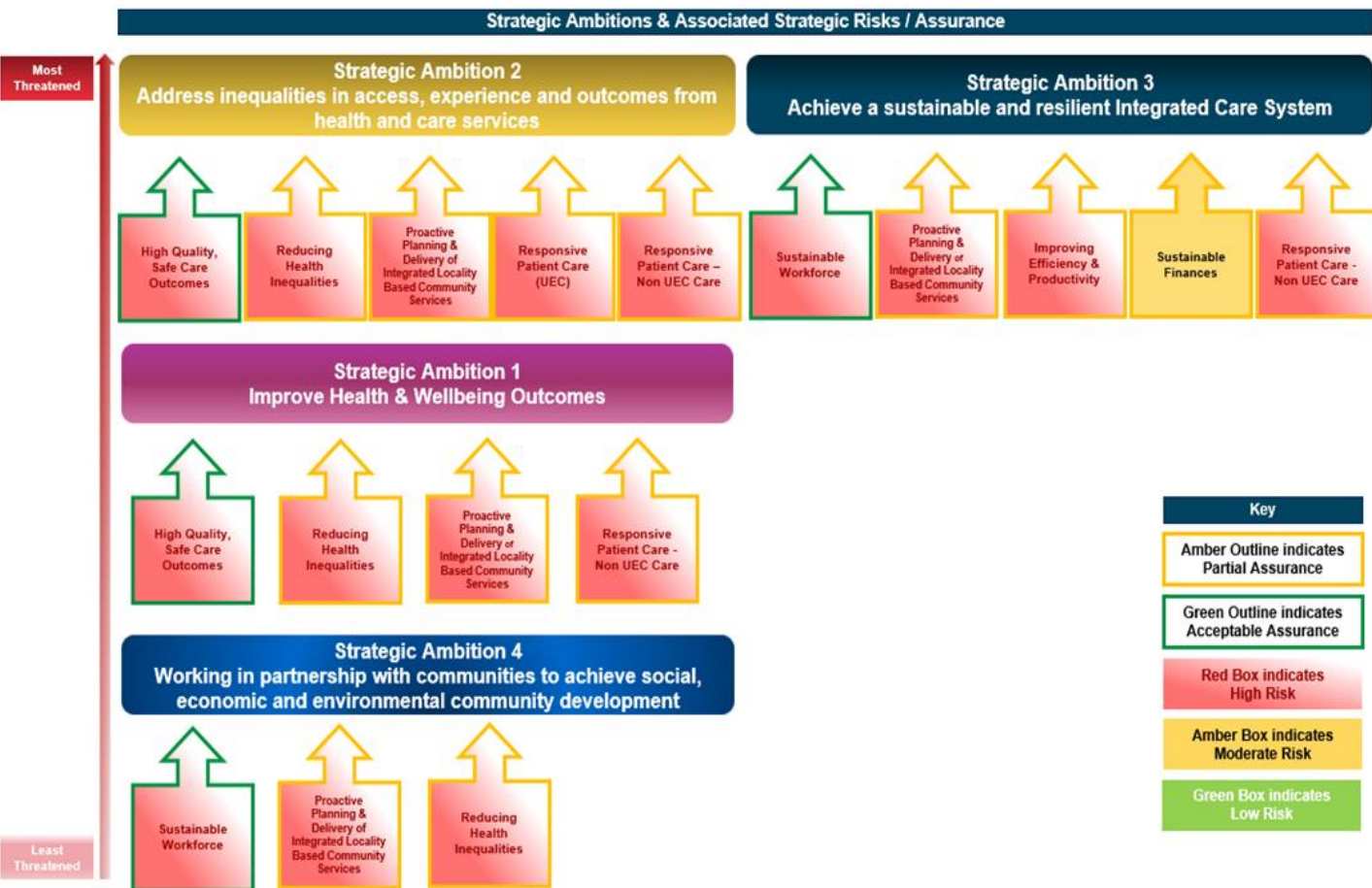


High Level Overview

Strategic Ambitions – Strategic Framework



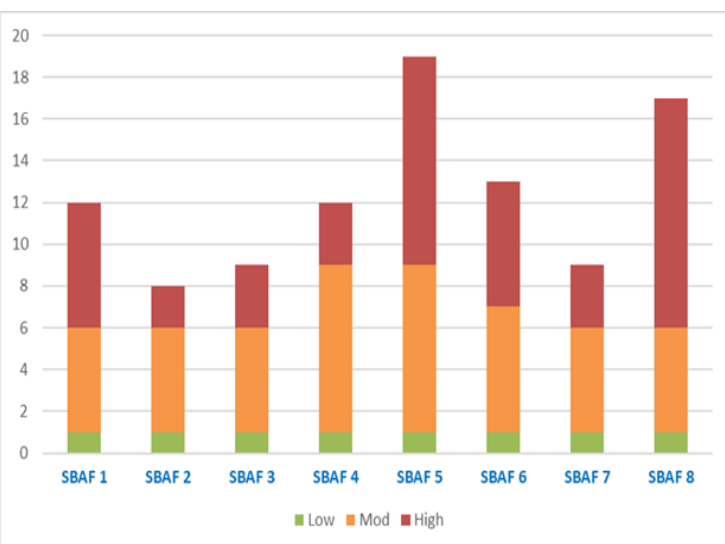
Threat to our Strategic Ambitions



Strategic Risk Summary

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

Risk Assessment and Linked Operational Risks



Seven Strategic Risks continue to be assessed as **High** this quarter, reflecting the ongoing complexity and system-wide challenges. **SBAF 6: Sustainable Finances** is assessed as **Moderate**.

Risk levels across the seven **Strategic Objectives** have remained **unchanged** since **Q2 2025/26**. The only movement this quarter is a **reduction** in the risk level for **SBAF 6: Sustainable Finances**

SBAF 5: High Quality, Safe Care Outcomes has the **highest** number of linked operational risks (19) while **SBAF 2: Responsive Patient Care (Non UEC Care)** has the **lowest** number of linked operational risks (8).

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

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



SBAF 1: Responsive Patient Care – Urgent & Emergency Care

Finance & Performance Committee | Chief Officer System Development & Integration

If the Urgent and Emergency Care (UEC) system does not have sufficient and appropriate capacity across the entire system pathway to meet demand and support flow, then should demand outstrip capacity, there will be pressure points within the UEC system, resulting in poor outcomes and experience for patients, increased pressure for our workforce and consequently poor performance and non-delivery of operational planning targets.

SA2: Address inequalities in access, experience and outcomes from health and social care services

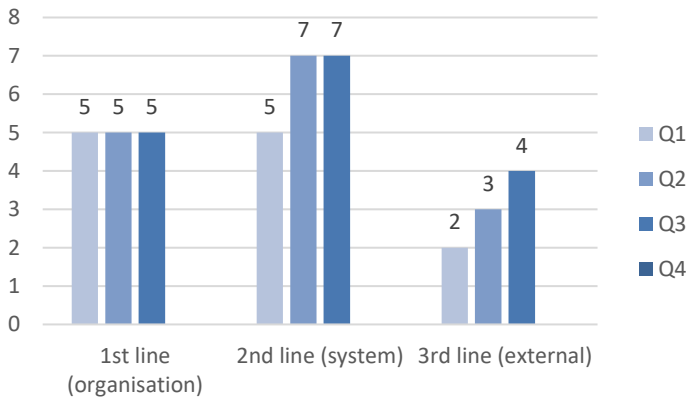
Assurance, Risk Level and Risk Tolerance

Partial Assurance	Q1	Q2	Q3	Q4	The consequence of not having the correct capacity in the UEC system will inevitably impact on delivery and patients not able to access the UEC they require. The biggest risk is having long waits for ambulances in the community.
	High	High	High		

Rationale for Risk Level & Progress Made in the Quarter

Throughout Q3 the key priority areas for improvement remain 4-hour Emergency Department (ED) performance towards achieving 78% by March 2026, 12-hour ED performance, reducing ambulance handover delays and therefore improving category 2 performance. Performance has been impacted by increased attendances, earlier than anticipated Infection Prevention (IP) demand, and workforce challenges, however a continued focus on delivery is required to support delivery of our operational planning commitments and subsequent risk reduction. Our UEC governance infrastructure continues to ensure collective leadership and system oversight of delivery and improvement, with all system partners. Additional support is in place both at a provider (UHNM) via GIRFT/ECIST and at a System Level via Tier 1 meetings. During the quarter the focus for the portfolio has been focussed on finalising the system wide surge plan and supporting mobilisation of the associated schemes. Development of the system-wide surge plan has been completed and been approved via a rigorous governance process. Final ratification has been received at ICB Board in November. The primary objective of the SSOT Integrated Care System is to work in partnership to ensure people receive the right level of care in the right location this winter, enabling an improved quality of experience, outcomes and flow across the system. The surge plan has enhanced oversight in place via Winter Oversight Group with a multi-faceted approach this year to the plan with leads from all key components of the system in place in a pillared approach. Daily oversight is provided by the SCC with strategic calls also in situ to support operational challenges with an SSOT Winter Director in place. The system escalation plan has been refreshed in tandem of the development of the system surge plan, which is developed with all system partners. Continuation of delivery of the UEC Improvement plan is ongoing and oversight is provided through UEC Governance. Key Delivery milestones and dependencies are monitored and reported through our governance to ensure oversight of the plan. The plan includes key deliverable of the Integrated Care Coordination Centre (ICC), Urgent Treatment Centres and the Discharge to Assess productivity review.

Assurance map



Summary Future Actions Plan

No	Action Required	Outcome
1	Delivery of System UEC Improvement Plan against trajectory	Achieve Operational Plan requirements; 4-Hour ED Target; 12-hour ED target; Cat 2 response – 30 mins
2	System surge planning	Development of system plan to mitigate increased activity prior, during & post winter
3	Integrated Care Coordination	Increasing appropriate utilisation and efficacy of system ICC offer

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



SBAF 2: Responsive Patient Care – Non UEC Care

(e.g. Elective, Cancer Diagnostics, Community/Mental Health/Primary Care)

Finance & Performance Committee | Chief Officer System Development & Integration

If the system fails to deliver on the specific expectations set out in the 2025/26 (and earlier) planning guidance relating to improvements of all aspects of health and care services, then services will not improve in line with national expectations, resulting in potential patient harm and reputational damage to the ICS.

SA1: Improve Health and Wellbeing Outcomes

SA2: Address inequalities in access, experience and outcomes from health and social care services

SA3: Achieve a sustainable and resilient Integrated Care System

Assurance, Risk Level and Risk Tolerance

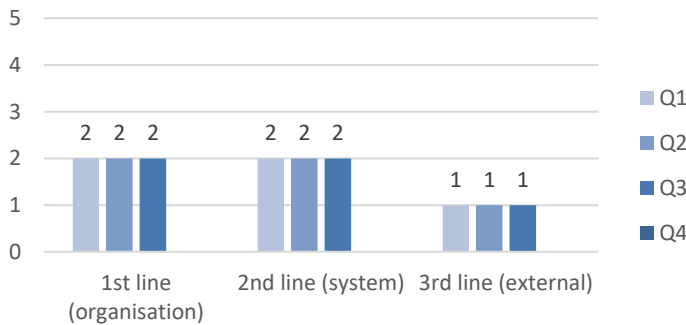
Partial Assurance	Q1	Q2	Q3	Q4	The tolerance of failing to deliver against this risk should be low as underachievement will have a knock-on effect to subsequent milestones. All efforts must therefore be focussed on delivery.
	High	High	High		

Rationale for Risk Level & Progress Made in the Quarter

Significant progress has been made in reducing long wait patient cohorts. However, at the end of September 2025 there were 139 patients waiting over 65 weeks. Work continues to improve this position, with a trajectory that aims to be as close to zero as possible by the end of the calendar year. The main specialities within this cohort are Ear, Nose and Throat; Ophthalmology; Orthopaedics; and Gynaecology. At UHNM additional activity is being delivered to support the clearance of long-waiters, which includes paediatric ENT weekend lists and super spine initiatives in trauma & orthopaedics. Performance against 52 week waits and time to first appointment is in line with the operational plan.

For cancer, the main drivers for being off plan are the number of referrals being higher than predicted for some tumour sites, most notably skin. A number of funding requests have been supported by the West Midlands Cancer Alliance for UHNM, which includes support to the skin pathway. In addition, support has been given for the colorectal pathway and gynaecology pathway, which are also priority pathways, along with support for pathology processing.

Assurance map



Summary Future Actions Plan

No	Action Required	Outcome
1	Develop plan for focused speciality review with end of end pathway approach	Identification of opportunities to reduce duplication and improve productivity
2	System capacity and demand review	Greater understanding of opportunities for productivity improvement
3	System collaborative for contracts to develop plans for efficiency and delivery of elective activity	Increased delivery of activity and continued reduction of long wait patients supporting Elective Recovery
4	Additional capacity investment to increase activity and productivity and clear remaining >65 week waits	Longest waiting patients treated
5	Provider indicative activity plans set that balance the national operational planning standards with levels of financial resources available	Greater control of activity and financial costs
6	Excluded Restricted Procedure (ERP) reflected in all provider contracts	Unapproved restricted procedures will not be funded to ensure that resources are spent effectively

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



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

Strategic Commissioning & Transformation Committee | Chief Officer Strategy & Improving Outcomes/ Chief Officer System Development & Integration

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

SA1: Improve Health and Wellbeing Outcomes

SA2: Address inequalities in access, experience and outcomes from health and social care services

SA3: Achieve a sustainable and resilient Integrated Care System

SA4: Working in partnership with communities to achieve social, economic and environmental community development

Assurance, Risk Level and Risk Tolerance

Partial Assurance	Q1 High	Q2 High	Q3 High	Q4	
					The consequence of not mitigating this risk and moving to a more proactive needs-based community model of care is that our system will remain reactive and reliant on services, particularly secondary and UEC. This will not meet the needs of our population, will challenge the sustainability of services and is not in line with our strengths-based strategy for our population.

Rationale for Risk Level & Progress Made in the Quarter

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

Crisis Assessment Centre (MPFT) – The new facility is on the St. George's Hospital site in Stafford. Operating 24 hours a day, seven days a week it will offer urgent assessment and support to individuals experiencing a mental health crisis who have come into contact with emergency services.

Crisis SMS Text Support - a New 24/7 urgent mental health support text services launched in October 2025.

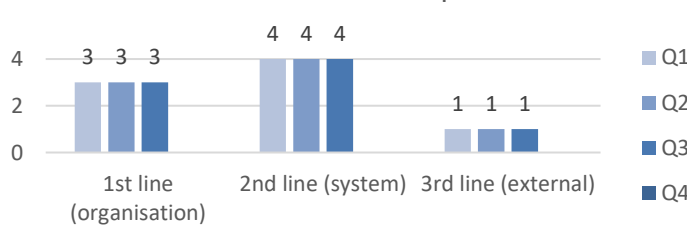
Community Mental Health Transformation: The implementation of the Mental Health Framework provides a historic opportunity to address this gap and achieve radical change in the design of community mental health care by moving away from siloed, hard-to-reach services towards joined-up care and whole population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

Intensive & Assertive Outreach ongoing review actions: A caseload management tool is in development and testing to compliment the clinical team working with this cohort of patients. This will assist with identification, management and on-going support for patients. On-going workforce training analysis is underway to determine the specific needs of the workforce supporting patients in this area and current gaps. Within the Integrated Community Equipment (ICE) contract, targeted initiatives, including the development of a new eligibility framework, refinement of decision-making panels, and sustained engagement with frontline teams, are driving improvements in service sustainability.

In parallel, the ongoing review and realignment of the Better Care Fund (BCF) ensures that resources are strategically deployed to meet population needs and strengthen system resilience. Further work is progressing to map and strengthen support for care homes, aiming to improve coordination across the system and promote greater consistency and equity in service provision.

Work on strengthening relationships with the local authorities continues with honouring secondment opportunities and joint commissioning meetings. Through our 2025/26 Neighbourhood Health and Care programme we will standardise our approach using 6 core components for consistency. The integrated care system will prioritise specific groups within this cohort where there is the greatest potential to improve levels of independence and reduce reliance on hospital care and long-term residential or nursing home care. A system wide review of Frailty and Falls services is being undertaken in order to deliver a consistent service offer which focuses on prevention of falls, proactive and reactive service offer.

Assurance map



Summary Future Actions Plan

No	Action Required	Outcome
1	Agree neighbourhood footprint aligned to PCNs and early implemented sites	Clarity to PCNs and other Providers
2	Agree changes to Stoke Joint Commissioning Boards (JCB) governance	Strengthened governance with broader system membership
3	Alignment of Community Transformation Programmes to the Better Care Fund (BCF) to maximise value for money and implementation of neighbourhood health	Clarity on BCF funding to support neighbourhood health

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



SBAF 4: Reducing Health Inequalities

Strategic Commissioning & Transformation Committee | Chief Officer Strategy & Improving Outcomes

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

SA1: Improve Health and Wellbeing Outcomes

SA2: Address inequalities in access, experience and outcomes from health and social care services

SA4: Working in partnership with communities to achieve social, economic and environmental community development

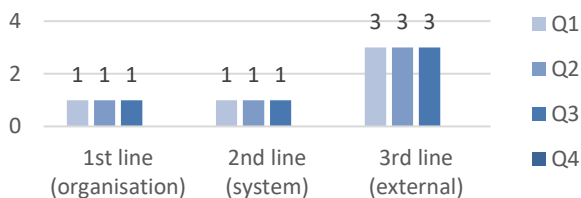
Assurance, Risk Level and Risk Tolerance

Partial Assurance	Q1 High	Q2 High	Q3 High	Q4	Tolerance is low as reducing health inequalities and working in partnership impacts on 3 of the 4 Strategic Ambitions. The target date is long-term and as such risk scoring would be expected to reduce over a longer period as health inequalities improvement is made and can be demonstrated.
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Rationale for Risk Level & Progress Made in the Quarter

Early targets for progress to reduce health inequalities were set against the agreement of an Integrated Care Partnership Strategy which was published at the end of March 2023, (this was reflected in the target risk). Evaluation of the reduction of health inequalities will be over a longer period (c. 10 years) and the target risk will be reviewed on this basis. The foundations to achieving this have been progressed in terms of the Integrated Care Partnership Strategy, Health Inequalities Strategy, Alcohol Strategy, procurement of a strategic partner to support the scale, spread and sustainment of a Population Health Management approach for SSOT that will positively impact on HI, establishment of the Improving Population Health (IPH) Portfolio Board, agreement of localities inside the two Place's aligned with UTLA's (Staffordshire – District and Borough Council alignment (8) and Stoke-on-Trent – Geographical alignment (4)), and now the launch of the Locality Improvement Framework (LIF) at Q1 2025/26. The LIF invests £2.2m in localities, providing a basis to incentivise integrated locality working based on population need and reducing health inequalities. Each locality will have an allocation of funding that it will be able to use for projects that will have clear and measurable impact on health outcomes, following changes in lifestyle and behaviour by working together as integrated community services. Sprints have taken place across all 12 localities to use the data to segment the population and identify cohorts who have poor outcomes. 7 proposals have been received from across Staffordshire, with 6 having been through Evaluation Panels, 5 approved by the IPH Portfolio Board and 4 localities (including 3 x Stoke localities) continuing to develop their proposals. Letter received from Department of Health and Social Care (DHSC) and NHS England (NHSE) outlining their reflections on SSOTs progress against the Core20Plus5 framework and the five strategic healthcare inequalities priorities. Their assessment drew on the information provided during a full day visit, as well as operational plans, system strategies, stocktake reports, and Quarterly System Review Meetings (QSRM) submissions.

Assurance map



Summary Future Actions Plan

No	Action Required	Outcome
1	Develop HI Outcomes Framework	Additional Control
2	LIF Delivery	Additional Assurance
3	HI Annual Report	Additional Assurance
4	Impact Sustainability	Additional Control

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



SBAF 5: High Quality, Safe Care Outcomes

Quality & Safety Committee | Chief Nursing & Therapies Officer

If we cannot ensure high quality, equitable and safe patient care, then we will be unable to achieve high standards of quality and safety, resulting in actual or potential harm to patients, loss of reputation, intervention from regulators, failure to deliver our statutory quality duties and increased costs associated with poor standards of care

SA1: Improve Health and Wellbeing Outcomes

SA2: Address inequalities in access, experience and outcomes from health and social care services

Assurance, Risk Level and Risk Tolerance

Acceptable	Q1 High	Q2 High	Q3 High	Q4	The system will prioritise quality and safety over performance and finance to prevent patient harm but will tolerate moderate risk levels resulting from system pressures.
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Rationale for Risk Level & Progress Made in the Quarter

UEC: The SSOT System Winter Plan 2025/26, developed collaboratively with system partners has been presented and approved by QSC. The plan introduces a new 'pillars' approach with named leads to strengthen oversight and resilience. A successful multi-partner Winter Plan exercise tested preparedness and identified opportunities for improvement. An extraordinary harms group has been convened to agree the process for assurance, harm review touch points and understanding patient experience which will be reported through to QSC and UEC Board.

Perinatal Services: The LMNS continues to deliver Year 3 of the maternity and neonatal improvement plan with oversight through QSOF and LMNS Partnership Boards. Five priority areas have been identified: preconception and antenatal health, data and infrastructure, neonatal and maternal care, tackling inequalities, and strengthening engagement and co-production. Key risks remain across workforce and service delivery, including midwifery deficit and AHP shortages in neonatal services.

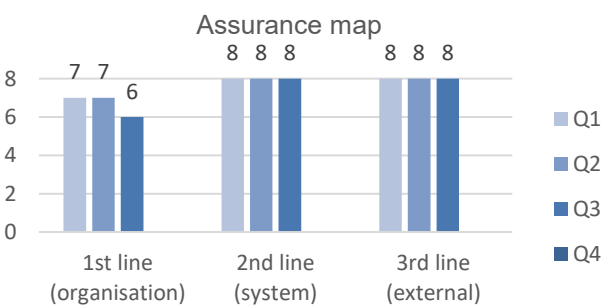
IHA/RHA: Initial Health Assessment (IHA) timeliness is 84% against a target of 85%, demonstrating continued positive progress except for children placed outside our area. Review Health Assessment (RHA) timeliness is currently 15% against a threshold of 85%, with month-on-month improvement and full recovery expected by March 2026.

QIA: NHS England's independent review determined Significant Assurance that SSOT QIA process was robust and sustainable. The ICB was asked to strengthen partner inclusion and patient voice in the QIA process and policy renewal.

Wheelchair Services: Service users waiting 18+ weeks decreased for 11 consecutive months (71% reduction) but increased in the last 5 months; longest waits remain at 78 weeks (adults) and 82 weeks (CYP). A Contract Performance Notice led to a Joint Investigation and Remedial Action Plan, and a new wheelchair contract is being procured for April 2026.

Paediatric Hearing Screening Improvement Programme (PHSIP): UHNM required to undertake a full five-year ABR review, now on track for December 2025 completion. Recall Clinics commenced in November 2025, supported by harm reviews and Duty of Candour processes.

Right Care, Right Person (RCRP): Escalations over perceived non-adherence led to a joint health-police review of four incidents; no similar cases since March 2025. Key improvements include clear governance and relaunching RCRP for consistent understanding across the system.



Summary Future Actions Plan

No	Action Required	Outcome
1	Collaboration with system partners and regional and national ICBs to look at innovative ways of improving the IHA challenges locally, regionally and nationally.	Reduction in timeline
2	Collaboration with system partners and regional and national ICBs to look at innovative ways of improving the IHA challenges locally, regionally and nationally	Reduction in backlog and waiting times
3	ED Harms oversight approach with UHNM established which will see bi-monthly visits to ED supporting continuous learning and improvement approach.	Patients experience safe and effective care
4	Collaborative approach to understanding and mitigating risk and potential harm resulting from delays within specific service provision.	The potential for harms as a result of a delay is reduced
5	Maternity Transformation plan in place which outlines a 3-year approach to improving services.	Achieve Ockenden recommendations and respond to national guidance/requirements across maternity and neonatal services
6	Develop a SSOT Multi-Agency Thematic Review/Deep Dive into ongoing incidents around the RCRP process.	Compliance with the RCRP national framework
7	System approach to improving outcomes of patients who are CHC eligible.	Individualised and need appropriate care commissioned which supports optimum patient outcomes

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



SBAF 6: Sustainable Finances

Finance & Performance Committee | Chief Finance Officer

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

SA3: Achieve a sustainable and resilient Integrated Care System

Assurance, Risk Level and Risk Tolerance

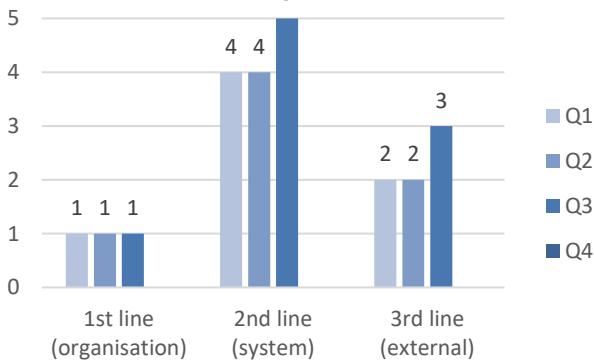
Partial Assurance	Q1 High	Q2 High	Q3 Mod	Q4	Tolerance is high as costs related to maintaining patient safety and workforce issues may cause additional financial demand.
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Rationale for Risk Level & Progress Made in the Quarter

At Month 7, the System is reporting a £18.7m deficit, representing a £0.7m favourable variance against the planned £19.4m deficit (£0.7m favourable at Month 6). Year-to-date, this includes deficits of £12.5m for the ICB, £10.4m at UHNM and £0.1m at NSCHT (partial offset with surplus of £4.0m at MPFT).

As a System we are forecasting to meet our year end financial plan of break even, subject to the receipt of £95m deficit support funding (DSF). Net risk has reduced to £12.9m at Month 7 down from £24.7m at Month 6, which is in line with the expectation of c£13.5m. This net risk is primarily made up of efficiency risk (£27.2m), additional cost risk (£24.0m) and offset by non-recurrent mitigations and anticipated allocations. UHNM holds the remaining net risk of £12.9m aligned to the recovery plan, with all other partners having fully mitigated their positions. UHNM have produced further actions to mitigate their risk and engaged Deloitte on 4 programmes of work.

Assurance map



Summary Future Actions Plan

No	Action Required	Outcome
1	System to focus on identification and delivery of additional efficiency plans to mitigate the current unidentified savings gap primarily through the touch choices workstream.	Additional Assurance
2	System Finance and Operational Teams to develop a medium-term plan to define the transformational solutions and actions that will ensure the delivery of the integrated care strategy and trajectory for return to financial sustainability.	Additional Assurance
3	Financial Recovery Director in post to ensure delivery of the CIP target.	Additional Assurance
4	Deloitte/Kingsgate to continue support to a number of projects to reduce the risk to CIP delivery and financial improvement.	Additional Control
5	Provider Collaborative to develop the CIP of £14.2m for Enabling Functions	Additional Control

SBAF 6	Risk Title	Risk Score
1205	Potential Counter Fraud Risk	9
1479	De-escalation of system surge capacity	8
1503	NHS Reform Requirements	9
1504	ICB Statutory duties & functions - delivery	9
1505	ICB Statutory duties & functions - reassignment	9
1506	ICB Capacity and capability to lead the ICS	4
1507	ICS Capacity and capability to support system working	9
1510	Maternity and neonatal voices partnership (MNVP) contribution to achieving Maternity Incentive Scheme (MIS) for Trusts standard 7	9
1523	Planned care savings targets not achieved	20
1528	Delivery of the 2025/26 System Financial Plan	20
1551	System Surge Capacity	20



SBAF 7: Improving Efficiency and Productivity

Finance & Performance Committee | Chief Finance Officer

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

SA3: Achieve a sustainable and resilient Integrated Care System

Assurance, Risk Level and Risk Tolerance

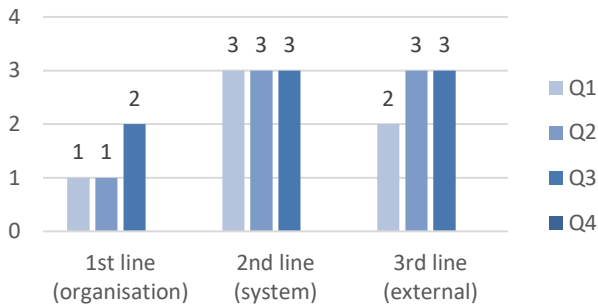
Partial Assurance	Q1	Q2	Q3	Q4	Efficiency and Productivity improvement is an essential ingredient of the System Plan and so a lower risk appetite target has been set.
	High	High	High		

Rationale for Risk Level & Progress Made in the Quarter

At Month 7, the reported System efficiency delivery YTD is £16.6m behind our submitted plan of £158.4m, this comprises of ICB (£10.3m), MPFT £0.5m, NSCHT (£0.5m) and UHNM (£6.3m). As a System this equates to 90% delivery YTD. We are continuing to monitor the development of the efficiency plans weekly. UHNM have submitted a recovery plan to NHSE which improves the forecast delivery.

All providers have productivity programmes which underpin elements of their efficiency plans. These are monitored via their own PMOs and where financially assessed, reported as part of their efficiency plans. Each organisation continues to focus on development of further recurrent CIPs and to seek non-recurrent mitigations to manage the risk of non-delivery.

Assurance map



Summary Future Actions Plan

No	Action Required	Outcome
1	Continue to develop and apply the agreed System approach to improving productivity encompassing all sectors.	Additional Assurance
2	Further support projects are currently being considered and scoped to further deliver against financial improvement targets/CIP	Additional Assurance
3	Primary Care Collaboratives fully in place covering all of SSoT	Additional Assurance

SBAF 7	Risk Title	Risk Score
1176	Digital Cyber security	16
1180	NHS Provider License	10
1503	NHS Reform Requirements	9
1504	ICB Statutory duties & functions - delivery	9
1505	ICB Statutory duties & functions - reassignment	9
1506	ICB Capacity and capability to lead the ICS	4
1507	ICS Capacity and capability to support system working	9
1526	Planned care national and local performance standards not achieved	16



SBAF 8: Sustainable Workforce

People, Culture & Inclusion Committee | Chief People Officer

If recruitment activity across the ICS reduces due to financial pressures; and there is an ongoing reduction in recruitment to non-registered and / or trainee posts, then workforce gaps will increase, employee health and wellbeing will be affected, and turnover may increase; and the future pipeline will destabilise, resulting in the inability to meet the requirements of the NHS Long Term Workforce Plan, deterioration of employee health, wellbeing and retention, with actual or potential impact on service delivery and quality of care.

SA3: Achieve a sustainable and resilient Integrated Care System

SA4: Working in partnership with communities to achieve social, economic and environmental community development

Assurance, Risk Level and Risk Tolerance

Acceptable	Q1	Q2	Q3	Q4	Tolerance is high in recognition of the workforce pressures and financial position. The system work programmes focus on reform, collaboration, productivity, maintaining safe staffing levels to reduce the impact.
	High	High	High		

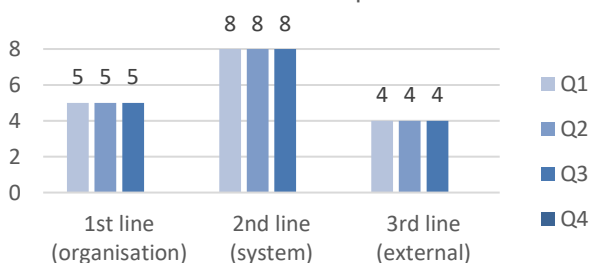
Rationale for Risk Level & Progress Made in the Quarter

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

Summary of the risk register, rationale for the Q3 score and progress as follows:

- All risks reflect the challenging 25/26 Operational Plan, NHS & ICB Infrastructure reductions and Reform.
- Additional risks have been added during the quarter to reflect the progress in NHS Reform, challenges linked to national process, and risks associated with an increasingly pressured and unstable workforce.
- All residual risk scores on the risk register are currently 16 or under.
- Regular review and scrutiny around risks continues via PCI Committee, ensuring risks are reflective of the system-wide health and social care workforce challenges. Established links with the Quality & Safety Committee to review and strengthen mitigation for cross-cutting risks.
- In addition to individual risk actions, the overarching risk is being addressed via targeted programmes of work, interventions and collaborative work at System and organisational level with evidence of an improved position in several areas including retention, wellbeing and strengthening the future pipeline.
- Whilst turnover is stable, sickness absence rates continue to increase – an indication of the current environment. Actions continue at Trust and System level to prevent further deterioration through prevention and targeted support. All monitored and driven via the ICS Employee Experience, Health and Wellbeing Sub-Committee – with alignment to the System Population Health, Health Inequalities and Prevention Strategies. Specific actions in place to support our workforce during winter and promotion of staff vaccinations.
- In addition, the 2024 Staff Survey Results have been analysed at Trust and System level, with actions being delivered to further improve experience and wellbeing of our workforce. The 2025 survey is currently live.
- The System OD plan is currently being reviewed to address the risk around culture, behaviour and leadership in an uncertain and financially challenged environment.
- An ICB/ICS People Delivery Plan for 2025/26 is in place following some delays due to awaiting the new Long Term Workforce Plan. It will be refreshed once the new workforce plan is published. The plan considers the overarching workforce risks, metrics, challenges and priorities, aligned to the 25/26 Operational Plan.

Assurance map



Summary Future Actions Plan

No	Action Required	Outcome
1	Collaboratively review and update the long-term ICS People Plan in line with ICB Blueprint, 10 Year Plan and refreshed Long Term Workforce Plan	Additional Assurance
2	Horizon Scanning for alternative workforce development funding sources.	Additional Assurance
3	Refresh System redeployment process and agreement/MOU	Additional Assurance

SBAF 8	Risk Title	Risk Score
1191	Employee health, wellbeing and experience	16
1239	Neonatal consultant workforce	12
1253	Digital Workforce recruitment and retention	6
1444	Demand for paediatric dietetic services	20
1479	De-escalation of system surge capacity	8
1503	NHS Reform Requirements	9
1505	ICB Statutory duties & functions - reassignment	9
1506	ICB Capacity and capability to lead the ICS	4
1507	ICS Capacity and capability to support system working	9
1504	ICB Statutory duties & functions - delivery	9
1511	Ability to deliver the 25/26 Operational workforce plan	16
1512	Ability to deliver required ICB & NHS Infrastructure reductions	16
1513	Impact of focussing on and implementing NHS Reform	16
1514	Ability to deliver the workforce transformation and change	16
1515	Impact on culture behaviour and leadership of uncertain and significantly financially challenged environment	16
1551	System Surge Capacity	20

Enclosure No: 10

Report to:	Integrated Care Board					
Date:	29 January 2026					
Title:	2026/27 Planning Update					
Presenting Officer:	Claire Skidmore, Chief Finance Officer					
Author(s):	Helen Dempsey, Director of Planning, and Julie Garside Director of Planning and Intelligence, Vicki Inch, Associate Director of Planning and Intelligence and Angie Parkes, Deputy Director of Planning and Performance					
Document Type:	Other		If Other: Summary slides			
Action Required (select):	Information (I)	<input type="checkbox"/>	Discussion (D)	<input checked="" type="checkbox"/>	Assurance (S)	<input checked="" type="checkbox"/>
	Approval (A)	<input checked="" type="checkbox"/>	Ratification (R)	<input type="checkbox"/>	<i>(check as necessary)</i>	
Is the decision within SOFD powers & limits	Yes / No	YES				
Any potential / actual Conflict of Interest?	Yes / No	NO <i>If Y, the mitigation recommendations – Click or tap here to enter text.</i>				
Any financial impacts: ICB or ICB?	Yes / No	YES <i>If Y, are those signed off by and date:</i> The planning process includes finance elements.				
Any impacts on ICB Undertakings?	Yes / No	YES <i>If Y, are those signed off by and date:</i> The planning process includes activity, finance and workforce elements.				
Appendices:	Planning Update					

1. Purpose of the Paper:

This paper provides an update on the 17th December planning submission and development of the 5-Year Strategic Commissioning Plan, which reflect local and national ambitions set out in the 10- Year Health Plan and Medium Term Planning Framework. The paper also sets out the approach for the next submission, including review and alignment of plans, development of draft five year commissioning plan, and governance.

2. History of the Paper & Whether for I-D-S-A-R (as above):

N/A

Date

Click or tap to enter a date.

3. Implications:

Legal or Regulatory	Part of the NHS England regulatory planning process.
CQC or Patient Safety	Quality of care, access and outcomes are an area of focus in the planning process.
Financial (CFO-assured)	Finance and use of resources are an area of focus in the planning process.

Sustainability	Sustainability is a key part of the planning process.
Workforce or Training	Workforce is a key aspect of the planning process.
Equality & Diversity	Equality & Diversity is a key aspect of the planning process.
Due Regard: Inequalities	Due regard for inequalities is a key aspect of the planning process
Due Regard: wider effect	Planning will be system focussed and have regards to the wider effect.

4. Statutory Dependencies & Impact Assessments:			
Assessment	Completed?	If No / N/A – Rationale	If Yes – Outcome & Date Reported / Signed off
DPIA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A	Click or tap here to enter text.	<i>Reported to IG Committee:</i> Click or tap to enter a date.
EIA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A	Click or tap here to enter text.	<i>Outcome and date of completion:</i> Click or tap here to enter text.
QIA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A	<i>(enter rationale, per ICB QIA Policy, that it does not impact on quality of services)</i> Click or tap here to enter text.	<i>SRO sign-off, outcome & date of completion:</i> Click or tap here to enter text.
Has there been Public / Patient Involvement?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A	Click or tap here to enter text.	

5. Integration with the System Board Assurance Framework & Key Risks:					
SBAF1	Responsive Patient Care - Elective	<input checked="" type="checkbox"/>	SBAF5	High Quality, Safe Outcomes	<input checked="" type="checkbox"/>
SBAF2	Responsive Patient Care - UEC	<input checked="" type="checkbox"/>	SBAF6	Sustainable Finances	<input checked="" type="checkbox"/>
SBAF3	Proactive Integrated Community Services	<input checked="" type="checkbox"/>	SBAF7	Improving Productivity	<input checked="" type="checkbox"/>
SBAF4	Reducing Health Inequalities	<input checked="" type="checkbox"/>	SBAF8	Sustainable Workforce	<input checked="" type="checkbox"/>

6. Executive Summary, incl. expansion on any of the preceding sections:
<p>2026/2027 Planning Round Update</p> <p>As part of the 2026/2027 planning round, the first submission was made on 17 December 2025. The first submission included: 2-Year Finance Plans, 4-Year Capital Plans, 2-Year Performance and Activity Plans, Integrated Planning Template, 2-Year Workforce Plans, and Board Assurance Statements</p> <p>The initial assessment against the Medium-Term Planning Framework (MTPF) ambitions and targets at ICB level was considered and discussed at the Board meeting on 9th December, followed by a formal sign-off meeting on 16th December. At the sign-off meeting, the final submission was reviewed and approved.</p> <p>We will continue to work closely with partners and NHS England to ensure the plans align with both national and local ambitions. This includes understanding the gap between current performance and the level of improvement required, and setting out the steps needed to achieve the agreed ambitions.</p> <p>The next submission is due on 12th February and will build on these components, incorporating the development of the 5-Year Strategic Commissioning Plan submission.</p> <p>Providers are expected to submit a 5-year delivery plan as part of the February submission.</p>

Development of the 5-Year Strategic Commissioning Plan

In line with the 10-Year Health Plan and the MTPF, Integrated Care Boards are required to produce a 5-Year Strategic Commissioning Plan, in addition to the December submissions. This needs to be submitted on 12th February 2026.

These plans are designed to support the delivery of local ambitions while aligning with the shared national ambitions set out in the 10-Year Plan, including the three key shifts. The Strategic Commissioning Plan will outline how the ICB intends to deliver its strategy over the five-year period from 2026/27 to 2030/31.

We will follow the broad national outline structure for the 5-Year Strategic Commissioning Plan, ensuring consistency with national guidance while reflecting local ambitions. The plan will cover: health and population context, commissioning intentions, finance and workforce, transformation and new care models, digital and infrastructure enablers, and risk and mitigations.

7. Recommendations to Board / Committee:

- Note the 17th December submission
- Note the development of a 5-Year Strategic Commissioning Plan
- Note the next steps required to meet the final submission deadline of the 12th of February.

Planning Submission Update

Public Board 15th January 2026



First Submissions - 17th December - Recap

- As part of the 2026/2027 planning round, the first ICB submission was made on 17 December 2025.

What was included in this submission?

- Each statutory organisation submitted detailed plans covering key areas of delivery.
- Provider submissions are more detailed than ICB submissions, reflecting operational and service-level requirements.



Next Submission – 12th February

As part of the 2026/2027 planning round, the next submission needs to be made on 12th February 2026.

What is included in this submission?

- The first submission on 17 December focused on shorter-term planning requirements, including 2-year finance and workforce plans, 4-year capital plans, and activity/performance plans. These provided an initial view of how the system will meet immediate priorities and national guidance.
- The next submission on 12 February will build on this foundation and include additional detail and longer-term planning elements. This will extend financial and workforce plans to three years, incorporate updated performance trajectories, and introduce the 5-Year Strategic Commissioning Plan for ICBs and 5-Year delivery plans for providers.

3-year finance plans

4-year capital plans

3-year performance and activity plans

Integrated planning template

3-year workforce

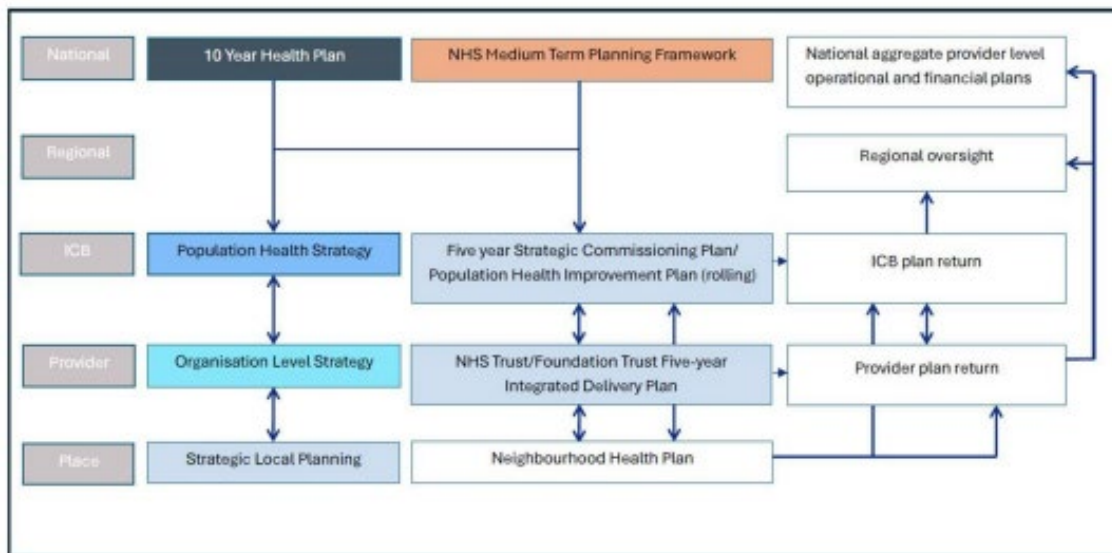
Board assurance statements

5-year commissioning plan (ICBs);
5-year delivery plans (Providers)

3-year ambulance operational plans (Ambulance Trusts only)

5 Year Commissioning plan

- As set out in the 10-Year Health Plan and the Medium-Term Planning Framework, ICBs are expected to produce a 5-Year Strategic Commissioning Plan.
- These plans are intended to support the delivery of both local priorities alongside the shared national ambitions outlined within the [10-Year Plan](#), such as the three shifts.
- The 5-Year Strategic Commissioning Plan will set out how the ICB intends to deliver its strategy for the five-year period, 2026-27 to 2030-31. The figure below illustrates the wider relationship between the key elements of the national planning architecture.
- There is a national outline structure for the ICB 5-Year Strategic Commissioning Plan. We will be following the broad national outline structure for the ICB 5-Year Strategic Commissioning Plan. This approach ensures consistency with national guidance while allowing flexibility to reflect local priorities and needs.



5 Year Commissioning plan – National Structure

1. Executive summary	<ul style="list-style-type: none"> • Overview of the ICB's Commissioning Strategy including vision and desired outcomes • How the Strategic Commissioning plan will seek to deliver the outcomes and key points of the plan
2. Health economy / Population health context	<ul style="list-style-type: none"> • Summary of integrated needs assessment and baseline mapping of current performance and quality of commissioned services • High level analysis of population health need now and in the future, the health and care economy and the implications of 10YHP and objectives in MTPF-delivering change together for the development and commissioning of provision. • Assessment of the quality, performance and productivity of existing provision and improvement opportunities including relevant benchmarking and clear identification of underserved communities
3. Commissioning intentions for 2026/26 – 2030/31	<ul style="list-style-type: none"> • A methodology/framework to set out priority commissioning intentions over the five-year period • Each priority/commissioning intention as a minimum should include: <ul style="list-style-type: none"> • defined outcomes and metrics • clear milestones and delivery timescales • delivery scale (e.g., neighbourhood, place, ICB, pan-ICB — potentially one or more levels) • governance arrangements
4. Finance	<ul style="list-style-type: none"> • An overview of the financial ambitions over the 5 years • Evidence of the financial rigour applied in decision making and the maintaining of long-term financial sustainability
5. Workforce	<ul style="list-style-type: none"> • Identify how their strategic commissioning plan will be impacted and supported by the workforce, including consideration of the workforce impact and implications of the 10YHP, the Medium-Term Planning Framework, and the Strategic Commissioning Framework • Set out the organisations strategic vision for its workforce across 5 years, including how the workforce will support the three shifts and the required productivity improvements
6. Transformation and new care models	<ul style="list-style-type: none"> • A description of the organisations approach to transformation • Summary of how the organisation will co-ordinate and work with all partners to deliver major transformation programmes including embedding digital transformation and enabling the 'left shift' by supporting the shift of resources from acute to community services and increasing community and neighbourhood health capacity • Description of new care models to maximise value for patients and taxpayers aligned to 10YHP and how the ICB will embed these models
7. Enablers	<ul style="list-style-type: none"> • Key enablers for the plan, how they will be resourced, any dependencies that have been considered in the development of the plan and how they will be aligned to support the plan. The key enablers could be: digital, data and technology; estates and facilities; workforce
8. Risk and mitigations	<ul style="list-style-type: none"> • Risk model • High-level risk analysis including: <ul style="list-style-type: none"> • assessment of likelihood • financial and non-financial impact • mitigating actions which should be implementable internally without the need for external resource i.e. additional funding from the centre

Next Steps to 12th February Submission (SSOT)

We have a structured process in place to ensure the development of robust plans that align with national guidance and local priorities. Key actions include:

Review and Alignment

- Ongoing iteration and review of submissions, ensuring ambitions are deliverable and realistic.
- Address any gaps between submissions and national expectations.
- Amend years 1 and 2 activity, performance, finance and workforce numbers
- Finalise year 3 activity and performance modelling
- Progress work on efficiency schemes

Development of Draft Strategic Commissioning Plan by 16th January

- Overview of strategic commissioning intentions with underpinning detail, actions and milestones
- Supporting narrative focused on wider organisation, transformation ambitions
- Alignment with provider 5-year delivery plans through task and finish group

Governance and Assurance

- Confirm and challenge sessions will review assumptions, risks, and dependencies.
- System planning meeting; specific provider contract and planning meetings
- Sign off: Initial update to ICB Board on 28 January 2026; Final amendments sign off by 11 February 2026

Next Steps to 12th February Submission (STW)

Key actions prior to final submission include:

Confirm and Challenge process:

- Review first submission and determine areas for focus
- Development of Key Lines of Enquiry (KLOEs) for ICB from first submission
- Confirm and challenge session to review prioritisation and KLOEs

System working:

- Identify areas for system wide focussed work for inclusion in plans by 9 January 2026
- Work to agree system wide impact of work by 21 January 2026
- Agree narrative for cross organisational issues by 21 January 2026
- Agreed to share 5-year Strategic Commissioning Plan and Provider 5-year Delivery Plans across system

Development of next iteration of plan by 21 January 2026:

- Amend years 1 and 2 activity, performance, finance and workforce numbers
- Develop year 3 activity, performance, finance and workforce numbers
- Update Integrated Strategic Needs Assessment
- Develop 5-year Strategic Commissioning Plan

Sign off of plan:

- Initial update to ICB Board on 28 January 2026
- Final amendments sign off by 11 February 2026

Report to:	Integrated Care Board					
Date:	29 January 2026					
Title:	Winter Plan Update					
Presenting Officer:	Phil Smith, Chief Officer System Development & Integration					
Author(s):	Hayley Allison (SSOT) & Gareth Wright (STW)					
Document Type:	Report	If Other: Click or tap here to enter text.				
Action Required (select):	Information (I)	<input checked="" type="checkbox"/>	Discussion (D)	<input type="checkbox"/>	Assurance (S)	<input type="checkbox"/>
	Approval (A)	<input type="checkbox"/>	Ratification (R)	<input type="checkbox"/>	<i>(check as necessary)</i>	
Is the decision within SOFD powers & limits	Yes / No	Choose an item.				
Any potential / actual Conflict of Interest?	Yes / No	NO <i>If Y, the mitigation recommendations –</i> Click or tap here to enter text.				
Any financial impacts: ICB or ICS?	Yes / No	NO <i>If Y, are those signed off by and date:</i> Click or tap here to enter text.				
Any impacts on ICB Undertakings?	Yes / No	NO <i>If Y, are those signed off by and date:</i> Click or tap here to enter text.				
Appendices:	Click or tap here to enter text.					

(1) Purpose of the Paper:

The purpose of this paper is to provide an update on the latest position of the Cluster Winter Plans. This is following an update to the Integrated Care Board meetings in September for Shropshire, Telford and Wrekin and November 2025 for Staffordshire and Stoke-on-Trent.

(2) History of the Paper & Whether for I-D-S-A-R (as above):

Date

Not applicable

Click or tap to enter a date.

(3) Implications:

Legal or Regulatory	Not applicable to this report.
CQC or Patient Safety	Achieving the best we can for patient care and outcomes under extreme operational pressure.
Financial (CFO-assured)	UEC contribution to Financial Plan 2025/26 by reducing cost of Escalation capacity and process improvements in Community pathways.
Sustainability	Not applicable to this report.
Workforce or Training	UEC contribution to the System Workforce Plan 2025/26, by reducing reliance upon temporary staffing.
Equality & Diversity	Not applicable to this report.

Due Regard: Inequalities	Addressing health inequalities will continue to be a deliverable within the UEC programmes 2025/26.
Due Regard: wider effect	Winter communications campaign aims to help patients choose the right care; empowering people to stay well and use services appropriately.

(4) Statutory Dependencies & Impact Assessments:			
Assessment	Completed?	If No / N/A – Rationale	If Yes – Outcome & Date Reported / Signed off
DPIA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A	Click or tap here to enter text.	<i>Reported to IG Committee:</i> Click or tap to enter a date.
EIA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A	Click or tap here to enter text.	<i>Outcome and date of completion:</i> Click or tap here to enter text.
QIA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A	<i>(enter rationale, per ICB QIA Policy, that it does not impact on quality of services)</i> Click or tap here to enter text.	<i>SRO sign-off, outcome & date of completion:</i> Click or tap here to enter text.
Has there been Public / Patient Involvement?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A		Click or tap here to enter text.

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

(6) Executive Summary, incl. expansion on any of the preceding sections:
<p>The winter plans for our two Systems were developed independently, and this report is the first that combines the progress as a cluster. It recaps on the separate approval governance routes and ongoing assurance oversight.</p> <p>The System Winter Plans are 'live' documents and remain under continual review to ensure that all activities and decisions are made to enhance the system response to the winter period.</p> <p>This report also includes an overview of the latest UEC Operational performance to end of December 2025, throughout a particularly challenging period of operational pressures, that has also involved a concurrent response to two periods of industrial action by BMA resident doctors.</p> <p>A full review of winter and identification of lessons learnt will be undertaken across the cluster in the Spring.</p>

(7) Recommendations to Board / Committee:
The Board in Common is invited to Note this update.

Winter Plan Update

January 2026

Introduction

The purpose of this paper is to provide an update on the latest position of the Cluster Winter Plans. This is following an update to the Integrated Care Board meetings in September for Shropshire, Telford and Wrekin and November 2025 for Staffordshire and Stoke-on-Trent.

The System Winter Plans are 'live' documents and remain under continual review to ensure that all activities and decisions are made to enhance the system response to the winter period.

The paper also includes an overview of the latest UEC Operational performance to end of December 2025.

Governance and Assurance

SSOT:

NHSE Board Assurance Statements for Winter were considered by the September ICB Board, with the formal ratification of the Winter Plan taking place in November. Partners across the ICS have continued to focus on the mobilisation of the plan and associated schemes via Surge MDT in line with agreed 'Pillars' approach to the Winter Oversight Group.

Due to the ongoing and sustained operational pressures seen across the ICS and in line with the System Escalation Plan, three times weekly Strategic Calls are in place to support the daily Tactical and Operational Delivery actions.

A bi-weekly winter executive report continues to be produced by the ICB UEC team and shared across the system for full oversight of delivery against the plan.

Of the 13 capacity pillars of the plan, it is positive to report 10 are currently on track with 3 workstreams reporting at risk of delivery. The schemes at risk are noted below and are being supported to develop alternative mitigatory actions and schemes.

- Community Transformation
- University Hospitals of North Midlands (UHNM)
- Acute Care at Home (ACAH)

STW:

The STW Winter Plan was approved by the Board on 24 September 2025, along with the fully assured Board Assurance Statement that was submitted to the NHSE national team.

The enactment and progress of the plan has been overseen by the UEC Delivery Group monthly, with escalated daily System operations touchpoints involving system Executives when specific interventions have been warranted to manage rising pressure.

Critical Incident & Industrial Action

SSOT:

During early December the system continued to see increased and sustained pressure upon UEC services. Services at UHNM as well as regionally were impacted by increased attendances, high levels of COVID, Flu and RSV presentations ahead of modelled timelines and sustained high absence levels due to sickness.

On 8 December this resulted in UHNM declaring a Critical Incident, which was reduced on 10 December to a Business Continuity Incident before formally being stood down on 12 December. During this period partners across the ICS responded in line with the System Escalation Plan to support the efforts of colleagues within UHNM to de-escalate the position and maintain services.

Nationally the NHS faced a further period of Industrial Action (IA) by Resident Doctors from the 17 to 22 December. A separate Industrial Action plan was produced to supplement the Winter Plan and focused on delivery of services and the 'Home for Christmas' programme to deliver the NHSE required 80% occupancy ahead of the Christmas period.

An initial 'Hot Debrief' in relation to both of these periods was undertaken to identify any areas of learning that would support delivery of the Winter Plan alongside a formal process in line with the EPRR framework.

STW:

The winter environmental pressures experienced in SSOT as outlined above were shared in STW. Responses to the periods of Industrial Action by the Resident Doctors were very well managed by SaTH, maintaining the national target of 95% of Elective activity, good flow and patient safety in Emergency Departments. Over the 5 day Industrial Action period in December the Trust reported 39% turnout of action from those expected on duty, which compares very favourably with the 65% nationally reported by the British Medical Association.

Operational pressure has been at times extreme, but SaTH has not reached the threshold of declaring a Critical Incident. It has been close at one or other of the two acute sites, but generally not both at the same time, which was the experience last year. This has enabled the SaTH team to balance pressures at times; backed up by decisive support from System partners, which in combination has eased it sufficiently.

Performance

SSOT:

Many key metrics are assessed across UEC pathways daily by all partners across the system as part of routine monitoring and oversight with regular reports provided to NHS England via the bi-weekly Tier 1 calls with NHSE. An overview of the latest validated UEC performance metrics is noted below:

Performance Summary:

- The expansion to the Integrated Care Coordination (ICC) service capacity has demonstrated an increase in calls – they received 5457 referrals during the month of December. This is an increase of 252 from November.
- Overall hospital occupancy for December was reported 0.4% above plan at 93.9%. However, it is positive to note that the system achieved the occupancy target of 80% by 24th December, at UHNM with all patient cohorts reporting a decreased proportion of patients occupying beds as a result.
- ED 12-hour performance improved by 0.8% to 16.26% for December, which is 4.2% better than the plan.
- WMAS Category 2 mean response time for the latest month (December) performance is 00:43:04, 52 seconds worse than plan.
- Average Ambulance Handover time at UHNM for December improved marginally compared to November to 1hr 35 minutes, but remained 12 minutes behind plan.
- December 4-hour ED performance is reported as 64.4%, 4.8% worse than plan.

STW:

- WMAS Category 2 mean response time for the latest month (December) was 00:39:52, 5.5% better than plan.
- Average Ambulance Handover time at SaTH for December was 1 hr 35 minutes. This is 16 minutes and 52 seconds worse than plan.

- December 4-hour ED performance is reported as 53.1%, 2.4% worse than plan.
- ED 12-hour waits were 21.7% of Attendances in December, which is just 0.1% worse than plan.
- Overall Occupancy for December was 2.9% better than plan at 92.1%. The NHSE occupancy target of 80% by 24th December was narrowly missed at SaTH with a very creditable 82.6%.

Winter Plan Progress

STW:

Phase 1 of the plan implemented high-impact enduring programme schemes including the addition of 56 inpatient beds at Royal Shrewsbury Hospital and 40 acute assessment spaces at Princess Royal Hospital. In addition the integrated out of hospital model has strengthened and extended access to key community services such as our Urgent Community Response team, finding and providing alternatives to Emergency Department attendance and hospital admission.

These measures, in addition to relentlessly hard work by staff and very strong partnership working, enabled a Phase 2 of the plan that countered the rising pressures without being overmatched ahead of the festive period, notwithstanding some very challenging days.

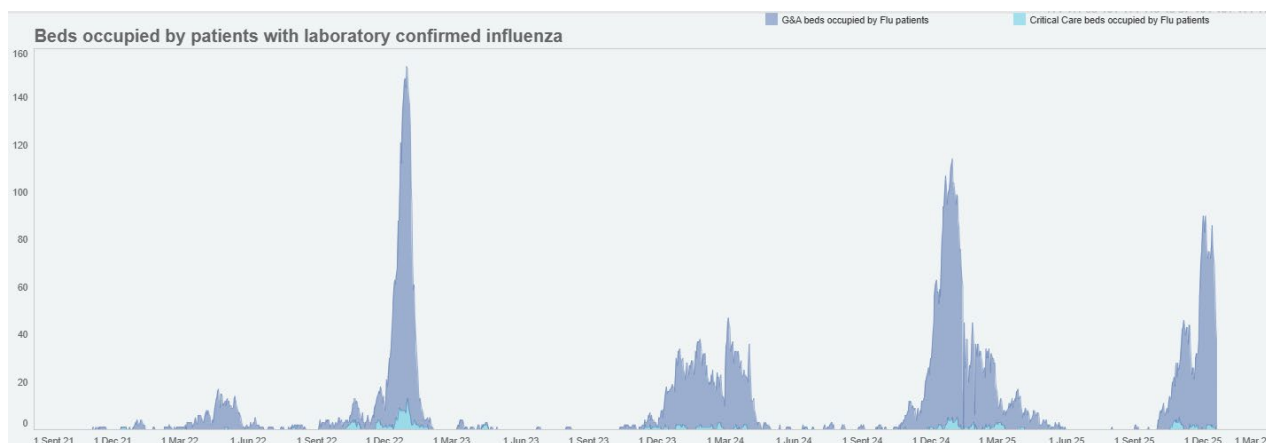
SSOT:

Despite the positive engagement of partners and strong system working, delays to schemes have inhibited full delivery of the Winter Plan schemes. The system is working collectively with partners across the NHS, Local Authorities and Voluntary Community and Social Enterprise (VCSE) sector to expedite elements of the plan and to deliver alternative mitigatory programmes where required. Key delays and mitigatory actions are summarised below:

- Elements of additional acute capacity were delayed due to estates and workforce challenges. To counter this and maintain flow, capacity was 'flipped' from elective to emergency care in a number of wards. The impact on the elective programme and in-year recovery is now a priority.
- Delays to Community Transformation workstreams have resulted in a revision of the anticipated impact by 13 beds. Alternatives schemes continue to be onboarded to support mitigation, this includes the enhanced support into Care Homes from existing services delivered by MPFT with an aim to reduce attendances.

Infection Prevention and Control (IPC) have also continued to affect our system operationally, with increased levels of Flu, COVID and RSV been seen. As reported in November's update to ICB board, Flu peaked earlier than predicted. Although this has plateaued across recent weeks, this continues impact operational delivery.

NHS Staffordshire and Stoke-on-Trent Integrated Care Board



(Graph 1. UHNM Flu Position)

Successes

Alongside operational challenges, we have had delivered a number of successes and improvements across UEC pathways.

STW:

Our level of ambition in preparing for this winter has been very high, with a considerable amount of reconfiguration of the bed base in our acute and community hospitals, as well as the community services and what we have asked of our Local Authority partners. The final changes have taken place during the onset of winter in the last two months. At times we have had to hold our nerve and make the bold changes required that have already proved their value and will do so well beyond the end of the winter period. None of this would have been possible without the remarkable dedication and hard work by our people across the System.

Our winter communications campaign has focused on 'Think Which Service' for the third year this winter. The campaign aims to help residents choose the right care; empowering people to stay well and use services appropriately, easing pressure on A&E, reducing ambulance handover delays, and supporting GP practices. We are taking a multi-channel approach to reach as many people as possible, ranging from local media, social media, digital screens in supermarkets on buses, pharmacy bags, leaflet drops, and shared materials with voluntary sector partners.

SSOT:

Discharge to Assess:

Additional Home Care capacity and Bed capacity has been onboarded as per the winter plan. D2A beds have been expedited to support operational pressures across the system with beds at Haywood and Cheadle opening prior to plan. A further 10 spot purchase beds have been mobilised above plan and continue to be utilised to support system pressures.

Home For Christmas:

In addition to the Winter Plan, the system developed "Home for Christmas" plan with the aim to achieve 80% occupancy for Christmas, in line with NHSE requirements. The plan was developed across the whole UEC pathway, with whole system actions, daily action tracker and subsequent trajectories in place to support delivery.

The plan was achieved with occupancy at UHNM being reported as 78% leading into the festive period.

Integrated Care Coordination

The services continues to improve and supports patients to be deflected away from UEC acute pathways into alternative service. There were record levels of referrals received into the in hours element of the ICC

over the festive period, with 194 referrals received on the 27th December. The senior leader leadership team from MPFT have been completing increased engagement with partners with a focus on Ambulance Service and Care providers through a targeted communications programme. This has supported to increase the number of referrals from Ambulance Crews on scene by 25.5% in December from November. Referrals from Care Home providers have increased by 31% within the same time.

Whilst supporting the increases in referrals, deflection rates have remained consistent supporting positive outcomes for our population.

Community Rapid Response Team (CRIS)

Referrals to the CRIS team have also increased during December to 1003, from 827 in November. Due to increased pressures from Care Homes, additional resource from the GP Federation has been onboarded to support admission avoidance on selected dates. Since commencing on the 13th December until the 4th of January, the additionality has provided 51 patient visits. The scope of the provision has been expanded to bolster the CRIS service to support the increased demand being received and support reduce hospital attendance.

System ED Conveyances Multi-Disciplinary Team (MDT) Review

The system has formed an MDT meeting to review potential inappropriate conveyances and the opportunity for alternative pathways and learning. A review of the MDT to date has been completed and shared with partners onwards discussion through appropriate governance routes. To time, a new Falls Standard Operating Procedure (SOP) has been developed and is due to go live to support more patients to be managed within the community.

Ongoing delivery and oversight of winter

Next Steps

STW:

Our winter plan is on-track. Our post-festive period of recovery – Phase 3 of the plan – is making steady progress and runs through to the end of January. Phase 4, starting in February is to sustain our response, avoid being overmatched by pressure and set conditions for a strong performance in March. Phase 5 from mid-March onwards will be our Transition from winter; tapering off the seasonal winter schemes and starting 2026/27 well. That will encompass our response to the Easter weekend, which is very early this year (3rd to 6th April).

SSOT:

Due to the continued challenges in relation to Ambulance Handover Delays colleagues at UHNM have formulated a “Release to Respond” test of change planned for mid-January. This is supported by partners across the ICS to ensure we are maximising the admission avoidance and discharge pathways. This initiative will be going live from 14th January this will support a structured and phased approach to delivery of 45-minute handover maximum during quarter 4.

Work to deliver the Winter Plan continues across the ICS. As we progress through January the focus moves to de-escalation of any additional capacity in line with the system bed model to ensure compliance with the agreed financial envelope.

Across the Cluster, a full winter lessons learnt event will take place in Spring with formal updates to be provided to ICB Board following ratification via the agreed UEC Governance.

Enc 12: NHS Reset – Governance Update

Meeting Name: Boards in Common Meeting of NHS Shropshire, Telford and Wrekin Integrated Care Board (NHS STW) and NHS Staffordshire, Stoke on Trent Integrated Care Board (NHS SSOT)

Meeting Date: Thursday 29th January 2026

Report Presented by: Simon Whitehouse, NHS STW and NHS SSOT, Cluster Chief Executive Officer

Report Approved by: Mish Irvine, NHS STW and NHS SSOT, Cluster Chief of Staff

Report Prepared by: Alison Smith, Chief Business Officer NHS STW and Paul Winter, Associate Director of Corporate Governance, NHS SSOT

Action Required: For assurance and approval

1.1. Purpose

- 1.1.1. The purpose of this report is to present to the Boards of NHS STW and NHS SSOT meeting in common, an update on several areas related to corporate governance of both ICBs that have changed or require amendment because of the NHS Reset Programme.

1.2. Executive Summary

- 1.2.1 This report updates the Boards of NHS STW and NHS SSOT on the following areas of corporate governance that are required to support the NHS Reset Programme and seek approval as required:

- ICB Non-Executive Member Appointments – this report provides the outcome of the recent appointment process of existing Non-Executive Members to vacancies on both Boards.
- Committees in Common – to provide an update on progress of moving to Committees in Common to support cluster working.
- Merger of ICBs - to provide an update on the NHS England process for mergers of ICB's in April 2027 and seek support for this direction of travel.
- Reduction in ICB Partner Members, Board participants and observers – following publication of the ICB Model Blueprint document there is a requirement by NHS England that clustering ICBs consider streamlining their Boards' composition to facilitate efficient and effective decision making. The report presents a proposal for reducing partner board members, participants and observers to the Board.
- Proposed constitution changes – in order to support reduction in Board composition and to assist in streamlining both Boards efficient and effective decision making in line with the ICB Model Blueprint, the report contains a number of proposed changes to the Constitutions of both ICBs for approval, in addition to those agreed at the November Boards' meetings.

1.3. Recommendations

The Boards of NHS STW and NHS SSOT are recommended:

1.3.1 **ICB Non-Executive Member Appointments**

To **NOTE** the appointments of Non-Executive Members to the Boards of NHS STW and NHS SSOT as set out in section 2.1. and **APPROVE** appointment to the Deputy Chair and Senior Independent Director role.

1.3.2 **Update on progress with moving to Committees in Common**

To **NOTE** the post-November 'early adopter' developments and new external factors, and to **SUPPORT** the original proposal made for all Committees to adopt full Joint Committee status effective 1st April 2026.

1.3.3 **Merger of ICBs:**

To **NOTE** the expectation of merger of the two ICBs by NHS England and **SUPPORT** the direction of travel towards merger and **CONFIRM** the desire of both Boards that the two existing ICBs be dissolved and a single ICB created in April 2027, to cover the wider geographical areas of Shropshire, Telford and Wrekin, Staffordshire and Stoke on Trent.

1.3.4 **Proposal regarding reduction in ICB Partner Members, participants and observers on the Boards:**

a. To **CONSIDER** and **APPROVE** the proposal to amend the ICBs' Constitutions to reduce the number of Partner Board Members, Participants and Observers as set out above in section 2.2 in this report, for onward recommendation to NHS England for ratification.

The Board of NHS SSOT is recommended:

b. To **COMMIT** to developing place boards and place-based working with the respective local authorities in its area.

1.3.5 **Proposed constitution changes**

To **APPROVE** the proposed changes to the ICBs Constitutions outlined in appendix 1, for onward recommendation to NHS England for ratification.

1.4 **Conflicts of Interest**

1.4.1 There is a conflict for Partner Members on each Board with the item regarding reduction of partner members in the future. The Board is recommended to recognise the conflict, but as these are not financial interests these should be recorded in the minutes, and the individuals can remain in the meeting for discussion and decision.

1.5 **Links to the System Board Assurance Framework (SBAF) for both ICBs**

1.5.1 Risks regarding NHS Reset are outlined within the SBAF and supporting risk registers of both ICBs.

1.6 **Alignment to Integrated Care Board**

1.6.1 This report supports transparency and probity of decision making by the NHS STW ICB and NHS SSOT ICB which contributes to the ICB's core aims.

1.7 **Key Considerations**

1.7.1 **Quality and Safety:** Some clinical risks will be concerned with Quality & Safety Management and assurance through Board Committees

1.7.2 **Financial Implications:** Some financial risks will be concerned with Finance Management and assurance through Board Committees

- 1.7.3 **Workforce Implications:** Board Development and OD will be required to assist smooth transition
- 1.7.4 **Risks and Mitigations:** None specifically identified as a result of this report.
- 1.7.5 **Engagement:** Engagement with local authority partners will be required as part of any ICB merger process
- 1.7.6 **Supporting Data and Analysis:** None specifically identified as a result of this report
- 1.7.7 **Legal, Regulatory, and Equality:** ICB Statutory Duties and NHSE Statutory Guidance: Delegation & Joint Working

1.8 Attachments

- 1.8.1 Appendix 1 - Proposed changes to the Constitutions of both NHS STW and NHS SSOT

1.9 Impact Assessments

- 1.9.1 **Has a Data Protection Impact Assessment been undertaken?** No
- 1.9.2 **Has an Integrated Impact Assessment been undertaken?** No

2 Background

- 2.1 In 2025 NHS England approved a clustering arrangement between NHS Shropshire, Telford and Wrekin ICB and NHS Staffordshire and Stoke on Trent ICB to facilitate a greater opportunity to collaborate to meet the reduce running cost envelope but remaining separate organisations legally.
- 2.2 Work to support the NHS Reset Programme and successful clustering between NHS Shropshire, Telford and Wrekin ICB and NHS Staffordshire and Stoke on Trent ICB is now happening at pace;
 - Appointment of Cluster Chair and CEO;
 - creation of, and appointment to, a joint Executive Team to support both ICBs as Strategic Commissioners;
 - voluntary redundancy scheme undertaken for staff employed by the two ICBs;
 - appointment of shared Non-Executive Members to both Boards;
 - Boards meeting in Common from January 2026; and
 - creation of committees in common and joint committees where appropriate.
- 2.3 This report seeks to update the Boards of NHS STW and NHS SSOT on the following areas of corporate governance that are required to support the NHS Reset Programme and clustering and seek approval as required:
 - ICB Non-Executive Member Appointments – this report provides the outcome of the recent appointment process of existing Non-Executive Members to vacancies on both Boards.
 - Update on progress with moving to Committees in Common to support cluster working.
 - Merger of ICBs - to provide an update on the NHS England process for mergers of ICB's in April 2027 and seek support for this direction of travel.
 - Reduction in ICB Partner Members, Board participants and observers – following publication of the ICB Model Blueprint document there is a requirement by NHS England that clustering ICBs consider streamlining their Boards' composition to facilitate efficient and effective decision making.

This report presents a proposal for reducing partner board members, participants and observers to the Board.

- Proposed constitution changes – in order to support reduction in Board composition and to assist in streamlining both Boards efficient and effective decision making, the report contains a number of proposed changes to the Constitutions of both ICBs for approval, in addition to those agreed at the November Boards' meetings.

3 Report

3.1 ICB Non-Executive Member Appointments

At the respective Board meetings of both ICBs held in November 2025, the Cluster Chair outlined the intention to undertake an appointment process to allow those existing Non-Executive Members of both ICBs, to be considered for appointment to both Boards during this period of transition.

The appointment process was successfully completed during December 2025 and the Chair can confirm that the following Non-Executive Members will be appointed formally to the following ICB's:

Appointment to NHS STW:

- Mike Lawton
- Shokat Lal

Appointment to NHS SSOT:

- Roger Dunshea
- Cheryl Etches
- Trevor McMillan

The Chair has made the following appointments to specific roles from 1st February 2026:

- Mike Lawton – Deputy Chair and Senior Non-Executive Director (SID) for NHS STW and NHS SSOT
- Roger Dunshea – Audit Chair for NHS SSOT

The Boards of NHS STW and NHS SSOT are asked to note these appointments and approve the appointment of the Deputy Chair and Senior Independent Director.

3.2 Update on progress with moving to Committees in Common

In November 2025, both Boards approved recommendations for both ICBs to move as quickly but pragmatically and efficiently as possible to new ways of committee decision-making that best support ICBs Clustering in the pre-Merger period. With “Committees-in-Common” as a precursor to full Joint Committees developmental pathway supported, ideally implemented in full by April 2026 for full realisation of the proposed benefits as were presented.

This section provides a short, latest status update on where we are with the proposed new Cluster Committee Governance Structure. It also suggests a number of possible amendments to the November pathway that the Board agreed, reflecting some external matters that have come to light since that original paper was written.

- (a) Transition Committees have had two in-Common meetings now, with initial ‘matters arising’ being well managed and approval in kind already given to proposed draft Joint Committee Terms of Reference. Suggesting that its next meeting should preferably be held as the first of that particular model.
- (b) Audit Committees will have their first in-Common meeting on 22nd January, with a well-planned agenda balancing the new with the

- predecessor operating models. (Note: due to legalities, Audit Committees can never hold full Joint Committee status and must remain in-Common).
- (c) Remuneration Committees have needed to hold several in-Common meetings to expedite urgent decisions to support Clustering. This is one area where there should be an immediate move to a full Joint Committee basis.
 - (d) The proposed new System Finance Committees in Common, Quality & Performance Committees in Common, Strategic Commissioning & Transformation Committees in Common and People Culture & Inclusion Committees in Common have all indicated February 2026 as their first meetings under the new arrangement.
 - (e) Hybrid Terms of Reference have now been drafted for each “new” Committee within the Boards-agreed Governance Structure (purposefully / flexibly created to work on either the in-Common or potentially a full Joint Committee basis). This is a key part of a Governance Implementation Plan shared with Transition Committees in Common. With the next steps being the ‘socialising’ of these, through planned “soft launch” OD discussions, with relevant Lead NEM Chairs & Execs, to support the developmental pathways each requires.
 - (f) The ICB Governance Teams have also established, through the Regional Governance Network, that our Midlands Peer Clusters have virtually all adopted the ‘straight to full Joint Committee Operating Model’. At the time of writing the November paper, this was not perceived to be the approach, and instead, a more evolutionary and ‘purer’ Good Governance model of in-Common first then Joint was suggested; hence our paper reflecting that.

Depending on the initial outcomes of “soft launch” discussions, this would now be the preferred option for the Governance Team – as benchmarked on how elsewhere is doing this, and due to the reality of greater urgency behind Clustering: e.g. NHSE-required Constitution changes, Cluster Management of Change processes / VR impacts, etc. those Committees in section 3.4(d) could see their pathways compressed quite quickly on this same basis, where or if agreed.

3.3 **Merger of ICBs**

In March 2025, NHS England announced that integrated care boards (ICBs) should reduce their running and programme costs by around 50% to become more efficient and reduce duplication, in line with their new role as a Strategic Commissioner as set out in the Government’s 10 Year Health Plan for England.

To meet these cost reductions a number of ICBs have agreed clustering arrangements, with two or more ICBs working together across a larger footprint but remaining separate organisations legally. In 2025 NHS England approved a clustering arrangement between NHS Shropshire, Telford and Wrekin ICB and NHS Staffordshire and Stoke-on-Trent ICB to facilitate a greater opportunity to collaborate to meet the reduce running cost envelope whilst remaining as separate organisations legally. Work to support successful clustering between NHS Shropshire, Telford and Wrekin ICB and NHS Staffordshire and Stoke on Trent ICB is now happening at pace.

However, to fully realise the efficiencies needed to meet the 50% reduction in running costs, improve collaboration to deliver against the 10 Year Health Plan for England and to facilitate alignment of ICBs to new local government strategic authorities in the future, ICBs are expected to merge, with some

exceptions. NHS England will exercise its power to vary or revoke the Establishment Order of ICBs, thereby abolishing or establishing ICBs or changing the boundaries of existing ICBs. Some mergers have already been approved for April 2026 with the majority of remaining clustered ICBs to merge in April 2027.

NHS England have issued new merger guidance for ICBs to follow as the implementation process for these mergers is being led by NHS England as part of a broader reorganisation. More detailed information will be provided by NHS England in terms of timeline, and the due diligence process the ICBs will be required to follow. The guidance can be accessed on the following link:

Implementing integrated care board mergers and boundary changes to take effect in April 2026 and 2027:

[NHS England » Implementing integrated care board mergers and boundary changes to take effect in April 2026 and 2027](#)

The timeline for merger has not yet been approved by NHS England, but the Boards are asked to note the following key known milestones:

- May 2026 some local authority elections across England
- Summer 2026 new unitary local authority footprints expected to be confirmed, and further strategic authority footprints confirmed (subject to the passage of legislation)
- Before end of September 2026 NHSE makes legal decision re ICB mergers
- End of September technical transition begins if supported by NHSE
- 1st April 2027 creation of merged ICBs as a single strategic commissioning entity

The Boards are also asked to note that in April 2026 ICB mergers have moved the whole of East and South-East Regions on to local and strategic authority footprints, which were considered and confirmed by ministers in the summer.

Further updates will be provided to the Transition Committees in Common and through the Chair's report to the Boards, as more detailed guidance is received from NHS England.

Acknowledging the expectation of merger of the two ICBs, the Boards are asked to endorse and support the direction of travel towards merger. The Boards are also asked to confirm that the two existing ICBs be dissolved and a single ICB be created in April 2027. This single ICB would cover the wider geographical areas of Shropshire, Telford and Wrekin, Staffordshire and Stoke on Trent. A final name for the newly formed ICB would need to be determined and agreed as per the NHS naming convention guidelines.

An important aspect of any merger is to ensure that there continues to be strong local engagement. The system architecture will need to reflect any future merged ICB structure. In discussion with LA CEO's there is acknowledgement of the national direction of travel. The establishment and functioning of effective Place Boards across the 4 upper tier LA boundaries will be a fundamental aspect of any future system architecture. There will need to be urgent joint work to support future delegation to these Place Boards if they are to be an effective part of the wider system governance under a merged single ICB.

3.4 **Proposal regarding reduction in ICB Partner Members, participants and observers on the Boards**

NHSE have clearly set out in the Model ICB Blueprint an expectation that ICBs that are clustering will take the opportunity to align Constitutions and reduce the number of Board members to ensure that decision making processes continue to be efficient and effective.

NHS STW and NHS SSOT have moved to a shared Chair and CEO, Executive Directors and Non-Executive Members. In addition to facilitating cluster working and Boards meeting in common, NHS England have set out a clear requirement that in parallel with any requested changes to the ICBs Constitutions, the clustering ICBs communicate a plan to review and reduce the number of partner Board members, that demonstrates how they will meet this part of the ICB Model Blueprint document.

The following outlines a proposal for reducing Partner Board Members and partners listed as participants and observers on the Boards of NHS STW and NHS SSOT for consideration.

A minimum number of partner Board Members per ICB is set out in legislation (which have to be jointly nominated):

- 1 Primary Care
- 1 NHS Trust/Foundation Trust
- 1 Local Authority

In addition, the ICB Chair should also seek to approve appointment of an individual who brings experience and knowledge in connection with services relating to the prevention, diagnosis and treatment of mental illness. This can be achieved by either:

- Ensuring there is an additional one of the above nominated partner roles that brings that experience and knowledge or
- The Chair appoints an additional ordinary member, that is not one of the three nominated roles above, to fulfil this role specifically.

The ICBs will, as a minimum, need to satisfy this legislative requirement until any new legislation that is introduced over the coming months changes this position. The NHSE Constitution policy guidance allows ICBs to appoint more than this minimum but should ensure that these are stated in the Constitution and there is a balance of knowledge and experience across sectors and types of providers.

Given the need to reduce the Board membership to a level that allows the two ICBs meeting in common to discharge decision making effectively but continuing to ensure there is a balance of knowledge and experience, it is recommended that the Boards adopt the minimum statutory level for partner Board members for each ICB as outlined above. Maintaining local engagement, as stated earlier in this paper, is of paramount importance to the ICB leadership.

To meet the requirement for having knowledge and experience regarding mental health services, the Boards are recommended to adopt the proposal to have an additional ordinary member for each ICB, appointed by the Chair rather than by nomination, to ensure this can be enacted as quickly as possible.

The table below shows the existing composition of each Board for voting members, including partner members and non-voting partner participants and observers:

VOTING	STW - current	SSOT - current	Proposal for each ICB to adopt
Chair	1	1	1 (shared)
CEO	1	1	1 (shared)
Non Executive Members	4	5	5 (shared)
Executives	4	5	5 (shared)
Partner Members:			(specific to each ICB)
Primary Care	2	2	1
Local Authority	2	2	1
NHS Trust/FT	4 (one of which fulfils the requirements to bring knowledge and experience of mental health services)	3 (one of which fulfils the requirements to bring knowledge and experience of mental health services)	1
Ordinary Member to fulfil requirements to bring knowledge and experience of mental health services	n/a – see above	n/a – see above	1 (specific to each ICB or shared)
Total	18	19	16
NON VOTING PARTNER ATTENDEES			
Participants	Chairs of NHS Provider Trusts/FT Leaders of Local Authorities		Nil
Observers	Co-Chairs of STW GP Board	Governors or NEDs from partner Provider NHS Trusts	Nil

In order to continue to support collaborative working at system level across both ICBs, it is proposed that the Board informal strategy development meetings are arranged to include a broader representation from partner members of NHS providers, local authorities and the VCSE.

There is a need to recognise the significant part the development of place-based service commissioning and delivery will play in responding to the NHS 10 Year Plan's ambitions of neighbourhood working. This will be reliant on our local authorities to lead and shape this work. As a result, the Board of NHS SSOT is asked to commit to developing place boards and place-based working in its area.

The Boards are asked to consider and approve the following-

- proposal to reduce the number of Partner Board Members, Partner Participants and Observers as set out in the table above,
- support the development of Boards informal strategy development sessions including a broader representation from NHS provider organisations, local authorities and VCSE
- that the Board of NHS SSOT commits to developing place boards and place-based working in its area.

3.5 **Proposed constitution change**

As a result of discussions with NHS England on the opportunities for further alignment of both ICBs Constitutions and in light of the proposals for reducing the number of Partner Board members that is outlined above, the Board is asked to consider and approve a number of additional changes to the ICBs Constitutions. This will enable the two ICBs to function more effectively as a cluster whilst also retaining their individual legal status. The changes proposed are summarised in appendix 1 to this report. The approach taken has been to simplify some content of both Constitutions which had additional local requirements added, to align with the prescribed parts of the Constitution template issued by NHS England. Other changes are made to ensure the proposed change in partner Board member numbers can be fully enacted.

The Boards are asked to approve the proposed changes to the ICBs Constitutions for onward recommendation to NHS England for ratification.

4 **Recommendations**

The Boards of NHS STW and NHS SSOT are recommended:

4.1 **ICB Non-Executive Member Appointments**

To **NOTE** the appointments of Non-Executive Members to the Boards of NHS STW and NHS SSOT as set out in section 2.1. and **APPROVE** appointment to the Deputy Chair and Senior Independent Director role.

4.2 **Update on progress with moving to Committees in Common**

To **NOTE** the post-November 'early adopter' developments and new external factors, and to **SUPPORT** the original proposal made for all Committees to adopt full Joint Committee status effective 1st April 2026, and regardless of any c.3 month in-Common bedding in (indicating potential May 2026 launches).

4.3 **Merger of ICBs:**

To **NOTE** the expectation of merger of the two ICBs by NHS England and **SUPPORT** the direction of travel towards merger and **CONFIRM** the desire of both Boards that the two existing ICBs be dissolved and a single ICB created in April 2027, to cover the wider geographical areas of Shropshire, Telford and Wrekin, Staffordshire and Stoke on Trent.

4.4 **Proposal regarding reduction in ICB Partner Members, participants and observers on the Boards:**

To **CONSIDER** and **APPROVE** the proposal to amend the ICBs' Constitutions to reduce the number of Partner Board Members, Participants and Observers as set out above in section 2.2 in this report, for onward recommendation to NHS England for ratification.

The Board of NHS SSOT is recommended:

To **COMMIT** to developing place boards and place-based working with the respective local authorities in its area.

4.5 Proposed constitution changes

To **APPROVE** the proposed changes to the ICBs Constitutions outlined in appendix 1, for onward recommendation to NHS England for ratification.

January 2026



Appendix 1 - Proposed changes to the Constitutions of both NHS STW and NHS SSOT

Ref	Proposed amendment to ICB Constitutions	STW reference	SSOT reference
1	Amend reference to the number of partner members (8 for STW and 7 for SSOT) to 1 for each category: NHS Trusts/FT, Primary Medical services and local authorities	Section 2.2.1	Section 2.2.1
2	Amend section listing those appointed to the Board as ordinary members to include an ordinary member that has knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.	Section 2.2.2	Section 2.2.2
3	Delete from SSOT Section 2.2.2 reference to broad portfolio descriptions; quality and safety, finance and performance and People Culture and OD which do not now align with the new transition committee structure being implemented and would then be aligned to STW section 2.2.2	N/A	Section 2.2.2
4	Amend section listing Board members in full to reduce partner member numbers down to 1 each for NHS and Foundation Trusts, primary medical services and local authorities.	Section 2.2.3	Section 2.2.3
5	Amend section listing full composition of the Board to include an ordinary member that has knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.	Section 2.2.3	Section 2.2.3
6	Amend sections to delete NHS and Local Authority Partner attendance as participants and observers.	Section 2.3.2 – (a) to (f)	Section 2.3.5 (a) last bullet point and section 2.3.6 (a) both bullet points

7	Delete additional local criteria for eligibility for SSOT Chair role to align with STW and national model Constitution template	N/A	Sections 3.3.2 (b) and 3.3.3 (c)
8	Amend SSOT term of office for the chair and total number of terms from 4 years and two terms, to three years and three terms to align with the existing substantive contract the Chair holds with STW which is based upon these terms, whereas the Chair's appointment to SSOT is based upon a shorter timescale reflecting the expected changes in current ICB boundaries.	N/A	Section 3.3.4
9	Delete additional local criteria for eligibility for SSOT Chief Executive role to align with STW and national model Constitution template	N/A	Section 3.5.3 (b) and 3.5.4 (c)
10	Delete reference to the requirement to bring specific knowledge , skills and experience in connection with services relating to mental health services from one of the NHS Trust/FT Partner Board members. This requirement will b filled by the addition of an ordinary member bringing this perspective (line 5 above)	Section 3.6.2 (b) (iv)	Section 3.6.2 (c) bullet point 5
11	Amend STW description of how partner NHS Trust /FT Board members will be appointed to align with SSOT: "These members will be appointed by an Appointment Panel following the process outlined below, subject to approval of the Chair."	Section 3.6.4	N/A
12	Amend STW section on nominations by Partner organisations from inviting one nomination per organisation to two nominations per organisation in line with SSOT	Section 3.6.5 (a) first bullet point	N/A
13	Amend STW section on nominations by Partner organisation from the Chair convening a panel to consider the nominations to the Chief Executive to align with SSOT	Section 3.6.5 (b) first bullet point	N/A
14	Amend SSOT section on nominations by Partner organisation in line with STW and delete the description of the detail of what the panel will consider: " via longlisting and/or shortlisting and as required competitive interview process using the role description ad eligibility criteria"	N/A	Section 3.6.5 (b) bullet point 3

15	Amend the number of terms NHS Partner Board members can complete by deleting the maximum of 3 terms to align with STW: There is no restriction as to the number of terms in total the same individual can be appointed, however after the completion of each term the individual will be subject to the process outlined in 3.6.5 above”	N/A	Section 3.6.6
16	Amend STW Partner Member – Primary Medical Services to delete section setting out that two roles covering two parts of the geography. There will only be one partner member for primary medical services per ICB so this will need deleting.	Section 3.7.3 (c)	N/A
17	Amend STW description of how partner Board Primary Care members will be appointed to align with SSOT: “These members will be appointed by an Appointment Panel following the process outlined below, subject to approval of the Chair.”	Section 3.7.5	N/A
18	Amend STW section on nominations by Partner Primary Medical organisations from inviting two nominations per organisation to one nomination per organisation in line with SSOT	Section 3.7.6 (a) first bullet point	N/A
19	Amend SSOT section on nominations by Partner primary care organisation in line with STW and delete the description of the detail of what the panel will consider: “ via longlisting and/or shortlisting and as required competitive interview process using the role description ad eligibility criteria”	N/A	Section 3.7.6 (b) bullet point 4
20	Amend STW appointment process for primary care partner members to change the panel being convened by the Chair to the Chief Executive and to delete reference to an interview process in line with SSOT.	Section 3.7.6 (b) bullets 2 and 3	N/A
21	Amend SSOT term of office an total number of terms from 4 years and 2 terms to align with STW of 3 years but with no restriction on numbers of terms:	N/A	Section 3.7.7

	“There is no restriction as to the number of terms in total the same individual can be appointed, however after the completion of each term the individual will be subject to the process outlined in 3.7.5 above”		
22	Amend the SSOT eligibility criteria to delete reference to one role having knowledge of urban services and one rural services as there is only 1 Local authority partner member per ICB.	N/A	Section 3.8.2 (c) bullet point 4
23	Amend STW list of when a local authority partner member will not be eligible to include “A conflict of interest is evident, as determined by the Chair or panel which results in the individual being unable to fulfil the role to align with SSOT	Section 3.8.3 (b)	N/A
24	Amend STW description of how partner Board local authority members will be appointed to align with SSOT: “These members will be appointed by an Appointment Panel following the process outlined below, subject to approval of the Chair.”	Section 3.8.4	N/A
25	Amend STW appointment process for local authority partner members to change the panel being convened by the Chair to the Chief Executive in line with SSOT.	Section 3.8.5 (b) first bullet point	N/A
26	Amend SSOT section on nominations by Partner local authority organisation in line with STW and delete the description of the detail of what the panel will consider: “ via longlisting and/or shortlisting and as required competitive interview process using the role description ad eligibility criteria”	N/A	Section 3.8.5 (b) bullet point 3
27	Amend SSOT by deleting total number of terms to align with STW with no restriction on numbers of terms: “There is no restriction as to the number of terms in total the same individual can be appointed, however after the completion of each term the individual will be subject to the process outlined in 3.8.5 above”	N/A	Section 3.8.6
28	Amend SSOT Chief Medical Officer eligibility criteria by deleting local criteria to align with STW	N/A	Section 3.9.1 (c)

29	Amend SSOT Chief Medical Officer disqualification criteria by deleting local criteria to align with STW	N/A	Section 3.9.12 (b)
30	Amend STW Chief Medical Officer disqualification criteria by deleting local criteria to align with SSOT	Section 3.9.2 (b)	N/A
31	Amend STW description of how partner Chief Medical Officer will be appointed to align with SSOT: "This member will be appointed by appointed by recruitment and selection process conducted by ICB HR service and be subject to approval of the Chair."	Section 3.9.3	N/A
32	Amend STW eligibility criteria for Chief Nursing Officer to be amended to include "be a registered Nurse or Midwife to align with SSOT and delete "current valid registration with Nursing or Midwifery Council"	Section 3.10.1 (b) and (c)	N/A
33	Amend SSOT Chief Nursing Officer eligibility criteria by deleting local criteria to align with STW	N/A	Section 3.10.1 (c)
34	Amend SSOT Chief Nursing Officer disqualification criteria by deleting local criteria to align with STW	N/A	Section 3.10.2 (b)
35	Amend STW Chief Nursing Officer disqualification criteria by deleting local criteria to align with SSOT	Section 3.10.2 (b)	N/A
36	Amend STW description of how partner Chief Nursing Officer will be appointed to align with SSOT: "This member will be appointed by appointed by recruitment and selection process conducted by ICB HR service and be subject to approval of the Chair."	Section 3.10.3	N/A
37	Amend SSOT Chief Finance Officer eligibility criteria by deleting local criteria to align with STW, but leaving only "be a qualified accountant with full membership and evidence of up-to-date continuing professional development"	N/A	Section 3.11.1 (b) all bullet points
38	Amend SSOT Chief Finance Officer disqualification criteria by deleting local criteria to align with STW	N/A	Section 3.11.2 (b)

39	Amend STW Chief Finance Officer disqualification criteria by deleting local criteria to align with SSOT	Section 3.11.2 (b)	N/A
40	Amend STW description of how partner Chief Finance Officer will be appointed to align with SSOT: "This member will be appointed by appointed by recruitment and selection process conducted by ICB HR service and be subject to approval of the Chair."	Section 3.11.3	N/A
41	Amend STW description of how Non Executive Members will be appointed to align with SSOT: "This member will be appointed by appointed by recruitment and selection process conducted by ICB HR service and be subject to approval of the Chair."	Section 3.12.2	N/A
42	Amend SSOT Chief Finance Officer eligibility criteria by deleting local criteria to align with STW	N/A	Section 3.12.3 (e)
43	Amend STW Chief Finance Officer eligibility criteria by deleting local criteria to align with STW	Section 3.12.3 (e) and (f)	N/A
44	Amend SSOT Non Executive Member disqualification criteria by deleting local criteria to align with STW	N/A	Section 3.12.4 (c) first bullet
45	Amend SSOT Non Executive Member number of 3 year tenures allowed to 3 from 2 to align with STW	N/A	Section 3.12.5
46	Amend STW description of how partner Chief Officer Strategy and Improving Outcomes will be appointed to align with SSOT: "This member will be appointed by appointed by recruitment and selection process conducted by ICB HR service and be subject to approval of the Chair."	Section 3.13.3	N/A
47	Amend STW description of how partner Chief Officer System Development and Integration will be appointed to align with SSOT: "This member will be appointed by appointed by recruitment and selection process conducted by ICB HR service and be subject to approval of the Chair."	Section 3.14.3	N/A

48	Amend SSOT Chief Officers Strategy and Outcomes and System Development and Integration eligibility criteria by deleting local criteria to align with STW	N/A	Section 3.13.2 (b) and (c)
49	Amend SSOT Chief Officers Strategy and Outcomes and System Development and Integration disqualification criteria by deleting local criteria to align with STW	N/A	Section 3.13.2 (e) 2 nd 3 rd and 4 th bullet points
50	Amend STW Remuneration Committee arrangements for approving remuneration of Non Executive Members so that it aligns to the SSOT description which is also aligned to the new Remuneration Committees in Comom terms of reference.	Section 3.16.1	N/A
51	Amend STW Committees and Sub Committees section on delegated functions to replicate the SSOT version	Section 4.6.4 (a, b and c)	N/A
52	Amend STW Arrangements for determining the terms and conditions of employees - arrangements for Remuneration Committee so that this aligns with SSOT and the new Remuneration Committees in Common terms of reference.	Section 8.1.3 (a, b and c)	N/A
53	Amend both STW and SSOT section on describing arrangements to consult its populations on the respective System Plans to create a more generic statement around the creation of a communications and engagement strategy and the need to have meaningful engagement with patients, service users, the public and partners: "Following the involvement systems and principles set out in the ICB's Strategy for engagement and involvement the ICB will seek to engage and involve patients, service users, the public and stakeholders in the development of the System Plan."	Section 9.1.2 (a, b and c)	Section 9.1.2 (a)
54	Amend both STW and SSOT to delete optional sections which describe local arrangements for working with partners as these are markedly different. This is an optional section which is not prescribed by NHS England guidance.	Section 9.1.4	Section 9.1.4

55	Amend SSOT to delete section to align with STW on describing local arrangements which will follow the principles on involvement described in section 9.1.3 which is a prescribed section. 9.1.6 is optional.	N.A	Section 9.1.6 (a)
56	Amend STW section on calling Board meetings to align with SSOT – Chair giving 14 calendar days notice of a meeting in writing and changing one third of members of the board requesting a meeting in convened to half.	Section 4.1.2 Standing Orders (a and b)	N/A
57	Amend STW section on Nominated deputies to align with SSOT	Section 4.5.2	N/A
58	Amend STW section on Nominated deputies to align with SSOT by adding two additional sections on accountability and liability	Add Sections 4.5.3 and 4.5.4 (amending current section 4.5.5)	N/A
59	Amend STW by adding additional section referring to ability to hold virtual meeting completely on line and that the same quoracy requirements apply.	Add Section 4.6.2 from SSOT Constitution	N/A
60	Amend both SSOT and STW section on quorum in light of proposal to reduce partner Board members to: The Quorum for meetings of the Board will be 50% of the total membership, including: <ul style="list-style-type: none"> • Either the CEO/CFO/ Cof SIO/Cof SDI • Either CMO or CNO • At least two others of NEM or Partner Board member 	Amend section 4.7.1	Amend section 4.7.1
61	Amend both SSOT and STW section on quorum where there is a vacancy or defect in appointment to: “In the event of vacancy or defect in appointment the following temporary arrangement for quorum will apply:	Section 4.8.2	Section 4.8.2

	<p>a) Local arrangements – (proportions reflect those described in 4.7.1 above)</p> <ul style="list-style-type: none">• The Chief Executive and one other voting executive board member or deputies• At least two others of NEM or Partner Board member”		
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Enc 13: Integrated Performance Report December 2025

Meeting Name: Integrated Care Board Meeting

Meeting Date: 29 January 2026

Report Presented by: Claire Skidmore, Chief Finance Officer

Report Approved by: Claire Skidmore, Chief Finance Officer

Report Prepared by: Angela Parkes, NHSSTW, Deputy Director of Planning and Performance

Action Required: For assurance and discussion

1.1. Purpose

The Integrated Performance Report is brought to the Board to provide the latest position regarding finance, quality, performance and workforce across the system. 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.

1.2. Executive Summary

Areas showing improvement:

Primary Care:

- Units of dental activity (UDAs) delivered and performance against contracted dental activity increased compared to the previous month.
- GP appointments within 2 weeks and same or next day appointments targets both increased compared to the last month.

UEC:

- 12-hour performance achieved local plan for the second month in a row.
- Shrewsbury and Telford Hospitals Trust (SaTH) report all-type 4-hour and 12-hour performance was the best month of December performance since December 2021
- Final two Integrated Out of Hospital (IOOH) services stepped up from 1st December, now fully operational.
- The planned final bed base reconfiguration at Royal Shrewsbury Hospital (RSH) was completed on 29th December, providing a total uplift of 18 beds. Plan for Princess Royal Hospital (PRH) to be completed by the end of January 2026.

Planned Care including cancer, diagnostics and community waits:

- **Long waits:** 65+ weeks wait for Shrewsbury and Telford Hospital (SaTH) has improved over the past 13 months. 52+ weeks wait for STW has improved over the past 11 months. 52+ weeks waits Children and Young People (CYP) for STW are on continuous improvement.
- **RTT:** Incomplete Referral to Treatment (RTT) <18 weeks at month end is better than plan. Time to first appointment <18 weeks is better than plan.
- **Community waits:** The number of Children and Young People waiting over 52 weeks has reduced further this month to 18 from 24 last month.

- **Cancer:** Faster Diagnosis Standard (FDS) is better than plan. 62-Day RTT is better than plan. Waits >62 combined backlog: 184 vs planned 217. Faecal Immunochemical Test (FIT) performance is meeting target.
- **Diagnostics:** 13-week waits continues to reduce and is now below 270.

Adult Mental Health:

- Talking Therapies recovery performance improved to 49% (from 47% last month) now above target.
- Talking Therapies first seen within 18 weeks performance is stable this month at 91% but remains below the target of 95%. Work continues in the service to improve this but patients' choice around when and where appointments can be offered is impacting on ability to achieve 95%.

Learning Disabilities and Autism including ADHD:

- There was 1 child in a Mental Health bed at the end of December which has been maintained and in line with the plan.

CYP:

- Eating Disorders (routine referrals) performance has improved and is now exceeding the 95% standard at 96% this month.

Quality:

- Maternity Bookings before 10 weeks' gestation, Mothers Smoking at Time of Delivery showing sustained, continued improved variation.

Areas showing concern:

Primary Care:

- Total primary care appointments, total face to face appointments and overall Pharmacy First activity all fell compared to last month, thought to be because the impact of giving flu jabs increased the activity levels markedly in the previous month. The total appointments and Pharmacy First activity remain above the monthly average and the respective targets.

UEC:

- Although SaTH report the best December since 2021 for 4-hour and 12-hour performance and 12-hour local plan was achieved, Emergency Department (ED) performance national targets continue to be significantly off track having not been achieved in 2025/26 period. Nationally we remain in the bottom quartile for both 4- and 12-hour performance.
- Average Ambulance Handover time is an area of high concern for December, with STW position being over one hour more than the national average and ranked bottom of all 121 reporting areas.
- >8-hour ambulance off load delays continues to increase; WMAS reported 69. SaTH reviewed 52 patients, average age 79. 23 falls of which 13 were admitted, including readmission for multiple falls.

Planned Care:

- **RTT:** 65+ weeks waits currently is at 61 for December and forecasting 40 for January.
- **Cancer:** 31-Day Decision to Treat (DTT) is below plan.
- **Community waits:** There are a small number of children with neuro-diverse needs who are waiting longer for restrictive intervention with the community provider (Wheelchairs service). Adult Waits: 14 patients waiting over 52 weeks.

- **Diagnostics:** 6 week waits below plan

Adult Mental Health:

- Inappropriate Out of area (OOA) inpatient placements remain above national target, nationally published data is subject to data quality issues which is acknowledged by NHSE and local numbers reported are higher (10 at the end of December).

Learning Disabilities and Autism including ADHD:

- Adult inpatients in a Mental health bed increased to 23 and remains above plan. Discharge planning is in place, but some patients are not clinically ready for discharge, and some are delayed due to barriers to discharge including housing.
- The number of adults waiting for an ASD assessment has increased slightly to 2,291 this month, of which 66% are Shropshire patients where longer waits are being experienced. Average waiting times are longer in Shropshire (c 70 weeks).
- The number of adults waiting for an ADHD assessment has increased slightly to 3,194; this includes both the existing and new referrals.
- The number of children waiting for either an ASD or ADHD assessment remains high (3,858) yet increasing only by 7 since last month. External capacity has been fully utilised for children appropriate online assessments, Staff in the CAMHS service are due to start in April.
- A full validation of the waiting list for children waiting with MPFT on the Neuro-developmental pathway is underway.

CYP:

- CYP Access performance has improved for the third consecutive month however remains below plan by 16%. A remedial action plan proposed by the main provider (MPFT) has been agreed with the ICB this month. The latest trajectory shows target should be met during 26/27 quarter 2.

Quality

- MRSA has breached 2025/2026 objective -1 case reported for November 25
- SCHAT have breached C. diff trajectory for 2025 / 2026 - no further cases for Nov 25
- C.diff is under monthly objective at 9 cases for November 25 (trajectory 12),
- E-coil has breached monthly objective at 43 cases for November 25 (trajectory 36),
- Klebsiella has breached monthly objective, however a reduction in cases has been noted -12 cases for October 25 (trajectory 7),

Workforce key messages:

- Overall provider workforce expenditure YTD is adverse to plan by £10.8M - bank overspend YTD at £9.78M.
- Current full year run rate is £20.4M adverse to plan although mitigations are forecast to reduce the final outturn to £10.6M adverse to plan with bank spend forecast at £6.2M adverse to plan.
- Overall WTE is slightly below plan by 18 WTE with bank exceeding plan by 48 WTE but mitigated by substantive and agency levels.
- NHS Infrastructure Support cost reductions are favourable to plan by £4.2M YTD. The mismatch in reporting between WTE and pay spend is a national

- issue due to different definitions within PFRs and PWRs and is being addressed through a regional workforce establishment working group.
- There is a new agency rule introduced nationally to eliminate Band 2/3 Agency usage by end January 2026 – currently SCHAT is non-compliant.

Finance key messages:

Revenue

- The STW system is slightly behind plan after 9 months of the financial year due to the additional cost of urgent care capacity and reduced delivery against WTE reductions.
- The system is reporting a £4.7m deficit, which is an overspend of £3.1m compared to plan.
- Mitigations have been identified to recover the year to date overspend and the system remains on track to breakeven by year-end (31st March 2026) after deficit support funding of £83.8m from NHS England.
- Q4 deficit support funding has been released to the System in Month 9.

Capital

- The STW system continues to be behind plan after 9 months (£32.3m) due to the profiling of capital spend being different to the original capital plan namely for HTP, noting that the capital scheme delivery itself is ahead of plan for HTP.
- The underspend will be recovered by year end and total system capital spend is expected to be £6.9m higher than plan due to new capital received in year above the original plan value.

1.3. Recommendations

For the Board:

- To **note** and **discuss** the contents of the report.

1.4. Conflicts of Interest

None identified.

1.5. Links to the System Board Assurance Framework (SBAF)

The subject of the report provides second line assurance against the following two strategic risks within the SBAF:

- Strategic risk no. 2a: Risk of not achieving underlying financial balance (ICB & System)
- Strategic risk no 2b: Failure to deliver the system and ICB revenue and capital resource limit plans
- Strategic risk no. 3: STW is seeing a growing and ageing population; services and the workforce will need to adapt and shape to meet these needs. There is a risk that this capacity and capability will not be sufficient to meet population needs nor be able to focus on tackling identified and emergent health inequalities in every instance.

1.6. Alignment to Integrated Care Board

The report aligns to the ICBs goals by:

- Seeking 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
- Identifying areas of concern which may support a requirement for further investigation to determine whether there is an impact on inequalities
- Identifying areas of concern which may support a requirement for further investigation to determine whether there is any impact on productivity or value for money

1.7. Key Considerations

Quality and Safety: Quality Leads have worked with Planning and Performance Leads to ensure Quality is reflected throughout the report. There is a Quality section that picks up areas not covered in other sections).

Financial Implications: The report identifies areas of concern which may support a requirement for further investigation to determine whether there is any impact on productivity or value for money. Delivery of the financial plan and efficiency plan targets support financial recovery and sustainability.

Workforce Implications: There is a workforce section of the report which identifies areas of concern relating to workforce.

Risks and Mitigations: No risks identified as a direct result of this report

Engagement: No engagement requirements identified as a direct result of this report

Supporting Data and Analysis: ICB big dash utilised to create the report

Legal, Regulatory, and Equality: No legal, regulatory or equality implications identified as a direct result of this report

1.8. Impact Assessments

1.8.1. **Has a Data Protection Impact Assessment been undertaken?** N/A

1.8.2. **Has an Integrated Impact Assessment been undertaken?** N/A

1.9. Attachments

None.



2. Integrated Performance Report December 2025

Contents

1. Agenda Item Number – Integrated Performance Report December 2025	1
1.1. Purpose.....	1
1.2. Executive Summary	1
1.3. Recommendations	4
1.4. Conflicts of Interest	4
1.5. Links to the System Board Assurance Framework (SBAF).....	4
1.6. Alignment to Integrated Care Board.....	4
1.7. Key Considerations	5
1.8. Impact Assessments	5
1.9. Attachments	5
2. Integrated Performance Report October 2025	6
2.1 Assurance Matrix Summary	7
2.2 Interpreting summary icons	8
2.3 Overview Matrix	9
2.4 Primary Care.....	12
2.5 Urgent and Emergency Care	13
2.6 Planned Care	15
2.7 Mental Health - Adults	17
2.8 Learning Disability and Autism – LDA.....	18
2.9 ASD and ADHD	19
2.10 Children and young people (CYP)	20
2.11 Quality	21
2.12 Workforce	23
2.13 System Financial Position.....	25



2.1 Assurance Matrix Summary

Interpreting SPC charts

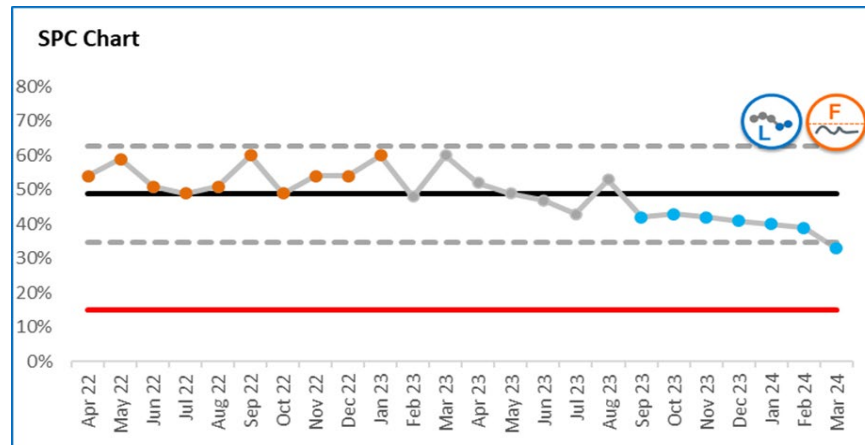
A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly).

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.







2.2 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.

2.3 Overview Matrix

SPC Matrix		Assurance				Movement in Month
		Consistently Achieving the Target	Inconsistently Achieving the Target	Consistently Failing the Target	No National Target	
						
Improving Variation		<ul style="list-style-type: none"> Patients accessing perinatal mental health - STW 	<ul style="list-style-type: none"> % Urgent Community Response patients seen within 2hrs - SCHAT Diagnosis to First Treatment< 31 days - STW CYP Eating Disorders (Routine) seen within 4 weeks - STW 	<ul style="list-style-type: none"> Incomplete RTT <18 weeks at month end - STW Time to first appointment <18 weeks - STW All Diagnostics - < 6ww against target - STW All Diagnostics - < 13ww against target - STW 28 Day Faster Diagnosis Standard - STW Referral to treatment < 62 days % - STW Talking Therapies First seen <18 weeks - STW CYP - persons U18 supported with at least 1 contact - STW % Annual Health checks per LD register aged 14 or over - STW A&E 4 hour performance achievement (Type 1&3) - SaTH 	<ul style="list-style-type: none"> ARRS - WTE - STW Direct Patient Care in Post (FTE) - STW Pharmacy First consultations - STW Number of people accessing IPS (rolling 12 months) - STW Proportion of PW split by discharge P1 - SaTH Maternity Booking before ten weeks - SaTH 	Metric Performance deteriorated from improving to normal variation or from normal to concerning variation
		<ul style="list-style-type: none"> LD adults currently inpatient in MH setting - STW Cat 2 Response Mean time - WMAS 	<ul style="list-style-type: none"> 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 - SCHAT Community Waits of 52 or more weeks for adult services - SCHAT 	<ul style="list-style-type: none"> CYP - ASD Total waits (5-17) - STW Adult - ADHD Total waits - STW Mothers Smoking at Time of Delivery - SaTH 		
Normal Variation		<ul style="list-style-type: none"> FIT - % of suspected Lower GI cancers with FIT - STW Talking Therapies reliable recovery after 2+ contacts - STW Talking Therapies patients reliably improved 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 Average handover time - WMAS 	<ul style="list-style-type: none"> A&E 4 hour performance achievement (Type 1&3) - STW OAP - Active inappropriate out of area adult placements - STW % Type1 attends, 12hrs+ in ED - SaTH % of Ambulance Handovers within - 45 mins - WMAS 	<ul style="list-style-type: none"> 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 Units of dental activity delivered in the period - STW Dental activity as a proportion of contracted activity - STW Referrals U18 from A&E to liaison psychiatry <1hr - STW No. of cases - MSSA - STW Total A&E attendances against plan - SaTH Proportion of PW split by discharge P2 - SaTH FFT: Maternity Birth % Positive - SaTH FFT: Maternity Postnatal Community % Positive - SaTH FFT: AE % Responded - SaTH FFT: AE % Positive - SaTH Mothers per 1000 with post-partum haemorrhage >=1500ml - SaTH Community Waits for CYP services, total - SCHAT FFT: Inpatient % Responded - RJAH FFT: Inpatient % Positive - RJAH FFT: Community % Responded - SCHAT FFT: Community % Positive - SCHAT FFT: MH % Responded - 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 	
Concerning Variation			♦ Autistic adults currently inpatient in MH setting - STW		♦ CYP - ADHD Total waits (5-17) - STW ♦ Adult - ASD Total waits - STW ♦ Proportion of PW split by discharge P3 - SaTH ♦ Community Waits for adult services, total - SCHAT	Metric Performance remained static
		♦ % of GP appointments attended within 2 weeks (ACC-08) - STW		♦ Proportion of Adult SMI having Physical Health Checks - STW	♦ FFT: Inpatient % Responded - SaTH ♦ FFT: Inpatient % Positive - SaTH ♦ FFT: Maternity Antenatal Care % Positive - SaTH ♦ FFT: Maternity Birth % Responded - SaTH ♦ FFT: Maternity Postnatal Ward % Positive - SaTH ♦ FFT: MH % Positive - MPFT	
Insufficient data						New metric for this report

Monthly Movement in Metrics:

Metrics where performance deteriorated from improving to normal variation or from normal to concerning variation.

- ♦ Mental Health: Talking Therapies patients reliably improved after 2+ contacts – STW
- ♦ Primary Care: Total Primary care appointments – STW
- ♦ Primary Care: Total Face to Face appointments – STW
- ♦ Quality: Mothers per 1000 with post-partum haemorrhage $\geq 1500\text{ml}$ – SaTH
- ♦ Quality: FFT: MH % Responded – MPFT
- ♦ LDA: Autistic adults currently inpatient in MH setting – STW
- ♦ UEC: Proportion of PW split by discharge P3 - SaTH

Metrics where performance improved from concerning to normal variation or from normal to improving variation.

- ♦ Primary Care: % of GP appointments attended same or next day – STW
- ♦ UEC: Proportion of PW split by discharge P2 – SaTH

New metrics this report

- ♦ Cancer: Diagnosis to First Treatment < 31 days – STW
- ♦ Planned Care: Incomplete RTT < 18 weeks at month end – STW
- ♦ Mental Health: Talking Therapies First seen < 18 weeks – STW
- ♦ Mental Health: Number of people accessing IPS (rolling 12 months) – STW

- ◆ Community: Community Waits of 52 or more weeks for CYP services – SCHAT
- ◆ Community: Community Waits of 52 or more weeks for adult services - SCHAT

2.4 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	Nov 25		260,312	⬇️			❌	254,786	
Total Face to Face appointments	Primary Care	STW	Nov 25		166,778	⬇️				171,227	
% of GP appointments attended within 2 weeks (ACC-08)	Primary Care	STW	Nov 25	85%	87.2%	⬆️	🟢	🟢	🟢	88.3%	
% of GP appointments attended same or next day	Primary Care	STW	Nov 25		51.7%	⬆️				52.2%	
ARRS - WTE	Primary Care	STW	Dec 25		285	⬆️				266	
GPs in Post (FTE)	Primary Care	STW	Nov 25		238	⬆️				237	
Direct Patient Care in Post (FTE)	Primary Care	STW	Nov 25		174	⬆️				160	
Units of dental activity delivered in the period	Primary Care	STW	Oct 25		60,772	⬆️			🟢	53,877	
Dental activity as a proportion of contracted activity	Primary Care	STW	Oct 25		84%	⬆️			🟢	81.5%	
Pharmacy First consultations (CP,BP,OC)	Primary Care	STW	Nov 25		5,097	⬆️			🟢	3,704	

Escalation charts

% of GP appointments attended within 2 weeks (ACC-08): Primary Care, STW

The chart displays the percentage of GP appointments attended within 2 weeks (ACC-08) for Primary Care, STW, from 2024 to 2025. The y-axis ranges from 86% to 90%. A solid horizontal line represents the target at 85%. A dashed horizontal line represents the mean performance, which fluctuates around 88%. A red dashed line at the bottom indicates a target for 2025. The data points show a general upward trend in 2025, with several points exceeding the 85% target.

Primary Care Escalation Points

Focus Headlines:

- Total number of appointments in primary care dropped by 20% compared to the previous month. There is monthly variation due to short term requirements in this case the cohort attending for flu jabs in October.
- Change to dental reporting to only show the data once the claim window has closed is now presenting a more accurate picture of the performance.

Narrative:

- The percentage of GP appointments within 2 weeks shows concerning variation however performance increased by 1.2% and continues to achieve the target of 85%. Same or next day appointments increased by 5.7% following a decrease last month.
- Units of dental activity increased by 11% compared to the previous month and continues to exceed the target
- Pharmacy First performance fell compared to last month but remains above the monthly target. The increase last month related to patients having unplanned BP checks when attending for flu jabs.

Key Actions:

- The decrease in total number of appointments will be alleviated going forward due to the planned increase in GP of 4.2wte and ARSS (Additional Roles Reimbursement Scheme) increasing by 7wte
- Quality visits continue to be prioritised in line with workforce capacity. The primary care team are keeping capacity under review to identify any additional opportunities
- Ongoing support for practices following the 1 October 2025 contract changes are still being discussed with NHSE and tailored advice continues to be provided to individual practices as clarity develops.

Key Risks and mitigations:

- PLS (Practice Level Support) programme engagement and outcomes will not be delivered as envisaged. The Quality visits act as mitigation for this risk.

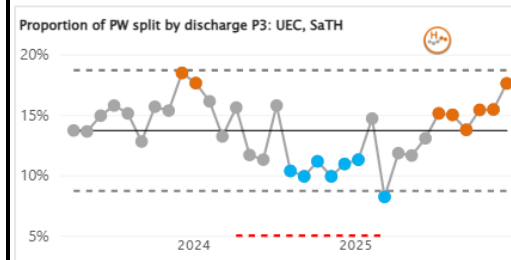
2.5 Urgent and Emergency Care

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	Dec 25	00:30	00:39	⬆️	⚠️	❌	✅	00:39
Average handover time	UEC	WMAS	Dec 25	00:45	01:35	⬆️	⚠️	❌	❌	01:12
% of Ambulance Handovers within – 45 mins	UEC	WMAS	Dec 25	100%	54.8%	⬆️	⚠️	❌	❌	58.2%
A&E 4 hour performance achievement (Type 1&3)	UEC	SaTH	Dec 25	76%	52.0%	⬆️	⚠️	❌	❌	51.9%
A&E 4 hour performance achievement (Type 1&3)	UEC	STW	Dec 25	76%	60.2%	⬆️	⚠️	❌	❌	61.3%
% Type1 attends, 12hrs+ in ED	UEC	SaTH	Dec 25	10%	21.7%	⬆️	⚠️	❌	✅	22.8%
Total A&E attendances against plan	UEC	SaTH	Dec 25	13,569		⬆️	⚠️	❌	❌	13,020
Proportion of PW split by discharge P1	UEC	SaTH	Dec 25	54.1%		⬆️	⚠️	❌	❌	42.1%
Proportion of PW split by discharge P2	UEC	SaTH	Dec 25	28.3%		⬆️	⚠️	❌	❌	31.5%
Proportion of PW split by discharge P3	UEC	SaTH	Dec 25	17.6%		⬆️	⚠️	❌	❌	13.7%
% Urgent Community Response patients seen within 2hrs	Community	SCHT	Nov 25	70%	84.8%	⬆️	⚠️	✅	✅	82.4%

Escalation charts



Focus Headlines:

- Ambulance handover: Category 2 response time achieved the West Midlands plan but was below the national target. Ambulance handover time did not achieve the national target or the local plan with the local target only being achieved 12 out of 31 days. STW ranked bottom of the 121 reporting trusts with the bottom six all in the West Midlands.
- A&E: 4-hour performance significantly off track against national target and missed local plan by 2.9%
- Pathway splits for discharge continue to be concerning with all failing to meet the local plans

Narrative:

- Ambulance handover: Category 2 response time showing improving variation due to the improved performance since January 25.
- 2-hour urgent community response (UCR) showing improving variation and exceeding target.
- In the bottom quartile nationally for both 4 and 12 hour waits
- 4-hour waits showing normal variation achieving 60.2% against a local plan of 63.1%. SaTH reporting that the 4 hour and 12-hour performance was the best December performance since 2021.
- Comparing A&E attendance data from April to November in 2024/25 to 2025/26 shows an increase of 3.45%

Key Actions:

- SaTH have committed to a maximum ambulance handover threshold with NHSE and West Midland Ambulance Services of 4 hours in January and 3 hours in February.
- UCR service extended opening until midnight from 1 December to enhances alternatives to ED and admission
- Integrated Front Door service continuing to stream patients arriving at ED to community pathways to decompress the department
- Bed base reconfiguration: RSH 18 bed uplift. PRH 40 additional acute assessment spaces including Frailty Same Day Emergency Care
- 2-hour domiciliary care bridging service started in December
- Minimum dataset reporting for the Integrated Out of Hours model expected in February enabling early findings for the service to be identified
- Additional Multi-disciplinary Discharge Events (MADE) took place in December to mitigate industrial action challenge

Urgent and Emergency Care (UEC) ctd.

Key Risks and mitigations:

- **Risks to ambulance offload delays:** 1) Inability to achieve timely Ambulance offload within the maximum time committed to; with delays greater than 8 hours associated with potential harms. 2) Offload To Assess is becoming blocked due to demand, resorting in staff reverting to assessing on the ambulance and delays in tests are also delayed as a result.
- **Risks to flow:** 1) Impact of the bed base reconfigurations is insufficient to make the shift we require in the time patients remain in our EDs before admission. 2) No criteria to reside patient numbers increasing. 3) Bedding in SDEC impacting assessment and flow. 4) Referrals for complex discharge requiring support outstrips the capacity of out of hospital. Care
- **Mitigations for all risks:** Give the changes time to embed. Executive level commitment to deliver. System support focused on reducing complex discharge waits and improving flow for NCTR patients. Care transfer hub and therapy teams to review patients identified for bedded discharge to see if a package of care can be put in place instead.

2.6 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	Nov 25	0	43			✗	✗	556
Incomplete RTT pathways of 52+ weeks	Planned Care	STW	Nov 25	0	786			✗	✓	3,420
Incomplete RTT pathways of 52+ weeks where patient age is <=18	Planned Care	STW	Dec 25	0	34			✗	✓	301
Incomplete RTT <18 weeks at month end	Planned Care	STW	Nov 25	60%	66.3%			✓	✓	54.5%
Time to first appointment <18 weeks	Planned Care	STW	Dec 25	67%	74.3%			✓	✓	59.6%
All Diagnostics - < 6ww against target	Diagnostics	STW	Nov 25	95%	86.7%			✗	✗	72.8%
All Diagnostics - < 13ww against target	Diagnostics	STW	Nov 25	100%	98.2%			✗	✗	92.3%
28 Day Faster Diagnosis Standard	Cancer	STW	Nov 25	80%	86.0%			✓	✓	71.0%
FIT - % of suspected Lower GI cancers with FIT	Cancer	STW	Dec 25	80%	83.9%			✓	✗	83.1%
Referral to treatment < 62 days %	Cancer	STW	Nov 25	85%	68.8%			✗	✓	57.4%
Diagnosis to First Treatment < 31 days	Cancer	STW	Nov 25	96%	92.2%			✗	✗	87.2%
Community Waits of 52 or more weeks for CYP services	Community	SCHT	Nov 25	0	18			✗	✗	76.5
Community Waits of 52 or more weeks for adult services	Community	SCHT	Nov 25	0	5			✗	✓	36.7
Community Waits for CYP services, total	Community	SCHT	Nov 25		2,910					3,071
Community Waits for adult services, total	Community	SCHT	Nov 25		4,958					4,551

Escalation charts

Community Waits for adult services, total: Community, SCH1

Month	Value
Jul 2024	4,000
Aug 2024	4,050
Sep 2024	4,300
Oct 2024	4,300
Nov 2024	4,300
Dec 2024	4,300
Jan 2025	4,400
Feb 2025	4,500
Mar 2025	4,600
Apr 2025	4,700
May 2025	4,600
Jun 2025	4,600
Jul 2025	4,958

Focus Headlines:

- **RTT:** 43 patients waiting over 65 weeks all at RJAH. 786 patients waiting over 52 weeks forecasts indicating reductions in January. Incomplete pathways seen within 18 weeks meeting target at 66.3%. First appointment within 18 weeks meeting target at 74.3%
- **CYP:** 52 week waits reduced to 34 against a local plan of 61. Continuous improvement in the CYP RTT waitlist reducing from 7,174 in December 2024 to 4,564 in December 2025.
- **Cancer:** 28 day Faster Diagnosis Standard (FDS) is better than plan. FIT is above target. 68 day standard is above plan. 31 day standard is just below plan at 92.2% (93.6% plan)
- **Community waits:** CYP patients waiting over 52 weeks has further decreased to 18; adult patients decreased to 14
- **DM01 diagnostics:** Decrease to 86.7% for patients seen within 6 weeks. 13-week waits have decreased by over 60 to 264

Narrative:

- All RTT continues to show improving variation. Tiering calls with NHSE continue for both providers
- 62-day and 31-day cancer standard and FDS all showing improving variation.
- Cancer performance has improved significantly following strengthened senior leadership and delivery of phase one cancer improvement programmes. Phase two is now underway.
- Workforce constraints remain a risk, particularly within Oncology and Maxillofacial pathways, alongside unavoidable delays driven by clinical complexity and multiple diagnostic requirements at RJAH
- Community CYP 52 week waits forecast to be eliminated by December 2025 with the exception of wheelchair services
- Speech and Language therapy now have only 1 child waiting over 52 weeks while wheelchair services has 17 children waiting due to the complexity. The provider has determined these patients are not suitable for the service and discussions are taking place to identify a solution.
- Diagnostics recovery plans in place for both RJAH and SaTH, which are being monitored via the ICB and tiering calls.

Planned Care ctd.

Key Actions:

- **Additional clinical capacity:** Additional locum in ENT; increase in minor ops capacity at Bridgnorth; lead consultant recruited for Non-complex acute pain service to start in Q2; increase case per sessions yielding 28 cases in January; Portland Insourcing have identified a spinal consultant to see new patients giving approximately 200 new patient slots; recruitment to Cancer Clinical Lead role and establishment of triumvirate leadership team. Insourcing to support oncology and maxillofacial pathways
- **Other additional capacity:** Additional support in place to assist bookings. Additional ultrasound slots to support urology cancer. MRI recruitment commenced with training plans in place. Additional mobile MRI capacity
- **Mutual support:** RJAH supporting SaTH after T&O ward closure at PRH. Partnership working with Royal Wolverhampton in cancer services.
- Consultant Connect gone live for dermatology
- RJAH programmes of work following GIRFT visits: standardised clinic templates from January; agree and monitor follow up protocols within specialties; increase cases per session within theatres
- Phase two of cancer improvement programme underway
- MDT review to manage complex clinical pathways and diagnostic sequencing
- Clinic template review underway to address paediatric tumour capacity constraints
- Process implemented to uncouple MRI and outpatient appointments to improve diagnostic access
- Agree formal plans for the children waiting for a restrictive intervention with the wheelchairs service, as not appropriate for the service but have a neuro-divergent behavioural need, with a system approach involving Local authorities.
- Business cases: Sustainable Endoscopy Business Case approved. MRI capacity to improve flexibility business case developed

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

2.7 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	Nov 25	48%	49%	⬆️	🟡	🟢	🔴	48.2%
Talking Therapies patients reliably improved after 2+ contacts	Mental Health	STW	Nov 25	67%	75%	⬆️	🟡	🟢	🟢	72.1%
Talking Therapies First seen <18 weeks	Mental Health	STW	Nov 25	95%	91%	⬆️	🟡	🔴	🔴	81.9%
OAP - Active inappropriate out of area adult placements	Mental Health	STW	Nov 25	0	5	⬆️	🟡	🔴	🔴	5
Patients accessing perinatal mental health	Mental Health	STW	Nov 25	501	950	⬆️	🟡	🟢	🟢	804
Proportion of Adult SMI having Physical Health Checks	Mental Health	STW	Dec 25	60%	52.4%	⬆️	🟡	🔴	🔴	53.9%
Number of people accessing IPS (rolling 12 months)	Mental Health	STW	Nov 25		580	⬆️	🟡	🟢	🟢	468

Escalation charts

Proportion of Adult SMI having Physical Health Checks: Mental Health, STW

Focus Headlines:

- Talking therapies performance is strong, 18-week first-seen performance shows sustained improvement but remains slightly below target.
- SMI patients' physical health check performance below target but on track.
- Inappropriate Out of Area (OOA) placements remain stable

Narrative:

- Talking therapies 18-week performance below target due to patient preferences for specific appointment times
- SMI patients' physical health check performance below target year to date but showing continued improvement; year-end target still expected to be met.
- Inappropriate OOA placements above target of zero. There are issues with national reporting, acknowledged by NHSE, so reporting will move to local data as this is deemed more accurate

Key Actions:

- Monitoring talking therapies service offering appointment choices to reduce waits
- Reminders to practices to review SMI data recording, support to PCNs with lower uptake rates to increase completion
- Revised capital bid submitted for PICU investment
- Exploring alternative local specialist services for Emotionally Unstable Personality Disorder patients with the longest stays by February
- MPFT reviewing rehabilitation and discharge pathways. Hospital to Home programme to be operational by March to support community reintegration and reduce readmissions.
- Housing workshop planned for February involving all system partners
- Ongoing MADE events to address discharge challenges

Key Risks and mitigating actions:

- 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

2.8 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	Nov 25	75%	40.8%					20.6%
Autistic adults currently inpatient in MH setting	LDA	STW	Dec 25	9	14					10.7
LD adults currently inpatient in MH setting	LDA	STW	Dec 25	7	9					9.38
LDA children currently inpatient in MH setting	LDA	STW	Dec 25	1	1					2.94

Escalation charts

Autistic adults currently inpatient in MH setting: LDA, STW

Month	Value
Jul 2024	8.5
Aug 2024	8.2
Sep 2024	8.8
Oct 2024	8.5
Nov 2024	8.8
Dec 2024	9.0
Jan 2025	11.0
Feb 2025	12.0
Mar 2025	14.0
Apr 2025	11.0
May 2025	13.0
Jun 2025	11.0
Jul 2025	14.0

Focus Headlines:

- There are 23 Adults at end of December occupying a MH bed of which 14 are Autistic and 9 with diagnosed LD, against Q3 plan of 17. Movement since then below.
- There is 1 CYP in a MH bed at end of December, in line with plan.
- Annual health checks continue ahead of plan and on track to meet 75% target by year end.

Narrative:

- **Adult Inpatients:** Three admissions and one discharge in month taking the number to 23 (one patient has been subsequently discharged). Numbers remain above plan, and there are 5 delayed transfers of care (DTOC).
- **CYP Inpatients:** Reduced to one child and now meeting plan; remaining child has a red-rated discharge plan

Key Actions:

- Monitor the Electronic Dynamic Support Register (DSR) and roll out further training with focus on reducing the number of patients on DSR to those who are most appropriate.
- Housing workshop scheduled for Feb 2026 (slipped from January) aiming to address some of the challenges.
- Oswestry bungalows project, continue monthly with NHSE Proposal needs to be agreed before end of March 2026 to retain funding.
- TCP will undertake review and hold the case management to review discharge plans, to address capacity issues in the ICB case manager team for the short term. A longer-term plan will be needed to be finalised within the ICB, and the cluster.

Key Risks and mitigations:

- **Risks:** 1) People are staying in hospital in more restrictive placement longer than necessary which can impact on their quality of life. 2) Lack of appropriate specialised housing and accommodation locally to meet the needs of people with complex care needs leading to delayed discharges. 3) Lack of capacity in the case management team (Individual commissioning) to undertake required 8 weekly visits to monitor progress of individual patients. Currently no mitigation in place for this.
- **Mitigating actions:** Treatment and discharge plans monitored for longer stay patients; proactive strategies to prevent avoidable admissions; consider discharge to OOA community placements where local accommodation is unavailable; MADE events to address barriers to discharge; lessons from admissions used to reduce readmission risks; all inpatients regularly reviewed through TCP

2.9 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	Nov 25	1					755	
CYP - ADHD Total waits (5-17)	LDA	STW	Nov 25	501					481	
Adult - ASD Total waits	LDA	STW	Nov 25	2,291					1,470	
Adult - ADHD Total waits	LDA	STW	Nov 25	2,393					2,798	

Escalation charts

CYP - ADHD Total waits (5-17): LDA, STW

Adult - ASD Total waits: LDA, STW

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:

- Children aged 5–17 waiting for an ASD or ADHD assessments increased slightly to 3,858, with average waiting times also increasing.
- Adults waiting for ADHD assessments increased by 83 to 3,194
- Adult ASD waiting numbers remain stable, with average waits of 73 weeks in Shropshire and 51 weeks in Telford & Wrekin.

Narrative:

- **Adult ADHD:** High demand continues to exceed commissioned capacity leading to long waits consistent with national trends. The average wait is 33 weeks with the longest at 67. Accredited providers are beginning to undertake more assessments.
- **Adult ASD:** High demand continues to exceed commissioned capacity with numbers waiting increasing to 2,291
- **Children’s ND:** Increased to 3,356 waiting. The provider has notified that external capacity for ASD assessment has been exhausted.

Key Actions:

- All CYP on the waiting list moved to the ND pathway to progress with a full waiting list validation exercise. A remedial action plan, including waiting list validation, is in place for children’s neurodevelopmental pathway with regular meetings

Key Risks and mitigations:

- **Risks:** 1) Longer waiting times for assessment and treatment that could potentially lead to Physical and Psychological Harm. Related to issues with staff recruitment and low retention rates in BeeU service which is a concern to meet high level of demand for assessments. 2) Issues around co-morbidity and shared care arrangements are still outstanding but are being worked through.
- **Mitigations:** Access to 24/7 Mental Health Access Team for support reducing harm from long waits; support offer to CYP waiting for assessment; 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; Adult ASD pathway improvements including enhanced pre-diagnosis support, streamlined clinic booking and guidance Autism Hubs to reduce risk of harm

2.10 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	Nov 25	45%						42.2%
CYP Eating Disorders (Routine) seen within 4 weeks	Mental Health	STW	Nov 25	95%	96%					83.1%
CYP - persons U18 supported with at least 1 contact	Mental Health	STW	Nov 25	8,341	6,935					6,084

Escalation charts
All SPC charts for this area showing normal or improving variation. No escalation charts required.

Children and Young People Escalation Points

Focus Headlines:

- Eating Disorders (routine) standard achieved for the second month.
- CYP access has improved again in-month but remains below plan; remedial action plan is in place.

Narrative:

- Eating disorder routine performance is now meeting target, with sustained improvement.
- CYP access has improved again for the third consecutive month but remaining below plan and target. Vacancies and turnover remain key drivers, though both are reducing. The updated trajectory shows anticipated achievement of the target by Q2 2026/27.

Key Actions:

- CYP access: A formal remedial action plan is in place with fortnightly task & finish group meetings reviewing progress against key actions around recruitment, productivity, and improving data quality.
- MPFT continue with measures to address clinical leadership capacity, with progress being reported through the monthly staffing report to support staff supervision & caseload management across CAMHS.

Key Risks and mitigations:

- **Risks:** 1) CYP risk harm or crisis while waiting for assessment or treatment. Provider data reliability (and MHSDS resubmission) is uncertain, limiting ability to predict CYP access performance. 2) BeeU reports several CYP unknown to service presenting to ED in crisis, with unmet clinical and mental health needs. 3) Recruitment and retention challenges persist, particularly in Crisis Teams and school-based Mental Health Support Teams.
- **Mitigations:** 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; Joint MPFT-ICB quality visits are scheduled throughout the year; The “Waiting Well” programme monitors CYP on waiting lists to identify changes in circumstances and mitigate risk; MPFT and SaTH, supported from the ICB BI team, are reviewing ED crisis presentations for CYP not previously known to BeeU, linking with social care; A recruitment and retention strategy is in place

2.11 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	Jun 25	100%						91.3%
Mothers per 1000 with post-partum haemorrhage >=1500ml	Quality	SaTH	Oct 25	29						27.1
Mothers Smoking at Time of Delivery	Quality	SaTH	Oct 25	6.5%						7.95%
Maternity Booking before ten weeks	Quality	SaTH	Sep 25	66.3%						47.4%

Metric Name	Workstream	Metric Type	Latest Date	Target	Value	Var.	Ass.	Target Met	Plan Met	Mean
FFT: Inpatient % Responded	Quality	RJAH	Nov 25	100%						100%
FFT: Inpatient % Responded	Quality	SaTH	Nov 25	2.55%						14.4%
FFT: Inpatient % Positive	Quality	RJAH	Nov 25	97.6%						98.5%
FFT: Inpatient % Positive	Quality	SaTH	Nov 25	95.1%						97.8%
FFT: Community % Responded	Quality	SCHT	Nov 25	0.993%						1.35%
FFT: Community % Positive	Quality	SCHT	Nov 25	99.6%						97.1%
FFT: Maternity Antenatal Care % Positive	Quality	SaTH	Sep 25	0%						80.5%
FFT: Maternity Birth % Responded	Quality	SaTH	Nov 25	0.703%						3.81%
FFT: Maternity Birth % Positive	Quality	SaTH	Jun 25	100%						91.3%
FFT: Maternity Postnatal Ward % Positive	Quality	SaTH	Nov 25	0%						52.0%
FFT: Maternity Postnatal Community % Positive	Quality	SaTH	Oct 25	0%						73.3%
FFT: AE % Responded	Quality	SaTH	Nov 25	6.24%						3.06%
FFT: AE % Positive	Quality	SaTH	Nov 25	70.5%						64.6%
FFT: MH % Responded	Quality	MPFT	Nov 25	0.955%						1.24%
FFT: MH % Positive	Quality	MPFT	Nov 25	89.1%						89.2%

Metric Name	Workstream	Metric Type	Latest Date	Target	Value	Var.	Ass.	Target Met	Plan Met	Mean
Number of cases - C-difficile	Quality	STW	Nov 25	12	9					14.0
Number of cases - E-coli	Quality	STW	Nov 25	36	43					40.1
Number of cases - Pseudomonas aeruginosa	Quality	STW	Nov 25	2	3					3.38
Number of cases - Klebsiella	Quality	STW	Nov 25	7	12					9.84
Number of cases - MRSA	Quality	STW	Nov 25	0	1					0.656
Number of cases - MSSA	Quality	STW	Nov 25	10						11.7

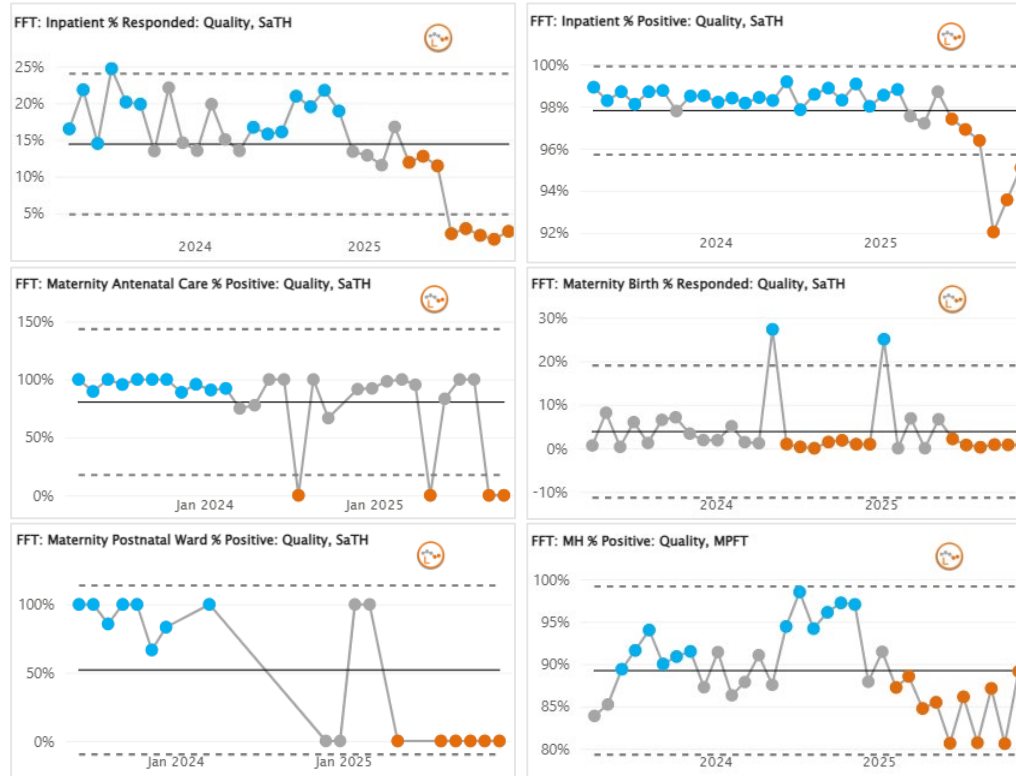
Focus Headlines:

- **Maternity:** Mothers smoking at time of delivery (SATOD) – Data continues to show sustained improvement this month at 6.5%. Maternity Booking before 10 weeks showing continued sustained improvement.
- **Maternity FFT:** Response rates remain low. FFT for Antenatal Care and Birth scores flagged as concerning variation
- **RJAH FFT:** Internal reports confirm >95% positive rating maintained
- **SCHT FFT:** Overall positive response but response rates remain low
- **MPFT FFT:** Scores dropped below lower limit line and may become concerning if trend continues
- **SaTH FFT:** Satisfaction declined across minority ethnic groups. ED waiting times remains the most frequent concern.
- Digital only FFT collection yields richer feedback but sharply reduced response rates, especially inpatients (second lowest in England).
- **IPC:** MRSA has breached 2025/2026 objective reporting 1 further case for Nov. SCHT have breached C. diff trajectory for 2025 / 2026 - no further cases reported for Nov. C.diff is within monthly objective at 9 cases for November 25 (trajectory 12), E-coil has breached monthly objective at 43 cases for November 25 (trajectory 36), Klebsiella has breached monthly objective at 12 cases for November 25 (trajectory 7) however continues downward trend. MRSA bacteraemia investigated, patient was MRSA positive on admission and had a long hospital admission in Switzerland following surgery.
- **IPC:** MRSA bacteraemia investigated, patient was MRSA positive on admission and had a long hospital admission in Switzerland following surgery.

Key Actions:

- **SaTH** – Patient feedback is being reviewed for thematic learning. Oversight of audit themes continues via weekly ED Quality Assurance meetings and monthly reports. During Experience of Care Week, wards and departments were recognised for achievements in gathering positive FFT and Local Inpatient Survey feedback.
- **SCHT** – Developing FFT text messaging and supporting teams to boost response rates.
- **MPFT** – Collecting telephone feedback for those unable to use digital methods;
- **Vaccination Uptake** – Frontline Healthcare Workers and public vaccination rates under scrutiny – pop up clinics arranged to address healthcare inequalities / focus on schools and maternity

Escalation charts



- **CDI** – reduced cases noted. To investigate any correlation between increased fidaxomicin prescribing for month of November. The business case will go to Functioning working group, and its use is to enable Fidaxomicin as first line treatment as it will benefit the system by reducing environmental contamination and incidents of relapse/recurrence

Key Risks and mitigating actions:

- **FFT Risks:** 1) Risk of not receiving timely data for FFT from NHS England means that we cannot act upon recommendations of patients. 2) The move to digital FFT responses is causing a decrease in response by patient in several organisations. 3) FFT responses are not representative of experience due to low response rates
- **Mitigations for FFT: MPFT** – Patient experience team supporting divisions with SMS/digital FFT rollout. **SaTH** – Deputy Director of Nursing and Patient Experience Lead promoting QR code and feedback methods in ED. **ED Audits** – 20 extra weekend audits per site; themes to be reviewed in new monthly assurance paper. **SCHT** – Teams encouraged to promote responses/escalation via divisional meetings; FFT text messaging service in development.
- **IPC Risks:** 1) Harm to patients and potential for extended hospital stay. 2) Unable to complete deep cleans as no decant ward / area available. Mitigations are the key actions identified above

2.12 Workforce

Workforce	
<p>Focus Headlines:</p> <ul style="list-style-type: none"> • Overall provider workforce expenditure YTD is adverse to plan by £10.8M - bank overspend YTD at £9.78M. • Current full year run rate is £20.4M adverse to plan although mitigations are forecast to reduce final outturn to £10.6M adverse to plan with bank spend forecast at £6.2M adverse to plan • Overall WTE is slightly below plan by 18 WTE with bank exceeding plan by 48 WTE but mitigated by substantive and agency • NHS Infrastructure Support costs favourable to plan by £4.2M YTD. The mismatch in reporting between WTE and pay spend is a national issue due to different definitions within PFRs and PWRs and is being addressed through a regional workforce establishment working group. • New agency rule introduced nationally to eliminate Band 2/3 Agency usage by end January 2026 – currently SCHAT non-compliant 	<p>Key Actions:</p> <ul style="list-style-type: none"> • SaTH continue to implement enhanced controls over bank usage with significant impact delivered on nursing bank and work underway to review impact of increased activity on medical bank. Regional bank rates rollout to theatre staff. • SaTH extraordinary meeting of SLT scheduled to review further mitigations for bank and impact of fragile services on bank usage • SCHAT recruitment plans in delivery for prison vacancy, monitoring impact of UCR expansion of agency usage (inc. Band 2/3 agency) and continued rollout of NHSP • Reconcile contracted and actual worked wte to understand underlying causes of misalignment between workforce spend and WTE alongside the NHSE Regional Pay Spend Disaggregation Template. <p>Key Risks:</p> <ul style="list-style-type: none"> • SaTH medical efficiency schemes fail to deliver planned savings and increase reliance on bank – mitigations in place overseen by the Financial Recovery Team. • Continued reliance on temporary staffing adversely impacts quality, performance and financial plans – mitigated but premium bank rates still in use across fragile services • Failure to comply with newly-introduced national agency rule that all Band 2/3 agency usage to be eliminated by end January 2026 – mitigated to large extent but UCR expansion may require continued use beyond January deadline

Shropshire, Telford and Wrekin: Workforce Highlight Report: M9 (DEC 2025)

STW M9 Workforce Expenditure (£000) NB: Numbers below are provider only and exclude capital pay costs

	Plan YTD £000	Actual YTD £000	Var YTD £000	FY Plan £000	FY Forecast £000	FY Run Rate £000	FY Plan vs Forecast £000	FY Plan vs Run Rate £000
Substantive								
Non Medical Clinical	260993	275839	14846	345183	366716	367785	21533	22602
Non Medical Non Clinical	68698	64015	-4683	91339	86055	85353	-5284	-5986
Medical Dental	124871	117107	-7764	166072	154807	156143	-11265	-9929
Total Substantive	454562	456961	2399	602594	607578	609281	4984	6687
Bank								
Non Medical Clinical	20012	24689	4677	25948	30003	32919	4055	6971
Non Medical Non Clinical	2993	3540	547	3774	3940	4720	166	946
Medical Dental	15151	19706	4555	19834	21837	26275	2003	6441
Total Bank	38156	47935	9779	49556	55780	63913	6224	14357
Agency								
Non Medical Clinical	5103	4164	-939	6283	5497	5552	-786	-731
Non Medical Non Clinical	526	460	-66	700	700	613	0	-87
Medical Dental	5397	5071	-326	6531	6743	6761	212	230
Total Agency	11026	9695	-1331	13514	12940	12927	-574	-587
GRAND TOTAL	503744	514591	10847	665664	676298	686121	10634	20457

Overall Headcount (WTE)

WTE	M9 Plan	M9 Actual	M9 Variance
Substantive	10660	10616	-44
Bank	688	736	+48
Agency	103	81	-22
Total	11451	11433	-18

NHS Infrastructure Support (WTE & £000)

	WTE M9 Plan	WTE M9 Actual	WTE M9 Var	£000 M9 YTD Plan	£000 M9 YTD Actual	£000 M9 YTD Var
Subs	2512	2615	103	68698	64015	(4683)
Bank	77	113	36	2993	3540	547
Agency	6	5	-1	526	460	(66)
Total	2595	2733	138	72217	68015	(4202)

KPI	Plan	Performance *exc MPFT
Delivery of 2025/26 Workforce Plan: WTE	WTE 11452	WTE 11433
Delivery of 2025/26 Workforce Plan: Expenditure across all staff types (exc capitalised pay costs)	£503.74m	£514.59m (£10.8m adverse variance)
Turnover	9.8%	9.5%
Sickness	5.2%	5.4%
% Agency Framework Compliance	100%	100%
Agency as % Total Pay	2.0%	1.89%
Consultant Job Plans	95% (national target)	STW 365/378 = 97% SCHAT 6/6 SATH 262/266 RAH 97/106

Key Messages:

- Overall provider workforce expenditure YTD is adverse to plan by £10.8M* - bank overspend YTD at £9.78M.
- Current full year run rate is £20.4M adverse to plan although mitigations are identified to reduce temporary staffing and yte reductions although the final FOT is under review.
- Overall WTE is slightly below plan by 18 WTE with bank exceeding plan by 48 WTE but mitigated by substantive and agency
- NHS Infrastructure Support costs favourable to plan by £4.2M YTD. The mismatch in reporting between WTE and pay spend is a national issue due to different definitions within PFRs and PWRs and is being addressed through a regional workforce establishment working group.
- New agency rule introduced nationally to eliminate Band 2/3 Agency usage by end January 2026 – currently SCHAT non-compliant

Key Actions:

- SaTH continue to implement enhanced controls over bank usage with significant impact delivered on nursing bank and work underway to review impact of increased activity on medical bank. Regional bank rates rollout to theatre staff.
- SaTH extraordinary meeting of SLT scheduled to review further mitigations for bank and impact of fragile services on bank usage
- SCHAT recruitment plans in delivery for prison vacancy, monitoring impact of UCR expansion of agency usage (inc. Band 2/3 agency) and continued rollout of NHSP
- Reconcile contracted and actual worked wte to understand underlying causes of misalignment between workforce spend and WTE alongside the NHSE Regional Pay Spend Disaggregation Template.

2.13 System Financial Position

Finance	
<p>Focus Headlines:</p> <p>Narrative - Revenue: The ICS is reporting a £4.7m actual YTD System deficit, £3.1m adverse to plan YTD at M9, post deficit support funding.</p> <p>The 2025/26 expected forecast outturn is breakeven after £83.8m deficit support funding.</p> <p>These forecasts include delivery of efficiency of £101.6m against a target of £95.5m, an over delivery of £6.1m.</p> <p>ICB – Has a year-to-date favourable variance of £2.4m this is namely due to the delivery of additional efficiency and prior year benefits.</p> <p>SaTH – Are reporting a year-to-date adverse variance of £5.8m, namely driven by additional costs of UEC capacity and non-delivery of wte reductions.</p> <p>RJAH – Are reporting delivery on plan year-to-date.</p> <p>SCHT – Have a year-to-date favourable variance of £0.3m.</p> <p>Narrative - Capital: Year to date system operational capital spend is £32.3m behind plan at month 9, namely due to the difference in spend profile of HTP compared to plan, all capital schemes are expected to be delivered in line with plan by year end. Additional capital of £6.9m has been received in year above the original plan value.</p>	<p>Key Actions:</p> <p>Revenue: Note that the ICS is reporting a £4.7m actual YTD System deficit v's £1.6m deficit plan, giving a £3.1m adverse variance at M9. Note that the 2025/26 expected forecast outturn is breakeven after £83.8m deficit support funding.</p> <p>Capital: Note that the ICS at Month 9 is reporting a £32.3m underspend against plan namely due to the profile of capital spend compared to plan. Note that in Month 8 all providers and the ICB confirmed expected FOT in line with the additional capital plan, with £6.9m of additional capital received and spent in year above the original plan value.</p> <p>Key Risks and mitigating actions:</p> <p>Revenue: At month 9 SATH have reported potential unmitigated risk of £3.6m, If this were to materialise, the System will seek to mitigate this difference to plan thus delivering the System plan overall.</p> <p>Capital: Ongoing capital programme management is in place to ensure capital spend is in line with plan.</p>

System Financial Position

System Financial Position Month 9

Financial Performance	YTD			FULL YEAR		
	Plan Surplus/ (Deficit) £000	Actual Surplus/ (Deficit) £000	Variance to Plan £000	Plan Surplus/ (Deficit) £000	Forecast Surplus/ (Deficit) £000	Variance to Plan £000
Commissioners						
NHS Shropshire, Telford and Wrekin	(1,209)	1,227	2,436	(1,999)	(1,999)	0
Total Commissioners	(1,209)	1,227	2,436	(1,999)	(1,999)	0
Providers						
The Shrewsbury and Telford Hospital NHS Trust	(1)	(5,848)	(5,847)	0	0	0
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS FT	(1,796)	(1,791)	5	0	0	0
Shropshire Community Healthcare NHS Trust	1,431	1,714	283	2,000	2,000	0
Total Providers	(366)	(5,925)	(5,559)	2,000	2,000	0
TOTAL SYSTEM Performance Financial Position Surplus/(Deficit)	(1,575)	(4,698)	(3,123)	1	1	0
Non Recurrent Deficit Funding	(68,301)	(68,301)	0	(83,795)	(83,795)	0
NHSE Approved Position	(69,876)	(72,999)	(3,123)	(83,794)	(83,794)	0

At Month 8 NHSE regional team assessed YTD delivery, expected FOT and progress made in relation to 2026/27 financial plan.

This assessment led to a recommendation to release the Q4 deficit support payment for the ICB and SATH, this has been received in Month 9.

Key Data

- **System** - In month 9 the system is reporting a £4,698k deficit, £3,123k adverse variance to plan.
- **ICB** - Month 9 surplus of £1,227k which is £2,436k favourable to plan. This is after the recognition of £29.0m non recurrent deficit funding. Efficiency delivery is ahead of the phased plan year to date (£7.1m favourable) due to individual commissioning but is in line with the overall annual efficiency plan.
- **SaTH** - Month 9 £5,848k deficit, supported by £39.3m of non-recurrent deficit funding. £28.6m efficiency delivery year to date which is £0.2m favourable against plan. Pressures on pay of £14.5m 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. Failure to deliver medium and high risk planned mitigating actions with regards to headcount and temporary staffing, pay award pressures and Industrial action costs have also contributed to the adverse variance although additional funding for Industrial Action costs has been provided in Month 9. The adverse variance is offset by income, namely in respect of WMCA income, and early recognition of some efficiency schemes.
- **RJAH** - Month 9 £1,791k deficit, £5k favourable to plan. £7,651k efficiency delivery year to date, £900k 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** - Month 9 surplus of £1,714k, £283k favourable to plan due mainly to cost pressures in Prison mental health and Rehab and Recovery Unit out of hours being offset by non-recurrent pay savings and efficiency performance. Pay underspend £620k driven by delays in filling substantive vacancies. Bank staff overspend offset by substantive vacancies and agency underspend. Efficiency is £129k favourable to plan.

System Risk Summary

System Risk	25/26 Gross Risk £'000	Mitigation £'000	Un-Mitigated Risk/ (Opportunity) £'000
NHS Shropshire, Telford & Wrekin ICB	10,148	(10,148)	0
Robert Jones & Agnes Hunt Hospital	5,258	(5,258)	0
Shrewsbury & Telford Hospitals	17,300	(13,700)	3,600
Shropshire Community Hospital Trust	2,028	(2,028)	0
Grand Total	34,734	(31,134)	3,600

ICB - Total Risk £10.1m; fully mitigated

- Efficiency risk **£1.2m** – Independent Sector activity, Medium risk efficiency schemes – mitigated by UEC Improvement Programme, Acceleration of pipeline efficiency schemes and stretch to existing schemes.
- Cost risk **£8.9m** – Individual Commissioning activity and inflation, Cat M prices and Prescribing costs, Better Care Fund, SaTH excluded drugs & devices and estimated Government Reset costs – mitigated by internal processes for reducing Individual Commissioning cost, Commissioning policies under development and control processes in place to monitor spend in line with agreed criteria.

RJAH - Total Risk £5.3m; fully mitigated

- Income risk **£4.9m** - LVA, Insourcing, non delivery of elective activity plan, Contract activity and Powys contract – mitigated by activity monitoring, workforce controls and ongoing contract negotiation.
- Efficiency risk **£0.3m** – medium risk schemes – mitigated by additional contingency schemes being reviewed monthly.
- Cost risk **£0.1m** - Inflation – mitigations identified - project oversight and contract management.

SATH - Total Risk £17.3m; £13.7m mitigated

- Income risk **£2.4m** - Activity and Clinical income - **£2.4m** unmitigated Powys Non-Elective activity growth - escalated to NHSE for support.
- Efficiency risk **£2.8m** - medium risk schemes - increased efficiency scheme delivery to meet the original plan target plus UEC investment - fully mitigated by additional contingency and pipeline mitigation schemes, being reviewed monthly.
- Cost risk **£12.1m** - Workforce, inflation, escalation and pay award additional costs – **£10.9m** mitigated through delayed investments, additional temporary staffing controls for bank/agency, reduced insourcing and elective activity cost reductions (reduced RTT activity in second 6 months), further non pay controls, balance sheet flexibilities and workforce management and FIP/FRG oversight and management. **£1.2m** unmitigated arising due to future industrial action activity.

SCHT - Total Risk £2.0m; fully mitigated

- Cost risk **£2.0m** – Estates, inflation, agency & staffing, pay award/NI impact – mitigated by contract monitoring, workforce management, FRG oversight, vacancy savings.

Efficiency Summary Month 9

25/26 Month 9 Planned Savings £69.5m	25/26 Month 9 Actual Savings £77.8m	25/26 Savings Month 9 Variance £8.3m	25/26 Savings Plan £95.5m	25/26 Savings Forecast £101.6m	25/26 Savings Variance £6.1m
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Partner Organisation	Annual Plan £'000	YTD Plan £'000	YTD Delivery £'000	YTD Variance to Plan £'000
ICB	39,180	30,467	37,561	7,094
SaTH	41,400	28,410	28,613	203
RJAH	9,594	6,751	7,629	878
SCHT	5,359	3,889	4,018	129
Total	95,533	69,517	77,821	8,304

- Key Updates**
- At Month 9 YTD STW has delivered **£77.8m** in efficiency savings against a plan of **£69.5m** which is **£8.3m** favourable to plan.
 - This is primarily driven by savings realised by the individual commissioning team through case review and reduced cost of UEC Pathways.
 - High-Risk schemes have increased slightly by 0.7m and total **£5m** of the forecast at month 9. These are being closely monitored, and mitigating actions are detailed on slides 15 & 16 of this pack.
 - Focus remains on all Medium Risk and pipeline Plans continue to be sourced to further mitigate.
 - A System financial improvement group continues to be held fortnightly to oversee progress of the plans.



Capital Summary

CAPITAL PROGRAMME	YTD			FULL YEAR		
	Plan	Actual	Variance to Plan	Plan	Forecast	Variance to Plan
	£000	£000	£000	£000	£000	£000
Organisation						
Total Charge against Capital Allocation (including impact of IFRS 16)						
NHS Shropshire, Telford and Wrekin	648	124	(524)	6,191	1,191	(5,000)
The Shrewsbury and Telford Hospital NHS Trust	16,461	13,138	(3,323)	22,530	27,321	4,791
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS FT	5,226	3,906	(1,320)	6,336	6,336	0
Shropshire Community Healthcare NHS Trust	3,115	2,482	(633)	4,253	4,453	200
TOTAL SYSTEM	25,450	19,650	(5,800)	39,310	39,301	(9)
Total CDEL						
NHS Shropshire, Telford and Wrekin	1,498	124	(1,374)	7,083	2,083	(5,000)
The Shrewsbury and Telford Hospital NHS Trust	106,283	76,056	(30,227)	145,915	156,740	10,825
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS FT	5,426	5,477	51	9,243	10,346	1,103
Shropshire Community Healthcare NHS Trust	3,592	2,805	(787)	4,975	4,975	0
TOTAL SYSTEM	116,799	84,462	(32,337)	167,216	174,144	6,928

- SATH operational capital YTD is £3.3m behind plan due to the delay in invoices being received for the decarbonisation scheme, noting the capital scheme is on track. The operational forecast also includes £4.8m additional allocation awarded for UEC capital with capital allocated to the ICB for this spend. Total SATH capital is £30.2m underspent year to date due to delays in billing for the decarbonisation, RAAC, Estates Safety and UEC/Constitutional Standards schemes in addition to a different cash profile for HTP. Total CDEL FOT is £10.8m higher than plan due to the additional £4.8m referenced above and additional CDEL of £6.0m received for Estates Safety schemes including LIMS/EV charging points. The HTP project is ahead of plan but under the original cash profile – subject to separate approval from NHSE.
- RJAH operational capital is £1.3m behind plan due to the phasing of digital and estates capital schemes which are expected to be caught up by the end of the financial year.
- SCHT operational capital is £0.5m behind plan due to delays in finalising an internal estates capital project which will be recovered in future months. The forecast/Plan also includes £0.2m additional allocation awarded for UEC capital.

YTD System spend against CDEL is behind plan by £5,800k primarily due to a delay in the receipt of invoices for SATH decarbonisation scheme, and phasing of major capital scheme for digital and estates reconfiguration in the internal SCHT and RJAH capital programmes - spend for both schemes are expected to fall in line with planned FOT.

The total system capital spend - CDEL plus national capital schemes including the Hospital Transformation Programme (HTP) - is £32,337k behind plan due to delays in SaTH schemes (RAAC/Modulars). Recovery is anticipated in the coming months with a large increase in capital spend projected in future months.

System FOT has increased by £6.9m largely due to additional CDEL received for RJAH estates safety (£1.1m) and SATH - EV charging points, cyber security and SaTH estates safety (£5.8m).

SaTH have submitted a change request to defer c.£9m of capital spend in relation to HTP, this has been approved by NHSE.

SCHT – the Capital Freedoms and Flexibility regime allows capital spend against prior year surplus - previous forecast included £0.6m in 2025/26. This has now been removed and deferred to the 26/27 capital plan - £3.6m (IT Hardware and Software, and Whitchurch Ward Refurbishment).

RJAH – the Capital Freedoms and Flexibility regime allows capital spend against prior year surplus (26/27 - £2.9m (Theatre refurbishment)).

ICB spend is phased from Month 8 onwards, some spend was delayed due to quotes awaited from practices but spend is expected to catch up by year end. The £2m forecast is compared to a £7m plan as a £5m system capital receipt for UEC Incentive Capital has expenditure recorded against SaTH/SCHT.

Enc 14: Quality and Performance Committee Briefing Report Committee/Group Meeting Date(s): 27th November 2026

Meeting Name: Integrated Care Board (ICB) Board Meeting

Meeting Date: 30th November 2025

Report Presented by: Vanessa Whatley, Chief Nursing Officer (Interim)

Report Approved by: Vanessa Whatley, Chief Nursing Officer, (Interim)

Report Prepared by: Vanessa Whatley, Chief Nursing Officer, (Interim) , Julie Garside Director of Performance, Planning BI and analytics, NHS STW

Action Required: For noting, for assurance.

1.1. Summary of Key Discussions and Decisions

1.1.1. The meeting discussed the risk register, quality and performance data and Healthwatch updates as standard as well as progress of the System Integrated Improvement Plan (SIIP) October Progress Report which demonstrated a further 7 completed actions and progress toward closure in March 26. The diabetes update against the risk was provided as was the Mental Health & Learning Disability & Autism focussed paper which discussed long ADHD and Autism waits and a gap in LD pathway which is planned to be addressed at a January 2026 workshop. The Shropshire, Telford and Wrekin Child Death Overview Panel Annual Report 2024/5 was presented by the independent chair demonstrating a 20% decrease in deaths in under 18-year-olds compared to the previous year (n=32 in 2024/5 vs 40 in 2023/4), improved policy and processes, education, partner engagement, action on modifiable factors (e.g. smoking) and data were noted. A review of risk scores for UEC and diabetes was discussed and will be progressed. Finally, an update was given on the Telford and Wrekin Joint Area Targeted Inspection was given on the publication of the final report and action plan.

1.2. Recommendations to the Board

1.2.1. Approved on behalf of the Board were

- Child Death (CDOP) Policy (EQIA & SOP provided)
- The Shropshire, Telford and Wrekin Child Death Overview Panel (CDOP) Annual Report 2024/25

1.3. Key Risks and Mitigations

Key risk updates are below:

1.3.1. Urgent and emergency (UEC) care performance and the impact on quality of care remains an extreme risk, there continues to be ongoing improvement in some UEC metrics, however, the number of Type 1



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attendances, where the patient was waiting over 12 hours in A&E remains high. Type 1, 12+ hours in ED – continues to remain off track at 23.8%, against national target (10%) and local plan (20.4%). Type 1 4hr off track for national target by 29.7% and is 3% below the local plan. Category 2 response time for October 25, was 38 mins on average against a target of 30 min. The percentage of over 65's attending ED to be admitted, is showing concerning variation, with values increasing since April 25, September 25 was 45.1% and has increased to 49.2% October 25. The system UEC improvement plan remains in progress, as part of this additional capacity (modular wards) has now opened and reconfiguration of short stay capacity at PRH is expected to deliver further improvement during Q4.

1.3.2. Diabetes and the impact on the population due to variability in services to support coordinated diabetes pathways, leading to poorer outcomes. A key action has been seeking to improve the provision of diabetic foot screening in general practice. Early indications are that screening is improving in both uptake and quality, further data is expected. A QI project is underway to design a Single Point of Access to the Diabetes MDT foot team to ensure a simple pathway to the right care for patients that are referred into Diabetes Foot care – this is being led by community podiatry, with support from SaTH podiatry. The roll out of the provision of Tirzepatide for weight loss through General Practice is progressing and further pilot of weight management medicines through community pharmacy. Diabetes has been drawn into a wider Cardiovascular, Renal and Metabolic (CVRM) workstream in line with the 10-year plan.

1.3.3. *Clostridioides difficile* infections continue to be above trajectory with these are being addressed by providers through action plans and by primary care prescribers of high-risk medication. However, there is currently no significant change to the rate of health care associated acquisitions and the system remains off monthly trajectory with a total of 121 cases against a trajectory of 94 at system level by November 25. Assurance on local organisational action plans has sought by system partners with commitment to take significant actions in quarter 3, including a decision on a business case to prescribe Fidaxomicin as first line treatment (above the current of relapses and severe cases). Gram negative bacteraemia numbers (e coli, pseudomonas and klebsiella) are also off trajectory but will be positively impacted by current focus on C diff actions.

1.3.4. The TB risk remains at 16 due to being a fragile service. However, this is now commissioned in line with the national service specification as a business case has now been approved by the ICB. The SaTH TB team are delivering essential patient care and are actively recruiting to the structure to support the agreed outcomes and service specification.

1.3.5. The Committee has identified a need for a consistent approach to assurance and has had observation from internal auditors, feedback at the next meeting in February 2026.



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1.4. Performance and Assurance

- 1.4.1. Cat 2 ambulance response mean time did not achieve the national target for a second month in a row in October and average ambulance handover time also deteriorated with the number of 8hr delays increased to 24 patients, the highest since April. Harm reviews are in place for all patient ambulance offload delays of more than 8 hours.
- 1.4.2. Diagnostics, in both acute providers, continue to reduce their waiting list backlogs and reducing the number of have patients waiting over 13 weeks. Both providers have recovery plans in place to reduce to zero, RJAH by the end of January and SaTH will be down to ~50 by the end of March 26.
- 1.4.3. Children & Young People's Neurodevelopmental Pathways waiting lists continue to rise. CAMHS mental health access continues to be of concern and the ICB and MPFT are meeting weekly with NHSE and MPFT senior leaders to gain assurance on the effectiveness of agreed actions against trajectory.
- 1.4.4. There continues to be improvement in cancer and reduction in long waits, especially at SaTH with all planned performance achieved or bettered. The small but persistent number of longer waits (>78wks) at RJAH remains cause for concern and all efforts including mutual aid are being made to improve this position.
- 1.4.5. Primary Care – As of 1st November, all GP practices are rated good or outstanding by the CQC (Care Quality Commission). Total numbers and total face to face appointments in primary care both increased by 16% compared to the previous month. The percentage of appointments within 14 days in General Practice improved by 0.6%. However following the recent upward trend in the number of GP fulltime equivalents, this value fell in November. Dental activity continues to be reported 3 months in arrears to ensure data is complete, with several actions are underway to continue to improve dental across the county. The latest month (July) showed a 9% increase on the previous month's total number of units of dental activity (UDA) completed.
- 1.4.6. Talking Therapies first seen within 18 weeks performance having improved to a peak of 93% in September, (from 91%) has fallen back for a second month in a row to 88% and remains below the target of 95%. This is believed to be due to a small number of patients requesting specific dates for appointments outside the 18week window.
- 1.4.7. There is positive assurance that Maternity Booking before 10 weeks, postpartum haemorrhage rates and birthing people Smoking at time of delivery continues to show sustained improving variation.
- 1.4.8. CQC inspections are dynamic in their approach but there remain no inadequate-rated healthcare organisations in Shropshire (acute, GP surgeries & care homes including LD&A). This is due to a focussed approach across a range of system partners.

1.5. Alignment to ICB Objectives and Core Functions

1.5.1. QPC discussions and activities progress towards meeting the ICB aim of improving outcomes in population health and healthcare and providing productivity and quality of services, in line with the 10-year plan.

1.6. Next Steps and Forward Plan

1.6.1. Outline actions agreed upon by the Committee, timelines, and any plans for future meetings or reviews.

1.7. Attachments

1.7.1. Approved Minutes 25th October 2025



**NHS Shropshire, Telford and Wrekin
Quality & Performance Committee Meeting**

Thursday 30th October 2025
Via Microsoft Teams

Members Present:

Cheryl Etches	ICB NED - Chair	NHS STW
Vanessa Whatley	CNO	NHS STW
Sharon Fletcher	Head of Safety & Quality Improvement	NHS STW
Clair Hobbs	Director of Nursing	SCHT
Jill Barker	NED	SCHT
Rosi Edwards	NED	SaTH
Tracey Slater	Head of Quality	NHS STW
Julie Garside	Director of Planning & Performance	NHS STW
Helen Onions	Director of public Health	T&W Council
Jan Suckling	Chief Officer, Healthwatch Telford & Wrekin	
Anne Maclachlan	Clinical Care Director	MPFT
Liz Lockett	Chief Nurse & Deputy Chief Executive	MPFT
Dr Ganesh	Medical Director	SCHT
Lisa Rowley	Meeting Administrator & EA to CNO	NHS STW

In attendance:

Name	title	Organisation
Lisa Newton	Assistant Chief Nurse & Patient Safety Specialist	Representing Sarah Needham RJAH
Kara Blackwell	Deputy Director of Nursing	Representing Paula Gardner SaTH
Kirsty Dyas	Quality Analyst	NHS STW
Kirsty Fenton	Head of Nursing – attending as an observer	MPFT
Samantha Mclver	Patient Safety Specialist	NHS STW

Apologies:

Sarah Needham	CNO, RJAH
Kirsty Foskett	Assistant Chief Nurse & Patient Safety Specialist, RJAH
Paula Gardner	Interim Director of Nursing SaTH
Lynn Cawley	Chief Officer, Healthwatch Shropshire
Sara Reeve	Deputy Director of Quality - MPFT



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1.0 Minute No. QPC-25.10.149 – Welcome & Apologies

Cheryl Etches welcomed Quality & Performance Committee members to the meeting.

1.1 Apologies were noted as above.

2.0 Minute No. QPC-25.10.150 – Quoracy

2.1 The meeting was confirmed as being quorate.

3.0 Minute No. QPC-25.10.151– Members’ Declarations of Interests

3.1 Members had previously declared their interests, which were listed on the ICB’s Register of Interests for ICB Staff only and was available to view on the website at: [Register of Interests - NHS Shropshire, Telford and Wrekin \(shropshiretelfordandwrekin.nhs.uk\)](https://shropshiretelfordandwrekin.nhs.uk)

Non ICB Staff have been requested to complete a Declarations of Interest form which is held separately on the attendance/action log of this Committee.

3.2 Members were asked to confirm any new interests or any existing conflicts of interest that they had specifically relating to agenda items. No further conflicts of interest were declared.

3.3 The chair reminded external ICB members to complete their declaration of interest forms.

4.0 Minute No. QPC-25.10.152 Minutes of QPC 30th October 2025

4.1 The Committee reviewed the minutes of the meeting held on 30th October 2025 and were accepted as an accurate record of the meeting.

5.0 Minute No. QPC25.10.153 SORR – Sharon Fletcher

This document was provided to the Committee for information purposes only.

6.0 Minute No. QPC-25.10.154 System Quality Risk Register, including System Oversight Risk Register (SORR) and Board Assurance Framework (SBAF) – Samanther McIver on behalf of Sharon Fletcher

The paper was taken as read and the following points were highlighted:

6.1 Two extreme risks were highlighted - Diabetes and Urgent & Emergency Care (UEC) and two new risks were introduced (1) Children’s Palliative & End-of-Life Pathway; A recent case highlighted the absence of a commissioned medical advice service following the cessation of charitable funding previously used by the Children’s Hospital. Spot purchasing from Birmingham is in place as an interim solution. A Workshop is scheduled for 24th November to design a seamless system-wide pathway in collaboration with children’s and adult hospices, nursing services, and transition pathways (16–18 years and 18+) and (2) Child Protection Medicals, a Task & Finish Group has been agreed. Full addition to the risk register is expected in November following SQG meeting.

6.2 **UEC** - Performance is improving with oversight, auditing, and monitoring continuing via multiple forums. The Virtual ward capacity remains above 80%.

6.3 **Diabetes** – the Chief Medical Officer is acting lead for this risk; the 2026–27 plan is in development with enhanced primary care interface support. Positive

engagement has reduced non-compliant practices in foot screening. PID to be refreshed to align with CVRM programme. NANNHIP Diabetes Stakeholder Group was relaunched on 10 October, 2025.

- 6.4 **Clostridium difficile (C. diff)** - Case numbers remain above trajectory. The outcome on the use of fidaxomicin as first-line treatment is awaited.
- 6.5 **Adult ADHD Pathway** – The Risk narrative has been updated following procurement and mobilisation, the risk score remains unchanged however there may a reduction pending ICB's decision. The referral pathway has been shared with GPs via the Referral Management Centre. An ADHD stakeholder event was held in July.
- 6.6 **Shared Care Prescribing** - (Renamed: Integrated Care Protocols) - work is ongoing to improve GP access to specialist advice. Amber-rated medications are under review for reclassification. Commissioning options are being considered for primary care initiation with specialist oversight. A pilot is in place for clinical pharmacists to lead via Shared Care SOPs.
- 6.7 **Tuberculosis (TB)** - There has been a national rise in TB, with a small increase locally. Contact tracing remains extensive; there is no current funding for latent TB testing. The TB business case has been approved and contract communication completed. Lorna Clarson (CMO) is confirmed as the nominated TB lead although the role is shared informally with Vanessa Whatley due to the nurse-led nature of the service.

Action: Sharon Fletcher to update the Risk Register to reflect Lorna Clarson as the official lead for the Diabetes Risk.

Finalise Children's Palliative & End-of-Life Pathway service specification and contract with Birmingham to ensure system-wide integration.

- 6.8 Dr Ganesh raised the importance of including RJAH due to their expertise in neuromuscular conditions and end-of-life care. Vanessa Whatley said she would confirm their involvement and highlighted that the index case had contact with RJAH.

Following Discussion, the committee: -

- Reviewed the report

- 7.0 **Minute No. QPC-25.10.155 - Quality & Performance Exception Report**
The report was taken as read and the following key points were highlighted:

7.1 **Performance Update**

- 7.1.1 Julie Garside provided an update highlighting new additions to the report such as mixed sex accommodation breaches and VTE risk assessments by provider; the inclusion of a quarterly mental health data quality update this month and a new CQC appendix which will now be reported quarterly from November. Positive developments were shared for UEC regarding integrated out-of-hospital services, with gradual improvements in four-hour performance despite ongoing challenges with ambulance handovers and category two response

times. Mental health metrics are generally strong except for out-of-area placements and children and young people's access. Encouraging progress was also reported in elective and cancer care, with the 62-day cancer backlog dropping below 200 patients, however, concerns remain around diagnostics, particularly patients waiting over 13wks, with recovery trajectories requested from providers.

- 7.1.2 Julie pointed out the positive move in GP recruitment trends and continued strong performance in key maternity metrics, including smoking at delivery and early booking. However despite some improvements in October compared to September, urgent and emergency care (UEC) pressures persist, with recent ambulance handover delays. The CYP neurodevelopmental waiting list has been escalated for further action
- 7.1.3 Julie also acknowledged the challenges of transitioning reporting responsibilities between providers and the ICB, noting that both sets of metrics are currently included to avoid gaps. Due to limited data points for some of the new metrics in Appendix 4a, SPC methodology is not yet applicable, benchmarking and analyst commentary are being used to support performance insights in the mean time.

7.2 Quality Update – Tracey Slater

- 7.2.1 Tracey Slater highlighted the significant work underway at SaTH to develop integrated out-of-hospital models. Tracey flagged concerns around APGAR scores below 7 at five minutes for full-term babies, which show concerning variation in SPC analysis but remain within normal limits and consistent with previous years. The issue is being monitored by the ICB maternity clinical quality lead with no immediate action required. Infection prevention and control (IPC) remains a challenge, particularly with MRSA bacteraemia and C. diff breaches. A system-wide IPC group is focusing on winter preparedness, including care home support and vaccinations; plans are in place at SaTH to facilitate deep cleaning through ward moves.
- 7.2.2 Tracey addressed concerns around learning disability and autism services, noting high numbers of adults and children waiting for ASD and ADHD assessments. Several mitigation strategies are in place, including a fortnightly LD&A task and finish group, monthly multi-agency TCP meetings, and use of the PISA framework to review admissions for learning opportunities. The inpatient quality transformation programme is overseeing related pathways and a pilot project for a specialist autism and ADHD service for individuals with mental health needs has been launched, with outcomes to be reported at a later date.
- 7.2.3 Rosi Edwards raised concerns about the wording in the report suggesting that deep cleaning capacity at the Shrewsbury and Telford Hospital NHS Trust would not be completed for some time. She clarified that discussions held earlier in the week indicated a more immediate plan, particularly targeting high-risk areas due to upcoming ward moves.
- 7.2.4 Kara Blackwell confirmed that deep cleaning will begin in early December, focusing on higher-risk wards particularly those with the most healthcare-associated infections (HCAs). The availability of Ward 25 and eventually Ward 18 as decant facilities will support this effort. She emphasized that while it may have taken years to reach this point, the actual cleaning process will not take years going forward. Plans are in place to clean priority areas at both

RSH and PRH sites, with weekly decant planning meetings underway to coordinate efforts, including pipework replacement on Ward 18.

- 7.2.5 Cheryl Etches asked for further clarity regarding the timing of deep cleaning plans at SaTH
- 7.2.6 In response, Kara Blackwell clarified that while the bulk of deep cleaning is planned for after winter, there is a small window of opportunity to begin work earlier. Ward 25 will be available for decanting when the modular ward opens in early December, allowing for partial cleaning of high-risk areas. Ward 18 will also provide additional space at RSH. Kara emphasised that the lack of physical space had previously prevented earlier action, but current plans aim to take advantage of available capacity before Christmas.
- 7.2.7 Helen Onions raised concerns about inconsistencies in the reporting of Children and Young People (CYP) mental health access performance, noting that resubmitted data was not reflected in published figures, which showed a deterioration. Julie Garside confirmed there was no known improvement in general CYP mental health access, though eating disorder services had shown progress. Helen highlighted that the TWIP report to the ICB board would flag ongoing concerns and that Telford & Wrekin Health Scrutiny had scheduled a workshop on CYP mental health for December. Anne MacLachlan added that a meeting with NHS England was planned to address data flow issues, access processes, and technical adjustments, with hopes that improved staffing and the conclusion of a major tender would allow for more focused efforts. Julie reiterated that while data issues persist, improvements may be underreported and that the newly awarded CYP procurement should help drive progress.

8.0 **Minute No. QPC-25.10.156- Monthly System Integrated Improvement Plan (SIIP) Closure – Julie Garside**

The paper was taken as read and following discussion, the following points were highlighted:

- 8.1 Julie Garside highlighted the positive progress on action plans, noting that only 11 items remain off track, all of which have mitigation strategies in place to ensure completion by year-end. The ICB has successfully completed all quarter two evidence panels with NHS England, and going forward, formal panels will no longer be required. Instead, the team will provide quarterly updates through internal reviews. Julie also confirmed ongoing support for SaTH colleagues aiming to exit RSP by year-end, including sharing processes and templates and attending their monitoring sessions. Cheryl Etches acknowledged the significant achievements and emphasised maintaining momentum to complete the remaining actions.

Following discussion, The Committee:

- Noted the contents of the highlight report

9.0 **Minute No. QPC-25.10.157– System Quality Group Chairs Report – Vanessa Whatley**

- The report was taken as read and the following points were highlighted:***
- 9.1 Vanessa Whatley highlighted ongoing concerns around high-dose opioid prescribing, noting that although rates are slowly declining, the area still ranks highest in the Midlands. Efforts are underway to address this through GP training and early patient education, particularly in musculoskeletal pathways where opioid use often begins. A key challenge is the complex and lengthy process of deprescribing, which falls outside standard GP contracts. Monthly reviews at the System Quality Group aim to drive a step change in performance. Vanessa also discussed emergency department pressures, including ambulance offload delays and the need for improved pathways for patients requiring diagnostics, such as CT scans for head injuries, which are being reviewed regionally to align with NICE guidance.
 - 9.2 Vanessa reported on a regional safer staffing assessment led by NHS England, where local trusts performed well, with no red ratings and only minor amber issues mostly related to data publication; action plans are in place to address these.
 - 9.3 A new risk was raised regarding insufficient capacity for child protection medicals, triggered by a delayed case earlier in the year. This prompted a deeper review, and work is ongoing to resolve the issue.

Following Discussion, The Committee:

- Noted the report and approved additional risks

10.0 **Minute No. QPC-25.10.158 – Health Protection Assurance Report – Helen Onions**

The report was taken as read and the following key points were highlighted: -

- 10.1 Helen Onions provided an overview of the report, noting an overlap with other discussions and highlighting the urgency around tuberculosis (TB) response, particularly the need for staffing appointments and updated data from UKHSA due to changing patterns. Helen highlighted place-based efforts to address inequalities in screening and immunisation programmes, including targeted work on HPV and MMR catch-ups through pharmacies and general practice. Winter immunisation efforts are being coordinated under Rachel Robinson's leadership (joint role with NHS STW and Shropshire Local Authority) with a focus on healthcare, staff flu vaccinations and improving uptake in vulnerable cohorts.

Following discussion the Committee:

- Noted the contents of the report, and the more positive picture regarding the TB service expansion.

11.0 **Minute No. QPC-25.10.159 – Assurance on Discharge Effectiveness Formal Report – Clair Hobbs**

The report was taken as read and the following key points were highlighted:

- 11.1 Clair Hobbs shared an update on the progress of the Discharge Improvement Group, noting that initial meetings focused on housekeeping and agreeing on terms of reference due to high interest and the need for inclusive membership. The group is co-chaired by representatives from SaTH and

Shropshire Community Health NHS Trust, with participation from MPFT, RJAH, EMED patient transport and Healthwatch. Efforts are underway to include patient and primary care representation. Eight workstreams have been established, each with a designated lead who reports monthly on progress, metrics, and challenges. Key performance indicators include reductions in length of stay, readmissions, and patients with no criteria to reside, as well as increases in pre-ten discharges. These metrics are reviewed at each meeting to ensure alignment and accountability across the system.

- 11.2 Vanessa Whatley asked if there was any prioritisation of the workstreams due to the large number of them, Clair explained that the eight workstreams were distilled from a much larger pool of potential areas, based on extensive data analysis. While all are considered important, some such as discharge lanes and therapies are further developed due to their critical role, especially in winter planning. Each workstream has a separate lead to avoid overburdening individuals, and the initiative is designed to be a joint effort between organisations, not solely a SATH responsibility. The urgency of addressing discharge issues is underscored by the data, and the group is committed to progressing without delay.
- 11.3 Vanessa Whatley raised a key question about the uniqueness of the Discharge Improvement Group's data monitoring, noting potential overlap with the UEC discharge group. Clair Hobbs acknowledged this explaining that while each workstream has its own metrics, not all data can be presented to the Committee. She emphasised the importance of providing assurance without duplication and suggested that further discussions outside the Committee could help determine what data should be shared. Julie Garside supported this idea, proposing a meeting with herself, Clair, Kirsty Dyas, and Vanessa to align metrics and ensure alignment with UEC work. Clair agreed and recommended involving the SATH's PMO team to support coordination.
- 11.4 Cheryl Etches welcomed the initiative, highlighting the importance of seeing consistent monthly improvements across all workstreams to enhance patient experience. Vanessa suggested establishing a reporting rhythm, proposing that key metrics be included in the monthly quality assurance report, with a broader progress update every three months. Clair agreed that quarterly updates would be appropriate, and Cheryl added that more frequent reporting would be onerous, while six-month gaps would be too long. Julie Garside suggested a structure similar to the UEC metrics, with primary metrics reported monthly and quarterly updates on actions and progress, which was accepted by the group.

Following Discussion, The Committee:

- Accepted quarterly updates are provided on discharge effectiveness
- Noted the work undertaken so far by the group including themes and agreed workstreams that will report directly to the Group for assurance purposes.

12.0 **Minute No. QPC-25.10.160 - Spotlight Report – Infection Prevention & Control- Vanessa Whatley**

The report was taken as read and the following key points were highlighted:

- 12.1 Vanessa Whatley highlighted the importance of infection prevention and control (IPC) as a key component of both winter pressures and everyday patient safety. She noted that the system is performing well overall across IPC metrics, although individual trusts vary. There have been no outbreaks or increased incidents in care homes this year. MRSA bacteraemia cases were few and not hospital-acquired, with one linked to dental neglect and another deemed unavoidable from an inpatient at UHNM. Vanessa emphasised that improving C. difficile (C. diff) management through environmental controls with antibiotic stewardship positively impacting other IPC areas. She also praised the strong antimicrobial stewardship across the system, particularly in prescribing practices, which are ahead of most Midlands areas.
- 12.2 A new flu testing and prophylaxis pathway for care homes is now in place, and updates to measles and avian flu protocols are underway. Vanessa referenced a significant avian flu outbreak earlier in the year that spanned multiple regions, prompting development of improved contact pathways. While no Mpox cases have occurred, a gap remains in vaccine administration, which is being addressed. Vanessa stressed the need for continued vigilance and coordination across the system, with IPC actions logged and monitored to ensure readiness and responsiveness.
- 12.3 Cheryl Etches asked about the current prioritisation of infection prevention and control (IPC) within organisations, given competing demands. Kara Blackwell confirmed that IPC remains a top priority at SaTH with daily quality checks and strong leadership support. Kara emphasised that IPC is fundamental to patient safety and must be upheld even during busy periods. Rosi Edwards added that IPC is regularly reported to the board, noting its impact on patient outcomes and system efficiency, including financial implications.
- 12.4 Lisa Newton stated IPC is treated as everyone's responsibility at RJAH and is embedded in their governance structure. Clair Hobbs reinforced that C. diff remains a key concern at SCHAT with monthly reporting and board-level scrutiny. Liz Lockett highlighted that IPC is equally important in mental health settings, especially due to patient movement and vulnerability. She also stressed the importance of flu vaccination uptake among staff and confirmed IPC is well-integrated into MPFT's quality governance.

Following discussion, The Committee:

- All members are asked to continue to seek assurance on HCAI in their respective organisations.
- Accepted the report.

13.0 **Minute No. QPC-25.10.161 Maternity & Neonatal Position Paper – Vanessa whatley**

The report was taken as read and the following key points were highlighted:

- 13.1 Vanessa Whatley presented the report for the Local Maternity and Neonatal System (LMNS) and highlighted the report reflects system-wide collaboration

beyond SaTH, involving local authorities, health services, and voluntary sectors to address broader issues like health inequalities, smoking cessation, and preconception care. It includes updates on delivery plans, assurance of safe services, and governance structures such as the LMNS Programme Board held quarterly and the Perinatal Quality Surveillance Group, held monthly which monitors performance and incidents. Vanessa pointed out that most maternity and neonatal metrics are positive, supported by CQC assessments and recent visits from both local and national teams.

- 13.2 The report highlights efforts to amplify patient voices through roles like the Maternity and Neonatal Independent Senior Advocate (MNISA) and the Maternity and Neonatal Voices Partnership (MNVP). The MNVP has focused on underrepresented communities, including LGBTQIA+ groups, with successful engagement and volunteer recruitment. SaTH have achieved full compliance with the Saving Babies Lives Care Bundle and the Maternity Incentive Scheme, securing financial benefits. Despite being an outlier in neonatal mortality, the region has made progress through collaborative work with public health and child death services. The report will be submitted to the board in November for formal review.
- 13.3 There has been a significant improvement in smoking rates at the time of delivery, now consistently below the national threshold of 6%, which is likely contributing to reduced neonatal mortality. Vanessa highlighted the collaborative efforts such as safe sleeping campaigns and acknowledged ongoing challenges, particularly in booking women into antenatal care before 10 weeks. Work is underway to deliver antenatal services at the neighbourhood level to improve access.
- 13.4 Helen Onions highlighted the strength of partnership working across various strands of maternity and infant mortality prevention. She noted changes to the Local Maternity and Neonatal System (LMNS) structure allows for a broader focus on performance and quality beyond strategic direction.
- 13.5 Cheryl Etches praised the work and expressed interest in visiting the maternity unit, with a new date to be arranged.

Following discussion, The committee:

- Accepted and discussed the report as an annual position of Maternity and Neonatal Services in Shropshire Telford and Wrekin
- The committee agreed that the report should proceed to Board, with no concerns raised.

14.0 **Minute No. QPC-25.10.162 Healthwatch Shropshire Verbal Update – Lynn Cawley**

14.1 Healthwatch Shropshire were not represented at the meeting; therefore no update was provided.

15.0 **Minute No. QPC-25.10.163 - Healthwatch Telford & Wrekin Verbal Update – Jan Suckling**

- 15.1 Jan Suckling shared that Healthwatch Telford and Wrekin continues to progress with its existing workstreams, particularly around hospital discharge and support for veterans. Jan pointed out the ongoing uncertainty about the organisation's future, with indications that it may remain active until March 2027, although this is not yet confirmed.
- 15.2 Cheryl Etches acknowledged the update and asked to be kept informed of any developments.

Following Discussion, the Committee:-

- Noted the verbal Update

16.0 **Minute No QPC-25.10.164 Closing Items – None noted**

17.0 **Minute No 25-10.165 – Escalations**

17.1 New risks: Paediatric Palliative Care and Child Protection Medicals

18.0 **Minute No. 25.10.166 – Any Other Business -**

18.1 No other business was raised

19.0 **Minute No. 25.10.167 - Evaluation of Meeting**

19.1 Helen Onions raised a scheduling conflict for the next meeting, noting that the Health and Wellbeing Board will be convening at the same time. As a result, she and her team will be presenting papers at the HWB and may not be able to attend QPC. Helen acknowledged the importance of local authority representation for quoracy and committed to discussing the matter with Rachel and her team to ensure appropriate representation is arranged.

19.2 Committee were asked to provide comments/suggestions on the running of the meeting to the note taker at Lisa.Rowley2@nhs.net

Date and Time of Next Meeting - The next meeting will be held on 27th November 2025, 2.00pm to 4.00pm Via Microsoft Teams.

Meeting Closed 15.57pm

Enc 15: Finance Committee Briefing Report (meeting held on 28th October 2025)

Meeting Name: Finance Committee

Meeting Date: 28th October 2025

Report Presented by: Dave Bennett, NHS STW Associate Non-Executive Director, & interim Chair of the Finance Committee

Report Approved by: Dave Bennett, NHS STW Associate Non-Executive Director, & interim Chair of the Finance Committee

Report Prepared by: Claire Skidmore, STW,SSoT Chief Finance Officer & Deputy Chief Executive Officer

Action Required: Content for noting

1.1. Summary of Key Discussions and Decisions

- 1.1.1. The October meeting was quorate.
- 1.1.2. The Committee received the month 6 position in October and noted that, after deficit support, the System remains on track to deliver the finance plan. The overall System reported being £2.5m ahead of plan year to date. Risks to delivery of the finance plan were discussed with each provider briefing on their position and mitigating actions. All providers and the ICB confirmed ongoing commitment to delivering the planned forecast outturn.
- 1.1.3. Capital spend to date was discussed at the October meeting, with a position of spend being behind plan but with providers confirming that this would be recovered by year end. SATH noted that they had agreed a deferral of HTP cash into 2026/27 to better align the allocation of funding with the actual cash requirement. The Committee were also briefed that SCHAT and RJAHS had secured capital freedoms to be used this year and next.
- 1.1.4. For its deep dive in October, the Committee received a presentation on progress with the System Finance Strategy action plan. Significant progress has been made with all Q1 actions being achieved and work to review the effectiveness of financial grip and control mechanisms well underway. The Committee also noted that the finance-related actions for the System Integrated Improvement Plan (SIIP), were largely complete, with remaining actions due to be closed by the end of March 2026.
- 1.1.5. The Committee were briefed on the latest planning timelines and guidance issued for capital and revenue plans. Further reports will follow as plans are produced, with the first outline plans expected to be shared with NHSE in late December.



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1.1.6. The Committee took the opportunity to review a mid-year report on its effectiveness this year and were pleased to note that, to date, its duties are being fulfilled with good attendance and engagement from members and participants. A full review of committee effectiveness will be completed for consideration nearer to the end of the financial year.

1.2. Recommendations to the Board

1.2.1. The Board is asked to note the content of this paper.

1.3. Key Risks and Mitigations

1.3.1. The Finance Committee is established to provide oversight and assurance to the Board in the development and delivery of a robust, viable and sustainable system financial plan.

1.3.2. The SBAF and SORR were reviewed at the October meeting and the Committee acknowledged that the principal risks to the ICS of not achieving the strategic and operational priorities had been accurately identified and that appropriate actions are being taken to manage them. No additional risks or issues were identified for escalation to the Board.

1.3.3. There is a significant task ahead to deliver a challenging but achievable finance position for 2025/26 (and the medium term to deliver breakeven for the System). Risks to addressing the underlying financial deficit of the system feature in the Board Assurance Framework and through that are reported to the Board.

1.4. Performance and Assurance

1.4.1. See commentary above.

1.5. Alignment to ICB Objectives and Core Functions

1.5.1. The work of this committee supports the four core aims of the ICB as follows:

1.5.1.1. **improve outcomes in population health and healthcare**

The Committee ensures that strategic finance risks (including risks to the delivery of value for money) and the consequential impact to health outcomes and care quality are effectively highlighted and considered, enabling the ICS to focus on improving the health and healthcare services delivered to the population.

1.5.1.2. **tackle inequalities in outcomes, experience and access**

There is regular committee oversight of financial performance which includes reviewing and addressing finance risk and the consequential impact. This impact may sometimes be related to access and equity. This supports the ICS's aim of reducing health inequalities and ensuring fair access to services for all communities. Population Health Management and Health Inequalities data is used to inform changes to services to improve outcomes, experience and access and is linked to use of resources



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1.5.1.3. enhance productivity and value for money

System Finance is scrutinised by the Finance Committee to ensure that financial risks are mitigated, allowing the ICS to enhance efficiency, optimise resource use, and achieve better value for money in delivering health services.

1.5.1.4. help the NHS support broader social and economic development

Collaborative working with the Local Authorities through the Better Care Fund, CHC and joint procurement may support broader economic development.

1.6. Next Steps and Forward Plan

1.6.1. N/A

1.7. Attachments

1.7.1. Minutes for the meeting held on 28th October 2025 are provided for information



NHS Shropshire, Telford and Wrekin System Finance Committee

**Minutes of Meeting held on
Tuesday 28th October 2025, 14.15
Via Microsoft Teams**

Present

David Bennett (DB)	Non-Executive NHS STW
Trevor McMillan (TMc)	Non-Executive NHS STW
Angela Szabo (ASz)	Director of Finance NHS STW
Sarah Lloyd (SL)	Director of Finance SCHAT
Richard Peach (RP)	Group Accountant T&W Council
Angela Mulholland-Wells (AM-W)	Chief Finance Commercial Officer RJAH
Marianne Cleeve (MC) on behalf of (FP)	Head of Accountancy and Assurance MPFT
Adam Winstanley (AW)	Acting Director of Finance SATH
Tina Long (TL)	Non-Executive SCHAT

In Attendance:

Kate Owen (KO)	Head of PMO NHS STW
Sarah Edmonds (SE)	Acting Deputy Director of Finance – Strategy SATH
Cynthia Fearon (CF)	Executive Assistant NHS STW (Note taker).

Apologies:

Claire Skidmore (CS)	Chief Finance Officer NHS STW
Ian Bett (IB)	Chief Delivery Officer NHS STW
Tracey Cotterill (TC)	Interim Director of Financial Recovery and Transformation SATH
Richard Minor (RM)	Non-Executive SATH

Minute No. SFC-25.10.001 – Welcome & Apologies

1.1 DB welcomed members and attendees to the meeting. Apologies were noted.



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Minute No. SFC-25.10.001 – Quoracy

1.2 The meeting was noted as being quorate.

Minute No. SFC-25.10.002 – Members’ Declarations of Interests

2.1 Members had previously declared their interests, which are listed on the ICB’s Register of Interests and are available to view on the website at:

[Register of Interests - NHS Shropshire, Telford and Wrekin \(shropshiretelfordandwrekin.nhs.uk\)](https://shropshiretelfordandwrekin.nhs.uk)

Members were asked to confirm any new interests that needed declaring or any existing conflicts of interest that they had relating specifically to the agenda items. There were no further conflicts of interest declared.

Minute No.SFC-25.10.003 – Minutes of Previous meeting

3.1 Minutes of the previous meeting held on Tuesday 30th September 2025, were agreed as a true and accurate recording of its proceedings.

Minute No.SFC-25.10.004 – Matters Arising and Action List from Previous Meetings

4.1 DB referred to the action list from the previous meeting. Actions outlined on the action log were reviewed and the committee agreed that actions that were noted as completed could be closed.

Minute No.SFC-25.10.005 - SBAF and SORR

Report received as read

- 5.1 **ASz** reported that no changes were made to the scores outlined in this month’s report compared to last month. The committee had an in-depth discussion during the previous meeting regarding financial performance related to the revenue performance, risks and mitigations. Following that discussion, it was agreed that the revenue risk remained unchanged.
- 5.2 **ASz** explained although we are in a healthy financial performance position, compared to plan from an ICB perspective, we are still carrying risks as a system that are reflected in the score.
- 5.3 For capital, **ASz** highlighted that we are underspending year to date. Plans are in place to get back on track by year end for 2025/26.
- 5.4 **ASz** noted that the government reset risk was closed at the last meeting for finance committee and will now be picked up and monitored by another committee.



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The System Finance Committee:

- Reviewed the current SBAF/SORR risk scores and confirmed that there is no change to the risk score for this month and that the principal risks to the ICS of not achieving delivery of the financial plan and recovery plan have been accurately captured. Appropriate mitigating actions are being taken to mitigate or manage them.

Minute No.SFC-25.10.006 - Monthly Revenue and Efficiency Report

Report received as read

- 6.1 ASz** reported overall as a System at Month 6, we are £2.5m favourable variance ahead of plan. That is mainly driven by the ICB, due to some prior year benefits that has been taken into the position. Which has offset some of the efficiency risks, which was forecasted to deliver in the second half of this financial year. This has helped to de-risk some of the risk within the efficiency plan.
- 6.2 ASz** highlighted that we are significantly ahead for Individual Commissioning efficiency delivery year to date, anticipating to over deliver by year end.
- 6.3 ASz** flagged that the remaining efficiencies are going to become more difficult to achieve. There are some cost growth within Individual Commissioning that will create a cost pressure in year.
- 6.4 ASz** noted that she had received a notification today, that the spend for prescribing within the ICB is forecasted to increase. The level of risk is being managed for that within the ICB position which is expected to be offset by the price growth contingency and additional efficiency delivery.
- 6.5** From a SATH perspective, **ASz** noted that they are £1.3m adverse variance to plan. Which is driven by excess pay award, industrial action and escalation costs. Discussions around recovery actions was discussed at length at last month's meeting.
- 6.6 ASz** highlighted that we are now reporting a £2.4m unmitigated risk for SATH's position at Month 6. That is related to the Powys non elective activity growth funding dispute. This has now been escalated to NHS England for further discussion.
- 6.7** With reference to efficiency, **ASz** reported that we are currently ahead of plan year to date. Where efficiency is behind plan year to date ongoing actions are as outlined within the report, which includes pipeline mitigations.
- 6.8** There is a focus on the recurrent underlying position which is under additional scrutiny by NHS England. NHS England have requested a further submission from all Provider organisations by 12th November 2025.
- 6.9 ASz** noted that the recurrent underlying position needs to be visible when reporting to the ICB Board, the following will be captured within the Finance Committee Chairperson's report for the ICB Board meeting. The overall movement year to date

for the recurrent underlying position compared to plan is £7.5m improvement after technical adjustments although actual costs in year have increased by £5.1m. £2.3m within the ICB, £1.3m SATH and £1.5m RJAH with no change at SCHAT, actions are in place to deliver the exit recurrent underlying plan by year end, as outlined within the report.

- 6.10** **DB** flagged that there was a significant issue relating to recurrent and non-recurrent for the delivery of CIP within the underlying position and queried if there were mitigations in place for that. **ASz** explained that we have some changes in technical treatment of our income (from non-recurrent to recurrent) and spend which has improved our overall recurrent underlying position. So, we do now show an improvement against the original plan. Where we do have spend, that has been moved out in year. There is a commitment to still recover that to plan.
- 6.11** **DB** queried, that it outlines within the report that we are over delivering on non recurrent versus recurrent for our CIP forecast outturn. **ASz** explained that relates to how we have treated the substantive vacancies across the providers from an efficiency perspective. The full year effect of those workforce reductions is not banked necessarily as recurrent in the efficiency plan, but in terms of recurrent underlying, when we exit the financial year in March 2026 recurrent underlying spend is expected to be in line with plan.

Action: KO and ASz to review reporting of the expected FYE recurrent impact of the 2025/26 non-recurrent efficiency, where applicable.

SATH

- 6.12** **AW** noted, the majority of the recurrent forecast slippage on efficiencies is for SATH. It relates to the whole-time equivalent (wte) reduction scheme and headcount reduction scheme. SATH have seen slippage in the first part of the year but are confident that when we get to Month 12, SATH will deliver on the recurrent reduction of spend. Therefore, there will not be an underlying impact. SATH have got a non-recurrent offset in year but are confident on delivery of the Month 12 recurrent plan, CIP to meet the exit underlying plan position.
- 6.13** **DB** queried the key drivers and size of impact that SATH are currently experiencing in relation to non-delivery of recurrent CIP reductions. **AW** explained, when we review our whole-time equivalent staffing plan, SATH is broadly on track with the work required to achieve by Month 6. The main issue identified is that SATH are currently under on substantive staffing and over-reliant on bank staff, particularly medical staffing, which comes at a premium cost. In August and September, SATH saw a significant increase in the number of resident doctors. As a result, SATH expect the use of bank medics to decline over the coming months. This aligns with the anticipated supernumerary periods, which should lead to some improvement in staffing balance across substantive and bank.
- 6.14** **AW** reported that SATH have implemented a non-medical, non-clinical bank panel towards the end of September, and have already seen a significant reduction in the number and value of requests coming through.
- 6.15** **AW** highlighted that NHS England visited SATH a couple of weeks ago to review bank expenditure. SATH expect feedback from NHSE within the next two weeks regarding the actions put in place, which will help identify any gaps or areas for improvement.

- 6.16** **AW** noted that the new medical staffing rates went live in October. Since then, SATH observed a reduction in booked hours and a corresponding decrease in expenditure. SATH anticipate a partial reduction in October figures, followed by a further drop in November.
- 6.17** **AW** highlighted, as part of SATH's recovery options, the trust has now reduced the unmitigated financial gap to £2.4m. SATH reported last month, the unmitigated gap stood at £9.7m. A significant portion of this was attributed to bank staffing costs. SATH are currently forecasting a £4m reduction in bank expenditure. It's important to note that this reduction is expected to be a genuine decrease in bank usage, rather than a shift to substantive staffing, to achieve the intended financial impact. Which is about 25% reduction on monthly spend in the last four months of the year.
- 6.18** **AW** noted that SATH have had a proposal come forward from one of the divisions within theatres where SATH have an enhanced Bank rate for non-medical staff. This proposal will be coming forward to SATH's Financial Recovery Group next week for approval. In terms of the overspend, there is probably about 50/50 split, some of it is premium because we are under our substantive establishment and over on bank. The other 50% is extra additional capacity.
- 6.19** To note, SATH are considerably ahead on ERF activity, however that will be included in as part of the recovery plan, reduced activity and income in the last 6 months.

RJAH

- 6.20** **AM-W** reported that RJAH have undelivered significantly on their ERF for the first few months. The plan is to bring in consultants to assist with the delivery of ERF, with the intention is to recover the first half year, where possible.
- 6.21** **AM-W** noted, the focus is currently on increasing RJAH's capacity through insourcing, job planning, and consultant recruitment. These efforts are being coordinated in agreement with SATH, particularly in response to the orthopaedic ward closures. As part of this collaboration, there is an agreement to transfer some activity from SATH to RJAH, with the shift expected to begin in the next quarter and will potentially continue through the end of the year.
- 6.22** **AM-W** explained that there are plans to drive the activity up through a number of means, but we don't expect to fully recover the full ERF by the year end. We are doing as much as we can to treat the patients as best as we can. We are not going to make up the ground we lost, as noted when we went through our ERF implementation plan in the early part of this year.
- 6.23** **ASz** noted that NHS England requested for a submission last week to check where all Systems were regarding ERF income. **ASz** is still waiting to hear feedback from NHS England whether there will be any surplus income that can be re-allocated to Systems.

SCHT

- 6.24 SL** reported that SCHAT expects to deliver in line with plan and currently has no high-risk efficiency areas identified. However, teams continue to develop in-year programmes of work, including non-recurrent initiatives. SCHAT are optimistic about exceeding targets and anticipate that new ideas and approaches will continue to emerge as the year progresses.
- 6.25 DB** noted overall good progress is being made with each Provider organisation, however, risks/actions/mitigations as outlined within the report will need to be reviewed frequently, to ensure deliver as far as possible in year.
- 6.26 ASz** confirmed that we are currently on track to meet the projected underlying exit rate for this year, with actions in place to support delivery of the plan. However, there are inherent risks, and while mitigations have been identified, maintaining this position may prove challenging for some areas within the STW system as the year progresses.
- 6.27 KO** flagged that there are potential emerging risks from the ICB, with the independent sector providers. A £2.5m reduction for independent sector provider contract values which is contingent on the delivery of reduced activity levels and activity currently exceeds planned levels. The PMO are working closely with the contracts team to monitor performance and ensure alignment with indicative activity plans and expected outcomes.
- 6.28 KO** reported that action plans are being developed to address the current challenges, with further detail expected next month. Overall, the system is forecasting high-risk areas related to efficiency, with a total of £3.4m in mitigations identified. The most significant risks are associated with headcount reduction at SATH and the use of high-cost drugs for SATH and STW ICB, both of which are being closely monitored.
- 6.29 KO** noted, year to date we are reporting a positive position for efficiencies with delivery ahead of plan.
- 6.30 ASz** reported in terms of Urgent and Emergency Care (UEC), we have de-risked the £2m integrated efficiency target. However, the finalisation of WMAS handover delays has incurred additional costs, which are now reflected in the ICB financial position. As a result, we have had to extend our mitigation measures to accommodate this impact.
- 6.31 KO** reported overall financial efficiency plan for UEC was set at £7.1m. That includes £4.1m savings for SATH for Integrated UEC pathways and £3m for the ICB including an expected reduction in WMAS handover delays, which is a scheme that is now carried forward into next year.

Action: KO agreed to circulate the summary update slides on UEC efficiency.

- 6.32 DB** queried escalation costs for SATH. **AW** confirmed that SATH has an approved winter plan in place, and are confident in SATH's ability to deliver during the second half of the year. The new modular wards are expected to become operational from December. Additionally, investment approved at the SATH Board meeting in September for PRH will also go live in December. SATH currently have additional nursing staff in the Emergency Department (ED), and given the current number of patients with a



decision to admit (DTA)., SATH anticipate a reduction in DTAs within ED as these patients will be transferred to the modular wards, which should result in cost savings.

- 6.33 AW** noted that SATH had their Month 6 Finance Committee meeting this morning. SATH confirmed the unmitigated risk of £2.4m although noted that this required delivery of recovery actions which will be picked up at SATH's Finance Recovery Group over the next couple of weeks.

The System Finance Committee:

- Noted that the ICS month 6 position is a £2.5m favourable variance to plan, after a contribution from deficit support funding (£83.8m full year). The month 6 position by organisation is as follows:
 - ICB £3,725k favourable variance to plan due to individual commissioning efficiency delivery being ahead of plan.
 - SCHAT £93k surplus and favourable variance to plan, pay is underspent which is offsetting overspends on non-pay for prison contracts.
 - RJAHS £8k favourable variance to plan, due to efficiency delivery ahead of plan through held vacancies offsetting reduced income.
 - SaTH £1,274k adverse variance to plan, (after deficit support), pay is overspent by £5.8m which is partially offset by income overperformance, non-pay and finance costs mitigations. Key drivers of the adverse variance are unavailability and temporary staffing costs due to industrial action and escalation costs above plan.
- Noted that all System partners are forecasting to deliver their planned year end position and whilst they are reporting risks to that delivery, mitigations have been identified to offset those risks if they arise.
- Noted that the underlying recurrent position has improved overall by £7.5m from £99.4m planned to £91.9m due to £12.7m recurrent re-categorisation of ERF income which is netted down by a deterioration at Month 5 of £5.1m, ICB £2.3m, SaTH £1.3m and RJAHS 1.5m. All system organisations have confirmed that actions are on track to recover this deterioration by year end so as not to impact on the exit run-rate going into 2026/27.

Minute No.SFC-25.10.007 - Capital Prioritisation Oversight Group Update - Monthly Capital Report

Report received as read

- 7.1 ASz** reported the spend for the ICB is forecasted for the second part of the year (months 7-12). PIDs have now been signed off for forecasted spend.
- 7.2 ASz** noted for SCHAT and RJAHS, the schemes that are behind have now all started, with the intention to recover within this financial year 2025/26.
- 7.3** Regarding capital freedoms for SCHAT and RJAHS, SCHAT are intending to spend



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£600K of their £3.6m flexibility in year. RJAH are intending to spend capital freedom of £1.9m within the next financial year 2026/27.

- 7.4 ASz** flagged that there are some timing issues for SATH in relation to charges for the decarbonisation scheme, modulars, estate safety and a that there is a possible overspend on RAAC. In relation to RAAC **AW** explained that SATH is forecasting an overspend and anticipates slippage into the next financial year 2026/27. The national RAAC team have conducted site visits at SATH and are satisfied with the plans currently in place. SATH are currently awaiting confirmation of additional funding from the RAAC Team.
- 7.5** For HTP, **AW** reported, that SATH are working closely with the cost advisors and builders for the profile of capital spend for this year, as SATH are considerably behind with our cash flow (although HTP as a project is ahead of plan) for this financial year. SATH are now having discussions with NHS England about deferring some of the cash profile of spend from 2025/26 into 2026/27. **AW** noted that SATH are still forecasting full spend against the original £312m.

The System Finance Committee:

- Noted that Capital spend to M5 is £22.6m behind plan YTD namely due to SaTH decarbonisation invoices and HTP and RAAC underspends YTD.
- Noted the expected 25/26 FOT is delivery of the capital plan with risks reported to the delivery of the RAAC programme and that HTP cash is under review for M7-12.
- Noted that SCHAT have been awarded £3.57m capital freedoms of which £0.57m will be spent in 25/26 and £3m in 26/27.
- Noted that RJAH have been awarded £1.9m capital freedoms which will be spent in 26/27.
- Noted that in year digital capital bids for NHS App and EPR development have not been successful.
- Noted that capital redeployment bids have been submitted and that to date, £5.6m of estates safety schemes have been shortlisted with £0.3m in reserve.

Minute No.SFC-25.10.008 – Deep Dive Report - Finance Strategy Delivery Plan Q2 update on progress

Report received as read

- 8.1 ASz** reported that significant progress had been made in terms of the delivery of the actions. Everything that was set out to do in quarter one has been achieved.
- 8.2** From a governance and financial control perspective **ASz** highlighted that the half of the grip control work has now been completed.
- 8.3** In terms of incentives and contracts, **ASz** reported that System partners are currently in the process of refreshing the System Collaborative Financial Management Agreement. This outlines the principles for managing in-year financial risk. These principles support the development of our medium-term financial plan, particularly in relation to how we collaborate on business cases going forward. A shared benefits realisation template has been developed, which enables assessment and scoring of investment opportunities from a system-wide perspective. This is undertaken using the strategic decision-making framework, which is now well established.



- 8.4 The Finance Training Development Council continues to oversee training and development and talent management are followed through to completion. This includes an event taking place this week and a focus on digital skills and how we can better support the finance community in developing these skills and capabilities.
- 8.5 From a data perspective, we are at varying stages of implementation with regards to the Federated Data Platform, alongside ongoing national work related to the cost collection programme. These initiatives are key to improving data consistency and supporting system-wide financial planning. All providers are accessing the available resources, and while this will continue to evolve, it is already being shared and actively used to support planning for future years.
- 8.6 **ASZ** noted that STW ICB and SATH are currently reviewing HTP assumptions from the original business case to understand their implications for the refresh of the medium-term financial plan. A 10-year capital plan is already in place. Once allocations are confirmed, this will enable an update of both the capital plan and the medium-term financial plan accordingly. **DB** queried how much of this is being impacted by the ICB reconfigurations and the implementation of the new ICB model?
- 8.7 In terms of governance for the Boards and Committees, at present **ASz** explained the ICB STW has separate Board and Sub committees from SSOT. Further discussions will need to be had in the upcoming months of how the committees will operate as we progress through the Management of change process.

The System Finance Committee:

- Noted progress made on the implementation of the System Finance Strategy through the implementation action plan update.
- Noted the dates of the next deep dives, with Q3 currently scheduled for January 2026 and Q4 scheduled for April 2026.

Minute No.SFC-25.10.009 - System Finance Improvement Programme (SIIP) Update

Report received as read

- 9.1 **ASz** reported that the majority of the actions have now been completed for SIIP. The bulk of the outstanding actions are not due to be closed until the end of quarter 4 - March 2026.
- 9.2 It was agreed by the Finance Committee, that the SIIP report did not need to come back to this committee until the March 2026 Finance Committee meeting.

The System Finance Committee:

- Noted the progress made so far in relation to delivery against the SIIP Finance delivery plan actions and agreed that the next update would be due in March 2026.

Minute No.SFC-25.10.010 – Mid Term Report

Report received as read

- 10.1 ASz** highlighted that the Mid Term Report confirmed that we are undertaking and completing all our duties as a Finance committee as per the agreed Terms of Reference.
- 10.2** The report outlines the attendance log of committee members to the Finance Committee meetings since the beginning of this financial year.
- 10.3** The report sets out some of the key discussions that has been had in the Finance Committee over the past six months and key decisions made.
- 10.4** The report highlights three key actions as part of the previous annual review. Which include:
- A discussion with the ICB Board around governance. That includes a discussion around the Finance Committee as we become a cluster with SSOT.
 - Committee members to feed back any reflections on what worked well/not so well to the System CFO/Chair at any time and to continue to review this as part of the annual questionnaire.
 - Finance Committee agreed that the attendance would be extended to clinical, operational, workforce and other colleagues to align with the deep dive topics.

The System Finance Committee:

- The committee noted the contents of the report.

The System Finance Committee: Minute No.SFC-25.10.011 – Medium-Term Financial Plan

Report received as read

- 11.1 ASz** updated the committee on key timelines for planning as shared by NHSE over the last week including capital guidance and the finance framework business rules that are due to be issued in the next week.
- 11.2 ASz** highlighted key information relating to capital business rules and confirmed that we will receive nine years of capital allocation for estates safety. **ASz** is awaiting confirmation from NHS England as to how that will be distributed across Systems and across the 9 years.
- 11.3** There is a change in the approach to provider operational capital: 5% of provider operational capital will now be pooled into the system for allocation to system-wide priorities. All parties will be involved in jointly agreeing how capital should be spent, ensuring alignment with strategic objectives and shared priorities.
- 11.4 ASz** noted, ERF revenue allocations, distinct from the distance-from-target funding, are expected to be distributed on a fair shares basis this year. This approach should result in increased funding for our System. However, we are awaiting confirmation of the figures and the details of how the allocation will be distributed. There will also be an ERF allocation for non-recurrent waiting list initiatives agreed with respective Systems.



11.5 ASz explained the deficit support payment seems that it is likely to be phased out more years rather than the originally anticipated two. There has been a balanced national discussion around the performance improvements required over the next three years and how quickly the deficit support payment can be withdrawn from allocations. In our last MTFP submission, we proposed a two-year break-even trajectory, not a three-year plan for deficit support withdrawal. We are currently awaiting confirmation of allocations to clarify the position.

11.6 ASz noted a significant change in the performance improvement targets expected from 2026/27 UEC (Urgent and Emergency Care) perspective. Specifically, the four-hour target is increasing from 70% to 82%, representing a substantial shift in performance expectations. Additionally, there is a further 7% stretch in RTT (Referral to Treatment) targets expected in 2026/27.

11.7 ASz noted from a revenue perspective that the running cost allocations for the ICB are partially based on the anticipated cost of change, the expected impact to running costs allocations is expected to be confirmed within the next week.

The System Finance Committee:

- Noted that a further update will be provided to Finance Committee to set out the impact of further planning guidance, allocations including the pace of change on the MTFP as soon as this is available.
- Noted that the approval for the draft financial plan submission for 2026/27 and MTFP is planned to be brought to November 2025 Finance Committee (pending receipt of the allocations).
- Noted that the December financial plan submission is planned to be approved by the Integrated Care board and reported to Finance Committee in January 2026.

Minute No.SFC-25.10.012 – Risk review and escalations to Board

12.1 No additional risks or escalations to Board were captured.

Minute No.SFC-25.10.013 – A.O.B

13.1 There were no requests for any items to be recorded under A.O.B.

Meeting Closed at 15.14

Date and Time of Next Meeting

Tuesday 25th November 2025, 14.15 via Teams.



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11



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Enc 16: Strategic Commissioning & Productivity Committee Briefing Report

Meeting Name: Integrated Care Board Meeting In Common
Meeting Date: 29 January 2026
Report Presented by: Lorna Clarson, Chief Officer – Strategy & Improving Outcomes
Report Approved by: Ian Green, Cluster Chair
Report Prepared by: Lorna Clarson, Chief Officer – Strategy & Improving Outcomes

Action Required: For Noting

1. Committee/Group Meeting Details

1.1 Extra Ordinary Strategic Commissioning and Productivity Committee Meeting Held on 11 November 2025.

2. Summary of Key Discussions and Decisions

The Committee considered the proposal to proceed with the Lung Cancer Screening Programme, part of the national ambition to diagnose 75% of cancers at an early stage.

Programme Overview

- Targets individuals aged 55–74 who smoke or have ever smoked, prioritising areas of high deprivation and lung cancer prevalence.
- Fully funded nationally for screening via the West Midlands Cancer Alliance, delivered by Alliance Medical.
- Downstream diagnostic and treatment activity would create additional demand and cost pressures for secondary care and Primary Care.
- Non-recurrent funding for 2025/26 has been identified; funding beyond this would need resolution through 2026/27 planning.
- Programme start was paused pending assurance and decision-making.

Key Concerns Raised

- Governance & process: Proposal had not received Executive sign-off; papers were late and overly detailed for Committee purposes.
- Financial risk: Finance team were not sighted on potential secondary care costs at the point of original contract award.
- Contractual risk: Contract already signed; risk of repayment to the Cancer Alliance if programme does not proceed.
- Primary Care capacity: Approximately 77% of activity expected to flow into Primary Care, with no accompanying paper detailing workload, funding, or workforce implications.



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- Secondary care capacity: Concerns regarding SaTH's ability to manage increased diagnostic and treatment demand.
- System alignment: Need for clarity on specialised commissioning impacts and confirmation of shared system agreement.
- Workforce sustainability: Heavy reliance on consultant workforce; alternative models (e.g. nurse-led clinics) suggested.

Committee Position

- The Committee agreed that further assurance is required before a decision can be confirmed.
- The item is to return to a future Committee once gaps have been addressed.

Action

- Mr Wright and Ms Wigley to provide a revised response addressing Committee questions, including:
 - Financial implications for secondary care and Primary Care
 - Capacity and deliverability assurance
 - Longer-term affordability and opportunity costs
 - Workforce model considerations

Risks & Escalations

- No formal risks escalated; however, material financial, capacity, and contractual risks were identified for further consideration.

3. Recommendations to the Board

- To note information within the report.

4. Performance and Assurance

N/A

5. Alignment to ICB Objectives and Core Functions

N/A

6. Next Steps and Forward Plan

N/A

7. Attachments

N/A



Ambition



Compassion



Optimism



Focus

Enc 16: Strategic Commissioning & Productivity Committee Briefing Report

Meeting Name: Integrated Care Board Meeting In Common
Meeting Date: 29 January 2026
Report Presented by: Lorna Clarson, Chief Officer - Strategy & Improving Outcomes
Report Approved by: Ian Green, Chair, Cluster Chair
Report Prepared by: Lorna Clarson, Chief Officer – Strategy & Improving Outcomes
Action Required: For Noting

1. Committee/Group Meeting Details

1.1 Strategic Commissioning and Productivity Committee Meeting Held on 25 November 2025.

2. Summary of Key Discussions and Decisions

2.1 Governance & Housekeeping

- Minutes from 28 October 2025 were approved.
- Concerns were raised regarding gaps in the forward plan, particularly around procurements and contract awards, due to recent recruitment impacts.
- Action: Forward plan and action log to be reset and updated for the next meeting.
- Action log reviewed; several actions closed, others progressing with Executive Lead allocation clarified.

2.2 Prescription Ordering Direct (POD) Service

- Decommissioning completed; staff issued notice on 24 November 2025 and service closing end of December.
- Transition support ongoing for GP Practices and patients, including migration to the NHS App.
- Practices have received financial support to assist with transition and backfill.
- Committee noted update.

3. System Board Assurance Framework (SBAF) & System Operational Risk Register (SORR)

- Further work required to align risks with new cluster arrangements.
- Discussion scheduled at Part 2 Board (26 November 2025).
- Committee noted update.

4. Finance, Revenue & Efficiency (Month 7)

- Month 7 financial position positive, consistent with Month 6.



Ambition



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Focus

- Key risks: prescribing cost pressures, high-cost individual packages, and partially funded redundancy costs.
- DSF milestone remains critical; engagement ongoing with NHS England.
- Capital issues noted, including delayed NHSE sign-off and flexibility requested for the Primary Care Modernisation Fund.
- Allocations received were better than expected; a strategic capital pot has been established.
- A capital planning and prioritisation paper will be brought to the January meeting.
- An Extraordinary Committee meeting will be held to review submissions prior to regional and national deadlines in December 2025.
- Committee gained assurance and noted update.

5. Targeted Lung Health Checks

- Business case revisited following earlier queries.
- Assurance received on: Specialist commissioning funding

6. Policies

- Accessible Information Standard Policy and Complaints Policy, including EQIAs, were approved subject to minor formatting and accessibility corrections.
- Action: Formatting amendments to be completed prior to publication.

7. Equality & Involvement

- Equality & Involvement Report taken as read.
- Winter plan presentation provided assurance.
- New IIA process clarified for Committee members.
- Committee noted update.

8. Commissioning & Primary Care Updates

- Commissioning Working Group Chair's report received for information.
- No escalations from the Primary Care Commissioning Group.
- Positive progress noted on GP Board engagement and emerging provider collaboratives.
- Action: Minor amendment to CWG report to be completed.

9. Risks & Escalations

- No risks or escalations to report.

3. Recommendations to the Board

- To note information within the report.

4. Performance and Assurance

N/A



Ambition



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Optimism



Focus

5. Alignment to ICB Objectives and Core Functions

N/A

6. Next Steps and Forward Plan

N/A

7. Attachments

N/A



Enc 16: Strategic Commissioning & Productivity Committee Briefing Report

Meeting Name: Integrated Care Board Meeting In Common
Meeting Date: 29 January 2026
Report Presented by: Lorna Clarson, Chief Officer – Strategy & Improving Outcomes,
Report Approved by: Ian Green, Cluster Chair
Report Prepared by: Lorna Clarson, Chief Officer – Strategy & Improving Outcomes,
Action Required: For Noting

1. Committee/Group Meeting Details

1.1 Extra Ordinary Strategic Commissioning and Productivity Committee Meeting
Held on 10 December 2025.

2. Summary of Key Discussions and Decisions

Adult ADHD – Commissioning Update

- Significant growth in Adult ADHD referrals (approx. 260 per month), with around 2,400 patients waiting and waits of up to two years.
- High in-year spend identified with non-contracted 'Right to Choose' providers, primarily for virtual assessments.
- Proposal agreed to require the top 5–6 non-contracted providers to work to:
 - Indicative activity plans
 - Existing ICB terms and conditions, including a minimum 16-week wait to support equity of access.
- Expected to deliver c.£0.5m in-year financial improvement.
- Committee supported the approach, recognising challenges around quality, equity, and financial sustainability.
- Longer-term redesign of autism and ADHD services (adults and children) acknowledged as necessary.

Planning – Capital and Revenue

Capital

- BAU capital allocation of just over £1m confirmed (GP IT refresh and GP premises accessibility).
- New strategic capital allocation received to support:
 - Connectivity and One Health & Care Record
 - £500k Primary Care Modernisation and Utilisation Fund
- System capital plan still requires formal sign-off.
- Constitutional standards and Community Diagnostics capital indicative allocations received, with a deadline of 17 December to confirm intended use.

Revenue

- Deficit support funding confirmed:



Ambition



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Optimism



Focus

- £32.5m in 2026/27
- £24.4m in 2027/28
- System-wide agreement to deliver 5% efficiency, including 2% productivity improvement, adopted by all providers and the ICB.
- Further triangulation required on efficiency programmes, particularly Urgent and Emergency Care.

Operational Plan & Board Assurance Statements

- The Committee reviewed the system operational plan and associated performance, workforce, and risk information.
- Key workforce concerns identified:
 - 12% growth in Primary Care administrative/non-clerical staff
 - Flat GP workforce over the last three years despite population growth
- A deep dive has been commissioned to inform the final February submission.
- Industrial action remains a key risk to delivery.

Committee Decisions

The Committee:

- Approved the first system operational plan for submission to NHS England by 17 December 2025.
- Approved the content of the ICB Board Assurance Statements.
- Noted key risks to delivery and next steps prior to final submission.
- Delegated authority for approval of any final amendments to the ICB Cluster Chief Executive, Cluster Chair, and Chief Finance Officer.

Risks & Escalations

- No formal escalations.
- Key risks noted: workforce capacity, industrial action, efficiency delivery, and affordability of future demand pressures.

3. Recommendations to the Board

- To note information within the report.

4. Performance and Assurance

N/A

5. Alignment to ICB Objectives and Core Functions

N/A

6. Next Steps and Forward Plan

N/A

7. Attachments

N/A



Ambition



Compassion



Optimism



Focus

Enc 17: Strategy and Prevention Committee Briefing Report

Meeting Name: Integrated Care Board Meeting In Common

Meeting Date: 29 January 2026

Report Presented by: Lorna Clarson, Chief Officer, Strategy and Improving Outcomes

Report Approved by: Ian Green, Cluster Chair

Report Prepared by: Lorna Clarson, Chief Officer, Strategy and Improving Outcomes

Action Required: For Noting

1. Committee/Group Meeting Details

Strategy & Prevention Committee Meeting held on 8 October 2025.

2. Summary of Key Discussions and Decisions

Key Approvals & Assurances

- Minutes and Action Logs (9 July & 12 September 2025) approved, with minor amendments to titles.
- System Board Assurance Framework & System Operational Risk Register noted with no changes.
- Digital Strategy Progress Update noted and recommendations approved.
- Data Strategy approved for publication, including governance and delivery arrangements.

Strategic Updates & Key Discussions

NHS 10-Year Plan & National Neighbourhood Health Implementation Programme

- Shropshire successfully included in the national neighbourhood programme.
- Regional engagement commencing October 2025.
- Focus on long-term conditions (e.g. frailty, diabetes), rurality, and integrated neighbourhood teams.
- Learning to be shared across the STW system and beyond.
- Governance reporting proposed through Place, Neighbourhood Health Implementation Group, and System Transformation Committee.

Healthcare Inequalities – Q1 2025/26

- 73% of deliverables achieved despite workforce and funding constraints.
- Delays acknowledged due to vacancy freeze; funding now stabilised.
- Positive impact noted from Community Diagnostic Centre, particularly for CYP asthma.
- Capacity remains a key system risk and is reflected in the BAF.
- Elective reform leadership now confirmed for Q2 onwards.



Ambition



Compassion



Optimism



Focus

Digital Strategy – Progress

- Continued alignment with NHS 10-Year Plan and digital transformation priorities.
- Progress on EPRs, Shared Care Record, patient engagement portals, and NHS App integration.
- AI development progressing cautiously with focus on safety, cyber security, and data risks.
- Digital inclusion and capital funding identified as ongoing challenges.
- Contract alignment underway across clustered ICBs.

Community Transformation

- Ongoing neighbourhood working, MDT development, and place-based governance.
- Strong alignment with commissioning intentions, clinical strategy refresh, and NHS reset programme.
- Governance interfaces between Place Partnership Boards and System Transformation Committee under review.

System Strategy & Medium-Term Planning

- Assurance provided that medium-term planning and Joint Forward Plan development are progressing.
- Planning approach adapting to ICB clustering and function changes.
- Further detailed update scheduled for January 2026.

Prevention Framework

- Work underway to align six priority areas with prevention levels, outcomes, and funding.
- Emphasis on sustainable commissioning, diabetes prevention, and strategy mapping.
- Strong PCN and pharmacy engagement noted.
- Further detailed prevention and commissioning update to follow.

Health & Wellbeing Boards

- Shropshire HWB focus on vulnerability, winter preparedness, frailty, fuel poverty, and prevention.
- Director of Public Health report published.
- Telford & Wrekin updates included smoke-free strategy, GP access, and healthy ageing.
- Smoke-free Telford & Wrekin presentation scheduled for next meeting.



Ambition



Compassion



Optimism



Focus

Data Strategy (AOB)

- Delivery phase commencing, supported by a refreshed Digital & Data Delivery Group.
- Key risks identified: data quality, interoperability, workforce capability.
- Strong system collaboration and national alignment noted.
- Strategy approved for publication.

Key Actions

- Circulation of community transformation and prevention slides.
- Further updates on prevention framework, diabetes prioritisation, commissioning intentions, and ICS clinical strategy.
- Detailed medium-term planning update to January 2026 meeting.
- Smoke-free Telford & Wrekin presentation at next committee.
- Digital & Data Delivery Group terms of reference to System Transformation Committee.

3. Recommendations to the Board

- To note information within the report.

4. Performance and Assurance

N/A

5. Alignment to ICB Objectives and Core Functions

N/A

6. Next Steps and Forward Plan

N/A

7. Attachments

N/A



Enc 18: Shropshire Integrated Place Partnership Briefing Report (meeting held on 18th December 2025)

Meeting Name: Shropshire Integrated Place Partnership (ShIPP)

Meeting Date: 18th December 2025

Report Presented by: Tanya Miles, Shropshire Council, Chief Executive

Report Approved by: Tanya Miles, Shropshire Council, Chief Executive

Report Prepared by: Rachel Robinson, Shropshire Council, Executive Director, Public Health (DPH)

Action Required: For assurance and discussion

1.1. Summary of Key Discussions and Decisions

1.1.1. ShIPP meets Bi-monthly, with the last meeting on the 18th December 2025.

The meeting covered

- ShIPP Accelerator Group update
- National Neighbourhood Health Implementation Programme (NNHIP) update
- ShIPP Prevention Funding update
- Healthy Ageing update
- Draft Special Educational Needs and Disabilities for 0–25-year-olds Joint Strategic Needs Assessment
- Lung Cancer Screening update
- Urgent & Emergency Care Winter Plan

1.1.2. The meeting was quorate

1.1.3. No conflicts of interests were declared

1.1.4. The meeting was well attended

1.2. Recommendations to the Board

1.2.1 The Board is asked to note the following briefing report from the Shropshire Integrated Place Partnership.

- **The ShIPP Accelerator group:** presented a written report on progress for information. Carla Bickley and Naomi Roche shared highlights and discussed membership of the group.
- **NNHIP update:** Naomi Roche presented an update and in response to the update there was discussion on capturing shared learning and public communication and engagement.
- **ShIPP Prevention Funding update:** Bev Baxter and Pete Ezard proposed a new plan for the VCSA to lead a partnership to carry the funding process forward, there was discussion about making sure that the process was fair and transparent.
- **Healthy Ageing update:** Anne Marie Speke detailed the outcomes of recent community engagement and mapping work that will be incorporated into the Healthy Ageing Strategy.



Ambition



Compassion



Optimism



Focus

- **Draft SEND for 0–25-year-olds JSNA:** Jess Edwards highlighted key data findings and the committee agreed to review the recommendations.
- **Lung Cancer Screening update:** Dr Emma Crawford detailed the roll out of the programme across the region.
- **Urgent & Emergency Care Winter Plan:** Gareth Wright presented the five-phase winter plan. There was discussion on communication and alignment with the NNHIP.
- **Any other business:** the committee were asked to attend the upcoming annual planning event on the 12th February at Guildhall.

1.3. Key Risks and Mitigations

There were no risks raised at this meeting

1.4. Performance and Assurance

1.4.1. **Assure** - positive assurances and highlights of note:

- **The ShIPP Accelerator group:** the group noted the update and agreed to use the upcoming February workshop to review terms of reference, clarify group roles, and ensure appropriate representation.
- **NNHIP update:** the committee noted the contents of the update, including an upcoming visit from the national SRO in February.
- **ShIPP Prevention Funding update:** ShIPP approved and endorsed the new proposals and operational delivery plan.
- **Healthy Ageing update:** the committee noted the outcomes of the engagement and mapping work, which will inform the implementation of the Healthy Ageing and Frailty Strategy.
- **Draft SEND for 0–25-year-olds JSNA:** ShIPP noted the information contained in the draft SEND JSNA and the request to provide feedback.
- **Lung Cancer Screening update:** the committee noted the contents of the update including the two-stage screening process and the increase in early-stage lung cancer detection
- **Urgent & Emergency Care Winter Plan:** The committee noted the progress of the system winter plan, to mitigate additional seasonal pressure, and safely maintain quality of care.

1.5. Alignment to ICB Objectives and Core Functions

1.5.1 The committee's discussion directly aligns with the Joint Forward Plan's key elements of:

- Taking a person-centred approach (including proactive prevention, self-help, and population health to tackle health inequalities and wider inequalities).
- Improving place-based delivery, having integrated multi-professional teams providing a joined-up approach in neighbourhoods, supporting our citizens and providing care closer to home, where possible.
- ShIPP is a crucial part of the development and delivery of the Joint Forward Plan and ShIPP's new strategy & priorities have been developed with the ICB Strategy Team and our other partners.



Ambition



Compassion



Optimism



Focus

1.6. Next Steps & Forward Plan

1.6.1 The following actions were agreed by presenters and committee members to carry the work forward:

ShIPP Accelerator Group

- **Planning workshop:** review terms of reference, clarify group roles, and ensure appropriate representation at joint HWBB/ShIPP Planning Workshop in February.
- **Merge groups:** merge the Healthy Lives Steering Group into the ShIPP Accelerator Group, reviewing membership and operational aspects to reduce duplication.

ShIPP Prevention Funding

- **CYP Social Prescribing Funding:** Clarify the position on funding for children & young people's social prescribing and the PCN's financial contributions going forward.
- **Prevention Funding Workshop Participation:** Ensure that those unable to attend the Joint Design Workshop for prevention funding can provide input and have their views represented in the process.
- **Prevention Funding Communication:** Send immediate communications to all applicants explaining the revised prevention funding process and timelines and provide ongoing updates following the Joint Design Workshop and funding review panel.

Draft SEND JSNA

- **Review Recommendations:** committee members were asked to review the detailed recommendations presented, with the aim of finalising the documents for Health and Wellbeing Board sign-off in March.

Urgent & Community Care Winter Plan

- **Winter Plan and Community Services Communication:** Clarify and communicate the differences and referral processes for urgent community response, rapid response, and virtual ward services to all relevant stakeholders, ensuring terminology is consistent and easily understood.
- **Neighbourhood Health and UEC Programme Alignment:** Arrange a meeting to align the National Neighbourhood Health Implementation Programme with UEC and other system programmes.

1.7. Attachments

Appendix A. ShIPP minutes 18.12.25



MINUTES

Meeting Title	Shropshire Integrated Place Partnership Board (ShIPP)	Date	18.12.25
Chair	Rachel Robinson	Time	15.00 - 17.00
Minute/Action Taker	Louisa Jones	Venue/ Location	Over Microsoft Teams

In Attendance:	Members: Rachel Robinson (Chair), Anne-Marie Speke, Dr. Catherine Beanland, Carla Bickley, Bev Baxter, Tomas Edge, Sharon Fletcher, Dr. Jess Harvey, Julian Birch, Dr. Katy Lewis, Pete Ezard, Emma Pyrah, Katie Turton, Geraldine Vaughan, Jess Edwards, Dr. Sid Patel (dep. for Dr. Charlotte Hart), Lynn Cawley
	Observers, Officers & Presenters: Naomi Roche, Louisa Jones (recording), Jenny Roach, Angelica Ghalustians
Apologies:	Tanya Miles (dep. Rachel Robinson), Peter Prokopa, Claire Parker, Laura Fisher, Paul Bowers, Jenny Daisley, Bridey Davies

	ITEMS FOR DISCUSSION	ACTION OWNER
1a.	WELCOME AND APOLOGIES FOR ABSENCE	Rachel Robinson
	Rachel welcomed all members, deputies, and observers to the meeting. A quorum of members was present.	
1b.	MINUTES OF LAST MEETING AND ACTIONS	Rachel Robinson
	The minutes of the last meeting were approved. Completed Actions: <ul style="list-style-type: none"> • ShIPP Accelerator Group & NNHIP - updates and summaries shared. • ShIPP Prevention Funding – new evaluation group has met, new proposals and timeline to be presented at today’s meeting. • Healthy Ageing Strategy Community Engagement - CWOT team involved in strategy roll out. • Vaccination Improvement Plan - vaccination assets for different age groups and populations have been provided by 	



	NHSE and ICB colleagues have also produced localised assets.	
1c.	DECLARATION OF PECUNIARY INTERESTS	Rachel Robinson
	No declarations were made	
2.	SHIPP Accelerator Group	Carla Bickley
	<p>Carla and Naomi provided a comprehensive update on the ShIPP Accelerator Group. Carla summarised recent activities including stakeholder engagement events, planning workshops, and awareness campaigns across neighbourhoods, diabetes, and healthy ageing. Key risks identified were lack of additional funding, competing priorities, and organisational changes impacting delivery.</p> <p>Discussion:</p> <ul style="list-style-type: none"> • Membership and Group Structure Concerns: Naomi and Rachel raised concerns about overlapping membership between ShIPP, the Accelerator Group, and the Health and Wellbeing Board, noting potential duplication and the need for clear roles and terms of reference. Jess and Naomi discussed the distinction between delivery-focused and oversight groups, suggesting that this be a subject for discussion at the upcoming planning workshop. • Action to Merge Healthy Lives Steering Group: Anne-Marie proposed merging the Healthy Lives Steering Group into the ShIPP Accelerator Group to reduce duplication, with agreement from Carla and Rachel to review and align membership and operational focus ahead of the February planning workshop. <p>Approval: the group noted the update and agreed to use the upcoming February workshop to review terms of reference, clarify group roles, and ensure appropriate representation.</p> <p>Actions:</p> <ul style="list-style-type: none"> • Planning workshop: review terms of reference, clarify group roles, and ensure appropriate representation at joint HWBB/ShIPP Planning Workshop in February (All). • Merge groups: merge the Healthy Lives Steering Group into the ShIPP Accelerator Group, reviewing membership and operational aspects to reduce duplication (Anne-Marie, Carla) 	
3.	NNHIP update	Naomi Roche



		Emma Pyrah
	<p>Naomi and Emma provided an update on the National Neighbourhood Health Implementation Programme:</p> <ul style="list-style-type: none"> • Programme Focus and Progress: Naomi outlined the programme's focus on adults with complex long-term conditions, the development of integrated neighbourhood teams, and the use of population health data to target interventions. • National Engagement and Site Visits: Naomi described plans for a visit from the national SRO in February, which will include site visits to neighbourhood teams to showcase both successes and challenges, with coordination across neighbourhoods to facilitate meaningful engagement. <p>Discussion:</p> <ul style="list-style-type: none"> • Capturing and Sharing Learning: Sharon asked how learning from funded initiatives would be captured and shared in real time to support proactive responses. Naomi explained the use of rapid learning cycles, involvement of improvement units, and the importance of multi-stakeholder engagement to ensure continuous improvement. • Public Communication and Engagement: Jess and Sharon discussed the need for effective communication with the public to ensure awareness of new services and support, with Naomi acknowledging this as an ongoing area for development and part of the programme's remit. <p>Approval: The committee noted the update</p>	
4.	SHIPP Prevention Funding	Bev Baxter, Pete Ezard
	<p>Prevention Funding Operational Delivery Plan: Naomi, Bev, and Pete presented the operational delivery plan for prevention funding</p> <ul style="list-style-type: none"> • Collaborative Approach and Work Streams: Bev and Pete described the plan to structure delivery around three work streams—healthy ageing and resilience, community infrastructure and workforce, and children and young people's emotional well-being—emphasising the need for coordination and equity across Shropshire. • Governance and Conflict of Interest Management: Pete outlined the governance structure, including a delivery group, a joint design workshop to reduce duplication, and a funding review 	



	<p>panel to provide independent assurance and manage conflicts of interest among applicants.</p> <ul style="list-style-type: none"> • Timeline and Monitoring: The team detailed the mobilisation timeline, aiming for grant agreements by late February and delivery from April, with quarterly reporting focused on outcomes, equity, and lived experience, and a full evaluation planned for 2027. <p>Discussion:</p> <ul style="list-style-type: none"> • Jess and Catherine queried the allocation of CYP social prescriber funding – if a PCN is already paying for a CYP social prescriber will they be reimbursed for that going forward? Naomi agreed to clarify the situation regarding funding. • Jess raised concerns about workshop scheduling and whether she would be able to attend with short notice. Bev and Pete committed to flexibility in gathering input and to clarifying funding arrangements to ensure fairness. <p>Approvals: ShIPP approved an endorsed:</p> <ul style="list-style-type: none"> • the proposal – “ShIPP Prevention Funding - A Way Forward” • the Operational Delivery Plan • governance sequence (Workshop → Panel → Board) • new mobilisation timeline • transparency & Accord alignment <p>Actions:</p> <ul style="list-style-type: none"> • CYP Social Prescribing Funding: Clarify the position on funding for children & young people’s social prescribing and the PCN’s financial contributions going forward (Naomi, Claire Sweeney) • Prevention Funding Workshop Participation: Ensure that those unable to attend the Joint Design Workshop for prevention funding can provide input and have their views represented in the process. (Pete, Bev) • Prevention Funding Communication: Send immediate communications to all applicants explaining the revised prevention funding process and timelines and provide ongoing updates following the Joint Design Workshop and funding review panel. (Bev, Pete) 	
5.	Healthy Ageing update	Anne-Marie Speke
	Anne-Marie presented the outcomes of engagement events on the healthy ageing and frailty strategy.	



	<p>Key Findings from Engagement: Anne-Marie summarised stakeholder feedback, identifying priorities including changing perceptions of ageing, integrating services, improving communication, addressing rural and digital barriers, and ensuring long-term sustainability beyond short-term funding.</p> <p>Approvals: the committee noted the outcomes of the engagement and mapping work, which will inform the implementation of the Healthy Ageing and Frailty Strategy.</p>	
6.	Draft SEND JSNA	Jess Edwards
	<p>Jess provided a high-level summary of the Special Educational Needs and Disabilities (SEND) for 0-25 year olds Joint Strategic Needs Assessment, (JSNA) detailing data on rurality, access, population trends, educational outcomes, and social care.</p> <ul style="list-style-type: none"> • Key Data Insights: Jess highlighted findings such as increasing deprivation, long travel times to services, a rising number of children with special educational needs, and significant increases in Education, Health and Care Plans (EHCPs) since the pandemic, with notable rural disparities. • Educational and Social Care Outcomes: The JSNA revealed lower educational attainment for SEND children, higher rates of exclusion and absence, and a growing proportion of SEND children in social care, with 73% of children in need having special educational needs. • Health Data and Service Access: Analysis showed incomplete health data recording for SEND children, higher rates of comorbidities, and challenges in accessing early help and short breaks, with ongoing efforts to improve data quality. <p>Approval: SHIPP noted the information contained in the draft SEND JSNA and the request to provide feedback.</p> <p>Action:</p> <ul style="list-style-type: none"> • Review Recommendations: Jess asked board members to review the detailed recommendations contained in Appendix A. SEND JSNA Summary Slides and accompanying chapters the by the end of January, with the aim of finalising the documents for Health and Wellbeing Board sign-off in March. (All) 	
7.	Lung Cancer Screening update	Dr. Emma Crawford
	Dr. Emma Crawford updated the group on the rollout of the national lung cancer screening programme	



	<p>Programme Structure and Outcomes: Emma explained the two-stage screening process for eligible individuals, the involvement of multiple partners, and the significant increase in early-stage lung cancer detection, with the programme rolling out in phases across the region.</p> <p>Approval: The committee noted the update</p>	
8.	<p>Urgent & Emergency Care Winter Plan</p>	Gareth Wright
	<p>Gareth presented the winter plan:</p> <ul style="list-style-type: none"> • Phased Winter Planning and Interventions: Gareth described the five-phase winter plan, including enduring service changes, targeted funding for discharge and respiratory illness, and responsive measures to manage system pressures during the festive period and beyond. <p>Discussion:</p> <ul style="list-style-type: none"> • Sustaining Improvements and Neighbourhood Focus: Carla and Gareth discussed the importance of sustaining improvements year-round, with plans to shift focus towards neighbourhood and community-based interventions, and to involve primary care more closely in future planning. • Rapid Learning and Community Impact: Sharon raised the need to capture and share learning from community-based interventions that prevent hospital admissions, with Gareth agreeing to bring proposals for neighbourhood-focused work streams to the board for input. • Clarification of Urgent Care Services: Jess highlighted confusion among primary care colleagues regarding the various urgent community response services, prompting Gareth and Katie to commit to issuing clearer communications and guidance to ensure effective utilisation. <p>Approvals:</p> <ul style="list-style-type: none"> • The committee noted the progress of the system winter plan, to mitigate additional seasonal pressure, and safely maintain quality of care. • The committee discussed what we have learned so far, with a look forward to the remainder of the winter period and how we will seek continuous improvement on our Urgent & Emergency Care pathway in the county. <p>Action:</p>	



	<ul style="list-style-type: none"> • Winter Plan and Community Services Communication: Clarify and communicate the differences and referral processes for urgent community response, rapid response, and virtual ward services to all relevant stakeholders, ensuring terminology is consistent and easily understood. (Gareth, Katie) • Neighbourhood Health and UEC Programme Alignment: Arrange a meeting between Emma, Naomi, and Gareth to align the National Neighbourhood Health Implementation Programme with UEC and other system programmes. (Naomi, Emma, Gareth) 	
9.	Any Other Business	ALL
	<p>The Chair asked that the Committee notes the upcoming HWBB/ShIPP Planning Workshop (in person) 12th Feb 2026, Guildhall, Shrewsbury. 12.30 - 16.00.</p> <p>The next ShIPP meeting will be for essential items only and will run 16.00 - 17.00 on the 12th February 2026, after the workshop.</p>	
	REVIEW OF MEETING	
	<p><i>The meeting was well attended, was quorate and held good discussions, agreeing, where appropriate, the report recommendations.</i></p> <p><i>The meeting ended at 16.56</i></p>	
	DATE OF NEXT MEETING	
	The next meeting of ShIPP is scheduled to take place on Thursday 12 th February 2026, 16.00 - 17.00, for essential items only	
	<p>The minutes of this meeting are agreed as an accurate record.</p> <p>Signed:.....</p> <p>Date:.....</p> <p><i>Chair: Rachel Robinson</i></p>	



Enc 19: Telford & Wrekin Integrated Place Partnership Briefing Report (January 2026)

Meeting Name: Telford & Wrekin Integrated Place Partnership (TWIPP)

Meeting Date: 13th November.

Report Presented by: David Sidaway, Telford & Wrekin Council, Chief Executive

Report Approved by: David Sidaway, Telford & Wrekin Council, Chief Executive

Report Prepared by: Louise Mills, Telford & Wrekin Council, Head of Health Improvement & Prevention and Telford and Wrekin Place Lead

Action Required: For assurance.

1.1. Summary of Key Discussions and Decisions

1.1.1. This report provides an update on the work of the Telford & Wrekin Integrated Place Partnership (TWIPP) Committee.

1.1.2. The group meets bi-monthly, with the next meeting scheduled for 27th January.

1.1.3. Discussions have focussed on

- The TWIPP Priority - Children and Young People's Mental Health
- Good Level of Development (GLD) - Early Years
- Healthy Conversations Campaign
- ICB Strategic Commissioning Intentions – Neighbourhood Health
- Neighbourhood Health and Medium-Term Planning

1.2. Recommendations to the Board

The Board is asked to note the:

1.2.1. System pressures in CYP mental health remain high; upcoming January updates are critical for assurance.

1.2.2. Early Years GLD improvement is now a nationally driven priority requiring multi-agency response and alignment with wider priorities by March 2026.

1.2.3. TWIPP are well positioned to transform and accelerate neighbourhood health plans and in January will be able to share achievements from the devolved ICB prevention budget with a view to securing additional funding for 2026/27.

1.3. Key Risks and Mitigations

1.3.1. The TWIPP Declaration of Interest Register is in place and is utilised as appropriate.



Ambition



Compassion



Optimism



Focus

1.4. Performance and Assurance

1.4.1. Alert – Matters of concern, gaps in assurance or key risks to escalate:

- An additional risk was added to the Committee’s risk register to reflect the ICB re-modelling.

1.4.2. Assure – positive assurances and highlights of note:

○ **The TWIPP Priority - Children and Young People’s Mental Health**

Members reflected on the September workshop and identified three priorities:

1. Stronger system-wide communication
2. A mapping exercise of services and strategic partnerships
3. Addressing challenges around waiting lists and rising demand

A follow-up workshop is planned for January to brief the TWIPP Committee on:

- The new service model intentions and transformation plan - strategic goals, key changes, timelines, strategic oversight and governance arrangements
- Overview of the early help and prevention support offer
- Waiting time management and improvement plan

○ **Good Level of Development (GLD) - Early Years**

Helen Onions Director of Public Health outlined new national expectations for improving children’s early development. A multi-agency task and finish group is being established to create a local plan by March 2026, closely aligned with the Family Hubs programme and neighbourhood health developments. Members were invited to participate and draft plans will return to TWIPP for review.

○ **Healthy Conversations Campaign**

Communications Lead Lauren Tye provided an update on the flu-focused phase of the Healthy Conversations campaign, which has achieved positive engagement and alignment with national NHS messaging. Members were asked to ensure messages are being shared locally and to highlight areas with low vaccination uptake. Future campaign themes proposed include smoking cessation (including vaping) and alignment with March’s national Pharmacy First push.

- **ICB Strategic Commissioning Intentions – Neighbourhood Health**

Gemma Smith presented the emerging 1, 3 and 5 year commissioning intentions for STW ICB, highlighting a shift towards neighbourhood-level commissioning, redesigned services, and targeted neighbourhood health centres. Members discussed funding uncertainty, tight timelines, and the need for TWIPP to act as a testing ground for neighbourhood-based approaches.

- **Neighbourhood Health and Medium-Term Planning**

Claire Parker shared local progress against the national Maturity Matrix, with most areas rated as “starting” or “progressing.” Members discussed barriers such as data sharing, funding flows and estates utilisation and were able to identify local strengths including strong partnerships, with Multi-Disciplinary Team development identified as a future focus.

1.4.3. **Advise** – areas that continue to be reported on and/or where some assurance has been noted/further assurance sought:

- The TWIPP Committee will receive an update report on children and young people’s mental health and wellbeing at the January meeting to seek assurance around progress towards managing waiting times and access to community-based preventative support.

1.5. Sharing of Learning

1.5.1. Not applicable

1.6. Actions to be considered follow up actions or actions you require colleague support

1.6.1 The Committee will receive an update on the ICB funded prevention projects at the January meeting. Following this, a report will be produced and shared with ICB colleagues. This will enable TWIPP to demonstrate the outcomes achieved through the devolved prevention budget for neighbourhood health and prevention initiatives, strengthening the case for securing additional ICB prevention investment for the 2026/27 financial year.



Enc 20: System Transformation and Digital Group Briefing Report

Meeting Name: Integrated Care Board Meeting

Meeting Date: 29 October 2025

Report Presented by: Andrew Morgan Committee Chair and Chair in Common Shropshire Community Health NHS Trust and The Shrewsbury and Telford Hospital NHS Trust

Report Approved by: Andrew Morgan

Report Prepared by: Jayne Knott Executive Assistant

Action Required: For noting

1. Committee/Group Meeting Details

1.1 System Transformation and Digital Group Meeting held on 29th October 2025

2. Summary of Key Discussions and Decisions

2.1 National Neighbourhood Health Implementation Programme

A presentation was given by the National coach for the programme and key points noted.

- Shropshire successful in national bid.
- Programme focuses on:
 - Psychosocial and medical integration.
 - Prevention and population health.
 - Trusted community spaces.
- 43 places selected nationally: Shropshire among them.
- Emphasis on collaboration, rapid learning cycles, and measurable outcomes.

Programme Requirements

- Accelerate delivery of existing NH plans
- Work collaboratively to unblock challenges
- Be ambitious – take bold, system-wide action
- Establish local NH programme teams
- Fortnightly progress reviews and workshops
- Attend three regional workshops
- Meet national reporting requirements

Next Steps

- Local workshop – 13th November
- Agree Shropshire focus, programme scale & delivery plan



Ambition



Compassion



Optimism



Focus

- Agree programme governance – System/ Place level leadership & NH delivery

2.2 **Future System Governance**

- Collaborative includes primary care, local authorities, and NHS trusts.
- Four workstreams: Neighbourhoods, Community Shift, Corporate Services, and Governance.
- Challenges:
 - Defining roles between ICB and collaborative.
 - Voluntary sector engagement.
 - Avoiding duplication and governance overload.
- Emphasis on clarity of purpose and shared delivery.

2.3 **Case for Change - Establishing a Group Model**

- Joint working between SaTH and ShropCom highlighted.
- Case for Change endorsed by Trust Boards in public on 23rd September.
- NHS England assurance process underway.
- Shared leadership and governance model to be implemented by January.
 - Aim: Integration, efficiency, and improved flow across trusts.

2.4 **System Planning and Priorities**

- Medium Term Planning Framework published 24/10 – reviewing + align to local process
- Revised local governance and sign off timetable being worked on by planning leads
- Continued local system focus
- Supporting documentation (?templates) - no date yet
- Neighbourhood health plans – no date for guidance
- Strategic Commissioning Framework - imminent
- Updated productivity packs within next few weeks
- Capital Guidance and Finance Framework (business rules) w/c 28/10
- Draft allocations w/c 3/11
- National Payment scheme and standard contract w/c 3/11 including Indicative Activity Plan (IAP)
- First returns by 18/12 - First 3 years – triangulating finance, activity and workforce - individual organisation submissions – local system combined view
- STW praised for collaborative planning approach

2.5 **Deep Dive – UEC Transformation**

- Significant improvements noted in ambulance handovers and flow.
- Integrated out-of-hospital model progressing well.
- Health Hero and GP decision-making models showing positive impact.



Ambition



Compassion



Optimism



Focus

- Flow Centre planned for April 2026.
- Focus on implementation and sustainability.

2.6 HTP Programme Oversight Group

- Transition from HTP Programme Board to HTP Oversight Group.
- Focus on clinical model delivery and construction.
- Updated Terms of Reference approved.

3. Highlight Reports

3.1 System Improvement Plan

- STW ICB exited highest level of oversight.
- Continued focus on delivery and assurance.
- SaTH expected to exit by March 2026.

3.2 Shared Services

Progress:

- **Finance:** Five task and finish groups established. Focus on aligning financial systems and processes. Exploring potential system mergers.
- **Workforce:** Prioritising learning & development, temporary staffing, and occupational health.
- **Digital:** Most groups active except for healthcare records due to system complexity.
- **Estates/Facilities:** Challenging due to structural differences across organisations. Some lack dedicated facilities leads.
- **Comms:** Newly added workstream with a task and finish group now active.

Challenges:

- Difficulty in assigning financial targets at this stage.
- Need for clearer governance and tracking mechanisms.
- Risk of fragmentation between STW, Group, and Cluster levels.

Next Steps:

- Clarify objectives, track progress, and determine financial viability without compromising collaboration.

3.3 Neighbourhood Health Implementation Group

Focus:

- Delivery of multimorbidity care through CVRM (Cardiovascular Risk Management) and frailty pathways.

Progress:

- CVRM strategy developed.
- Clinical model supports integrated care for diabetes, CVD, CKD.
- MDT approach for patients with multiple conditions.



- Funding split: backfill for clinical leadership and PCN-level CVRM champions.

Next Steps:

- Use National Neighbourhood Health Programme to accelerate implementation and align with system priorities.

3.4 **Elective Reform including MSK Transformation**

Key Issue: Surge in demand and backlog at Referral Management Centre (RMC).

Progress:

- RMC backlog expected to be cleared by November.
- MSK (Musculoskeletal) services flagged due to rising demand (e.g., DEXA scans).

Risks:

- Potential mismatch between demand and capacity.
- Need to understand if this is a temporary spike or a new normal.

Next Steps:

- Demand analysis underway.
- MSK deep dive planned for November meeting.
- Strategic alignment with commissioning intentions.

3.5 **UEC Transformation**

Progress:

- Significant improvements in ambulance handovers and flow.
- Health Hero model live for Category 3 ambulance calls.
- Integrated out-of-hospital model nearly fully mobilised.
- Expansion of UCR (Urgent Community Response) to midnight by December.
- Extended discharge planning and weekend therapy cover in place.

Next Steps:

- Sustain improvements through winter.
- Launch Flow Centre by April 2026.
- Continue cultural change with ambulance services and Health Hero.

3.6 **MH LD&A**

Progress:

- CAMHS service reprocured; MPFT successful.
- New PQ (Psychiatric Intensive Care) unit planned at Redwoods (12 beds).
- Flow work continues; 15% of MH beds delayed due to discharge issues.

Challenges:



Ambition



Compassion



Optimism



Focus

- Housing and care packages for complex MH/LD cases.
- Rising demand for autism and ADHD diagnoses.

Next Steps:

- Housing workshop with NHSE.
- Address diagnostic pressure and explore needs-based support models.

4. Recommendations to the Board

- To note updates within the highlight reports.

5. Key Risks and Mitigations

- Rising demand across services.
- Multiple priorities and risk of overload.
- Need for prioritisation and strategic alignment.

6. Performance and Assurance

N/A

7. Alignment to ICB Objectives and Core Functions

N/A

8. Next Steps and Forward Plan

N/A

9. Attachments

N/A



Report to:	Integrated Care Board					
Date:	29 January 2026					
Title:	Report to the ICB Board on Performance and Finance					
Presenting Officer:	Claire Skidmore – Chief Finance Officer					
Author(s):	Colin Fynn – Head of Intelligence and Analytics, Matt Shields – Head of System Finance					
Document Type:	Report	If Other: Click or tap here to enter text.				
Action Required (select):	Information (I)	<input checked="" type="checkbox"/>	Discussion (D)	<input type="checkbox"/>	Assurance (S)	<input checked="" type="checkbox"/>
	Approval (A)	<input type="checkbox"/>	Ratification (R)	<input type="checkbox"/>	<i>(check as necessary)</i>	
Is the decision within SOFD powers & limits	Yes / No	NO				
Any potential / actual Conflict of Interest?	Yes / No	NO <i>If Y, the mitigation recommendations –</i> Click or tap here to enter text.				
Any financial impacts: ICB or ICB?	Yes / No	NO <i>If Y, are those signed off by and date:</i> Click or tap here to enter text.				
Any impacts on ICB Undertakings?	Yes / No	YES <i>If Y, are those signed off by and date:</i> Click or tap here to enter text.				
Appendices:	Performance and Finance report					

(1) Purpose of the Paper:
The purpose of this paper is to provide the board with a summary of performance and finance as received at the System Performance Group (SPG) and discussed at the System Finance & Performance Committee (SFPC). It outlines at a high level the current position of key system metrics and aligned programme delivery against the Integrated Care System (ICS) Annual Operational Plan and our month 8 finance position.

(2) History of the Paper & Whether for I-D-S-A-R (as above):	Date
System Performance Group (I)	Click or tap to enter a date.
System Finance & Performance Committee (S, D)	06 January 2026

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

Sustainability	N/a
Workforce or Training	N/a
Equality & Diversity	N/a
Due Regard: Inequalities	N/a
Due Regard: wider effect	N/a

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

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

(6) Executive Summary, incl. expansion on any of the preceding sections:
<p>The report was discussed at the System Finance and Performance Committee (SFPC) on the 6th January 2026.</p> <p><u>Performance</u></p> <p>The group were updated on current operational performance. Areas of discussion focused on;</p> <ul style="list-style-type: none"> Planned Care <ul style="list-style-type: none"> Referral to Treatment (RTT), 100 patients waited over 65 weeks, mainly at University Hospital of North Midlands (UHNM) in specialties Ophthalmology, ENT, Orthopaedics. All cancer metrics were under plan: 28-day at 74.4% (target 78%), 31-day at 91.1% (target 93.6%), 62-day at 62.8% (target 72.9%) Urgent and Emergency Care (UEC) <ul style="list-style-type: none"> A&E 4-hour performance at UHNM improved to 64.1% but remains below plan. Bed occupancy increased to 96.8% Ambulance handover delays improved, but still high with 7,399 hours lost. Primary Care Urgent dental activity delivered 78.3% of plan this month. GP appointments delivered 93.3% of plan this month, however the ICB met 99.9% against YTD plan. Mental Health (MH) and Learning Disabilities & Autism (LDA): Out of Area Placements reduce to 21 (down from 28). Autism assessment waits increased at Midlands Partnership Trust (MPFT) and North Staffordshire Combined Healthcare Trust (NSCHT). Individual Placement Support access improving but still below plan; Oliver McGowan training Tier 2 overperformed target for the first time, although Tier1 remains below target. Children and Young People, Maternity and Neonates: Epilepsy emergency admissions above target. Community Transformation: Palliative care register prevalence plateaued at expected level.

- **Improving Population Health:** Flu vaccination 72.8% in November, below plan but expected to meet year-end target.

Finance

- At month 8, the system is reporting a £16.3m deficit, representing a **£1.0m favourable variance against the planned £17.3m deficit** (£0.7m favourable at month 7). Year-to-date, this includes deficits of £12.6m for the ICB, £8.2 at UHNM and off set by a surplus of £4.0m at MPFT and £0.5m NSCHT. While the overall position remains broadly on track, the key driver of variances continues to be lower than planned efficiency delivery, offset by a number of non-recurrent mitigations. Following the adverse variance reported at month 1, recovery trajectories were developed where appropriate. At month 8, the system is now £7.0m behind these recovery trajectories (£2.6m behind at Month 7).
- The reported system **efficiency delivery YTD** is £19.9m behind our submitted plan of £186.0m, this comprises of ICB (£11.2m), MPFT £0.1m, NSCHT (£0.2m) and UHNM (£8.7m). As a system this equates to 89% delivery YTD.
- As a system we are **forecasting** to meet our year-end financial plan of break even, subject to the receipt of £95m deficit support funding (DSF). Net risk has reduced to £6.7m at month 8 down from £12.9m at month 7. This net risk is primarily made up of efficiency risk (£0.4m), additional cost risk (£7.2m) and offset by non-recurrent mitigations and anticipated allocations. UHNM holds the remaining net risk of £6.7m aligned to the recovery plan, with all other partners having fully mitigated their positions.
- The system submitted a **compliant capital forecast at month 8**, any deviations from this will potentially impact 2026/27 should there be material underspends in the remaining months. The freedom and flexibility funding will be locked down at month 9. Key movements in month include the disposal of land at former RI and COPD site has deferred into 2026/27 and the region have informed of an increased CDEL limit to cover the IFRS16 pressure at MPFT.
- The Board is asked to note that in line with the NHS standard contract for 2025/26, Indicative Activity Plans (IAP) were issued to **Independent Sector (IS) providers** prior to 30th June 2025 and were effective from 1st July 2025. IAPs have been used to help ensure that ICB is commissioning levels of activity, which balanced the national operational planning standards with levels of financial resources available to the NHS. After 3 months of the IAPs being in place (Sept 2025 data), a number of the providers were above their year-to-date trajectory and forecasted year-end position was not affordable. The providers worked with the ICB through the AMP process to bring their trajectory down to an affordable level, whilst also balancing performance and patient needs. However, for some providers there was insufficient remaining funds in their contract for them to continue to treat patients that had been booked. The decision was taken to prioritise urgent patients and those who would have been waiting 52-weeks for treatment at the end of March 2026. The impact of these cancellations is expected to be negligible on overall performance, due to the smaller quantum of activity. The providers continue to work to less than 1% of their patients waiting over 52 weeks for treatment.

(7) Recommendations to Board / Committee:

The Integrated Care Board is asked to:

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

Performance and Finance Report

December 2025

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



Planned Care

Programme	Measure Name	Currency	ICB / Provider	Reporting period	Current Month & direction from previous month		Target		Variance	Plan / baseline	Variance	Trend from April 2024 to current month
Electives	Elective - ordinary spells	Number	ICB	Oct-25	2,287	▲	n/a	-	-	2,234	53	
	Elective - day case spells	Number	ICB	Oct-25	17,498	▲	n/a	-	-	17,468	30	
	First outpatient attendances - Consultant-led	Number	ICB	Oct-25	44,318	▼	n/a	-	-	45,542	-1,224	
	Follow-up outpatient attendances - Consultant-led	Number	ICB	Oct-25	74,579	▼	n/a	-	-	69,817	4,762	
Referral to Treatment (RTT)	Time to first attendance, waiting less than 18 weeks	%	ICB	Oct-25	72.3%	▲	71.8% March 2026	0.5%	0.5%	67.9%	4.3%	
	Total waiting list (Referral to Treatment - Incomplete Pathways)	Number	ICB	Oct-25	137,977	▲	147,032 March 2026	-9,055	-9,055	149,511	-11,534	
	% Patients waiting less than 18 weeks (Referral to Treatment - Incomplete Pathways)	%	ICB	Oct-25	64.2%	▼	63.4% March 2026	0.7%	0.7%	60.7%	3.5%	
	% Patients waiting more than 52 weeks (Referral to Treatment - Incomplete Pathways)	%	ICB	Oct-25	1.8%	▼	0.8% March 2026	1%	1%	1.6%	0.2%	
	Number patients waiting more than 65 weeks (Referral to Treatment - Incomplete Pathways)	Number	ICB	Oct-25	100	▼		100	100	0	100	
Diagnostics Tests	Diagnostic test activity	Number	ICB	Oct-25	53,818	▲	n/a	-	-	59,760	-5,942	
	Diagnostic Test Waiting List less than 6 weeks	%	ICB	Oct-25	76.0%	▲	n/a	-	-	74.3%	1.7%	
Cancer	People treated beginning first or subsequent treatment of cancer within 31 days	%	ICB	Oct-25	91.1%	▲	94.0% March 2026	-2.9%	-2.9%	92.4%	-1.3%	
	Total patients seen within 62 days (on cancer 62 day pathway)	%	ICB	Oct-25	62.8%	▼	75.2% March 2026	-12.4%	-12.4%	72.9%	-10.1%	
	Cancer 28 day waits (faster diagnosis standard)	%	ICB	Oct-25	74.4%	▲	80.0% March 2026	-5.6%	-5.6%	78.0%	-3.6%	
	Lower gastrointestinal (GI) referrals with an Faecal Immunochemical Test (FIT) result (Year to Date Cumulative)	%	ICB	Oct-25	73.3%	▲	n/a	-	-	73.0%	0.3%	
Procedures Completed (Local Metric)	Increase the proportion of procedures completed in outpatients or as a day case (UHNM)	%	UHNM	Oct-25	89.3%	▼	n/a	-	-	87.8%	1.5%	
Community	Community care contacts	Number	ICB	Sep-25	162,680	▲	n/a	-	-	143,975	18,705	
	52+ weeks in community services	Number	ICB	Oct-25	1	⇒	n/a	-	-	7	-6	
	Combined elective/non-elective length of stay (LOS) - community beds	Bed days	ICB	Oct-25	19.0	⇒	n/a	-	-	17.9	1.1	

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	<p>First outpatient attendances - Consultant-led</p> <p>In October 2025, there were 44,318 Outpatient First attendances, against a plan of 45,542.</p> <p>This is the first month in 2025/26 the level of activity is below plan, and year to date there has been 6% more attendances than planned.</p>	<ul style="list-style-type: none"> Activity levels in October 2025 consistent with previous months, however plan for October 2025 is highest level for 2025/26. No specific drivers identified. 	<ol style="list-style-type: none"> No further actions required as year date performance is above plan.
	<p>Follow-up outpatient attendances - Consultant-led</p> <p>In October 2025, there were 74,579 Outpatient Follow-Up attendances, against a plan of 69,817 (a variance of 4,762 attendances).</p> <p>Year to date (YTD), there were 505,044 Outpatient Follow-Up attendances, against a plan of 465,761 (a variance of 39,283 attendances).</p>	<ul style="list-style-type: none"> Drivers remain consistent with those reported in the previous months. Although there has been a reduction in Follow-Up attendances compared to 2024/25, providers, particularly NHS providers, have not yet reduced activity to the planned levels. 	<p>Actions remain the same as last month:</p> <ol style="list-style-type: none"> Indicative Activity Plans (IAPs) have been agreed with the two main Independent Sector Providers of acute care for ICB. These specify the 'new to follow up' rates for outpatients by specialty. These IAPs are effective from 1st July 2025 to 31st March 2026 and require providers to not breach agreed levels of activity. Providers are being actively managed through the Contract Management process. 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 2026/27.

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
<p>Referral to Treatment (RTT)</p>	<p>Number patients waiting more than 65 weeks (Referral to Treatment - Incomplete Pathways)</p> <p>Across all providers there were 100 patients waiting over 65 weeks to start treatment at the end of October 2025. This is an improvement from 139 at the end of September 2025.</p>	<ul style="list-style-type: none"> Retained driver: Recovery efforts are being impacted by several factors: Patient choice, which can delay scheduling and treatment, as well as staffing Orthopaedic theatres at weekends. Of the 100 patients currently waiting, 64 are at University Hospitals North Midlands (UHNM). Key specialties contributing to the backlog at UHNM include Ophthalmology (18 patients), Ear Nose and Throat (ENT) (16 patients), and Orthopaedics (11 patients). 	<ol style="list-style-type: none"> ENT business case approved For additional activity. External third-party capacity running paediatric weekend lists at weekend. This has been extended to the end of March 2026 Action planned last month: Ophthalmology: A service review has commenced at UHNM to assess current capacity against demand and identify opportunities for improvement. Also, additional Corneal capacity has been sourced. Orthopaedics: at UHNM 'Super clinic' on 6th December 2025 (saw 144 patients)
	<p>% Patients waiting more than 52 weeks (Referral to Treatment - Incomplete Pathways)</p> <p>At the end of October 2025, there were 2,491 ICB patients waiting over 52 weeks at all providers. This is above the planned trajectory of 2,400, but a reduction from the number waiting at the end of September 2025 (2,622). As a percentage of the total waiting list, 1.8% of patients were waiting over 52 weeks, against a target of 1.6% (0.2% over plan).</p> <p>For patients aged under 18, there were 140 patients waiting over 52 weeks at the end of October 2025. 44 were in Ear Nose and Throat, 27 in Oral Surgery, and 15 in Orthopaedics.</p>	<ul style="list-style-type: none"> 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	<p>Cancer 28 day waits (faster diagnosis standard)</p> <p>Performance in October 2025 for ICB (all providers) was 74.4% against a target of 78.0%.</p>	<ul style="list-style-type: none"> A significant increase in demand over summer months for Skin Cancer referrals has led to a backlog affecting both 28 days, 31 days performance. Additional outsourced capacity is being used to treat this additional demand, but issue will continue to affect performance until new year. 	<ol style="list-style-type: none"> Additional capacity has been secured externally to manage the backlog caused by increased number of Skin Cancer referrals. Daily and weekly oversight of the Patient Tracking List (PTL) is in place, with escalations to relevant specialties to ensure data completeness and accuracy. The Cancer Validation Lead is conducting spot checks on breaches to ensure compliance with national cancer waiting time guidance.
	<p>People treated beginning first or subsequent treatment of cancer within 31 days</p> <p>Performance in October 2025 for ICB (all providers) was 91.1% against a target of 93.6%.</p>	<ul style="list-style-type: none"> See comments above regarding Skin Cancer Also need identified at UHNM for increased surgical capacity including weekend lists for (colorectal, gynaecology & skin cancers), 	<ol style="list-style-type: none"> At UHNM, a collaborative working group has been established involving Histopathology, Clinical Directorates, and Cancer Services to identify and triage specimens appropriately, aiming to streamline reporting pathways and improve turnaround times. At UHNM new post has a function to review future fails for the near miss patients and escalate for treatments in target and to highlight solutions to pathway issues noted during validation. Cancer services working with oncology to gain weekly oversight of oncology capacity through the cancer improvement meetings.
	<p>Total patients seen within 62 days (on cancer 62 day pathway)</p> <p>Performance in October 2025 for ICB (all providers) was 62.8% against a target of 72.9%.</p>		

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
<p>Diagnostic Tests</p>	<p>Diagnostic test activity: Total Tests Completed: 53,818 Variance from Plan: 5,942 fewer tests (10% below plan of 59,760). YTD position: 52,440 fewer tests (-13%) than plan. Patients waiting over 6 weeks has reduced from 13,680 (April) to 7,378 (October) At the end of October 2025, 76.0% of patients were waiting less than 6 weeks, compared to the target of 74.3%</p>	<p>Driver as previously identified:</p> <ul style="list-style-type: none"> • UHNM, the 2025/26 CT activity plan was set 34% higher than the actual delivery in 2024/25 to meet rising demand. However, activity has not increased in line with the assumed planned uplift and remains consistent with 2024/25 levels. No issue with waits over 6 weeks. 	<p>Actions previously planned Driver continue driving improvements :</p> <ol style="list-style-type: none"> 1. Computed Tomography (CT) activity levels in line with 2024/25. No action required. 2. UHNM continued to reduce the Non-Obstetric Ultrasounds backlog partly through continuation of transfer of patients to Cannock Community Diagnostic Centre.
<p>Community</p>	<p>Combined elective/non-elective length of stay (LOS) - community beds The average length of stay for ICB patients discharged from community beds in October 2025 was 18.1 days, against a target of 17.9 days.</p>	<ul style="list-style-type: none"> • Variations in average length of stay, within one month, can be affected by the discharge of a small number of long stay patients. Particularly for a relatively small cohort of patients in community beds. • Variation to plan does not necessarily indicate wider performance issue. If longer trend does shows non-compliance further actions will be taken. 	<ol style="list-style-type: none"> 1. Due to this metric meeting targets in previous months, and small cohorts of patients causing fluctuations, no further actions required at this stage.

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	Nov-25	65.2%	▲	78.0%	March 2026	-12.8%	68.1%	-2.9%	
	A&E Types 1 & 2 - more than 12 hours	%	UHNM	Nov-25	17.0%	▼	16.65%	2025/26	0.4%	19.9%	-2.9%	
	Ambulance handover time (average)	Minutes	UHNM	Nov-25	01:36:27	▼	00:43:00	March 2026	00:53:27	01:11:00	00:25:27	
	Total Non-Electives spells	Number	UHNM	Oct-25	6,065	▼	n/a		-	7,373	-1,308	
	Non-elective average of Length of Stay	Bed days	UHNM	Oct-25	7.55	▲	n/a		-	7.60	-0.05	
	General and Acute bed occupancy	%	UHNM	Nov-25	96.8%	▲	n/a		-	93.3%	3.5%	
	Average delay - bed days lost through discharge delays	Days	UHNM	Oct-25	3.7	▼	n/a		-	3.9	-0.2	
	Virtual Ward Occupancy	%	ICB	Nov-25	88.9%	▲	n/a		-	81.9%	7.0%	
	Urgent Community Response (UCR) referrals	Number	ICB	Oct-25	900	▼	n/a		-	713	187	
Urgent and Emergency Care (UEC) (Local Metrics)	Childrens A&E Type 1 - 4hr performance	%	UHNM	Nov-25	68.1%	▼	78.0%	March 2026	-9.9%	-	-	
	Urgent community response (UCR) - patients seen within 2 hours	%	ICB	Oct-25	79.6%	▼	70.0%		9.6%	70.0%	9.6%	
	Ambulance Hours lost due to Handover delays > 15min (UHNM)	Minutes	ICB	Nov-25	7,399	▼	n/a		-	7,136	263	
	Ambulance Compliance - % Handovers within 45 minutes	%	UHNM	Nov-25	54.2%	▲	100%	March 2026	-45.8%	-	-	
	Readmissions	Number	ICB	Oct-25	338	▼	n/a		-	602	-264	

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

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

Programme Area	Metric Name	Drivers for underperformance	Top 3 Planned actions provided by portfolio
Urgent and Emergency Care (UEC)	<p>A&E Type 1-3 4hour Performance University Hospitals North Midlands (UHNM)</p> <p>4-hour Performance at UHNM improved by 1.1% during November 2025 to 65.2%, which was 2.9% worse than plan for the month.</p>	<ul style="list-style-type: none"> Attendances at Type 1 locations, whilst reducing by 4.3% to 15,475, equated in real terms to only a per day reduction of 6 fewer patients attending Emergency Departments (ED) at Royal Stoke (RSUH) and County Hospital. Acuity of patients remained high with Resus patients representing 18% of Type 1 attendances at UHNM. Medical patients continued to represent 1 in 7 ambulance conveyances during November 2025 with breathing problems due to flu and respiratory illness accounting for a further 11%. 	<ol style="list-style-type: none"> Urgent Treatment Centre (UTC) – Capital/building works commencing and on track for January 2026 interim model. UHNM operating GOLD Command with associated Getting It Right First Time (GIRFT) UEC Coaching. GOLD Command competency framework in development with GIRFT UEC Colleagues. Mitigations to be sought for Paediatric ED spaces and assessment areas at RSUH. Delays due to challenges with Estates, aim to go live in December 2025.
	<p>General & Acute (G&A) Beds Occupied (UHNM)</p> <p>Bed Occupancy for November 2025 increased to 96.8%, up 0.7% on the previous month. This was 3.5% worse than plan.</p>	<ul style="list-style-type: none"> Rising Flu and respiratory infection numbers placing extended pressure on the bed base. Continued utilisation of Discharge to Assess (D2A) beds at the front door resulted in reduced capacity to assist early or timely discharges from Inpatient bed base. Increased number and proportion of Discharges into Pathways 1, 2 and 3 from UHNM, although the average delays in discharge decreased overall and 7+, 14+, and 21+ Length of Stay patients represented a reduced proportion of the bed base. 	<ol style="list-style-type: none"> Home For Christmas system discharge plan developed. Discharge Targets agreed and tracked through Daily system calls in line with Home For Christmas system plan. UHNM Length of Stay review continues to be supported by GIRFT with recommendations / outputs to be embedded operationally.

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

Programme Area	Metric Name	Drivers for underperformance	Top 3 Planned actions provided by portfolio
Urgent and Emergency Care (UEC)	Average Ambulance Handover Time University Hospitals North Midlands (UHNM)	<ul style="list-style-type: none"> Medical patients continued to represent 1 in 7 ambulance conveyances during November 2025 with breathing problems due to flu and respiratory illness accounting for a further 11% 	<ol style="list-style-type: none"> Development of Enhanced pathway for Falls patients and Anticoagulants in development to facilitate more patients to be supported in community settings. Mobilisation of additional primary care support into Urgent Community Response (UCR) services to target Care Home Emergency admissions. Support commencing December 2025 until the end of January 2026. Consultant assigned to enact Rapid Assessment and Treatment (RAT) of Ambulances on arrival at RSUH.
	Average Handover Time at UHNM during November 2025 was reported as 01:36:27, 00:25:27 worse than plan.		
	Ambulance Hours lost due to Handover delays > 15min (UHNM)	<ul style="list-style-type: none"> Infection Prevention and Control (IPC) constraints around the rising Flu position, and the above acuity issues increased operational pressures around maintaining handover and flow through the departments. 	
	Total Hours lost during Handovers dropped to 7,399 hours in November 2025, ending the month 263 hours worse than the previous year.		
Ambulance Compliance - % Handovers within 45 minutes (UHNM)	<ul style="list-style-type: none"> Pressured bed base impacted on flow out of ED with 3,100 Temporary Emergency Department Escalation Beds spaces and 624 Inpatient Beds used during November 2025. 	<ol style="list-style-type: none"> Home for Christmas Action plan in place. Discharge targets being tracked by operational teams, lead by the System Coordination Centre through daily calls. High Intensity Team (HIT) visits in place across acute and community with LOS reviews in situ. Additional Cheadle D2A beds opened in a phased approach to support flow and expedited from Winter Plan. 	
Handover compliance during November 2025 reported as 54.2%, a 0.6% improvement on the previous month	<ul style="list-style-type: none"> Earlier than expected Flu surge impacted flow at the back end of the Discharge process through reduced access to D2A capacity. Overall increase in discharge totals for October adjusted proportionality of outcome with 260 more patients discharged on their DRD and total bed days lost during the month reducing. 		
Percentage of patients discharged on Discharge Ready Date (DRD) (UHNM)	<p>October 2025 reported 90.1% of patients were discharged on their Discharge Ready Date, a reduction of 0.3% on September, and 1.7% worse than plan.</p>		

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

Metric	University Hospitals of Derby & Burton (UHDB) Queens Hospital Burton (NHS Derby and Derbyshire Integrated Care Board)	The Royal Wolverhampton (RWT) New Cross Hospital (Black Country Integrated Care Board)
4-hour Performance (%) Type 1-3 [Provider level]	<ul style="list-style-type: none"> November 2025 reported performance of 72.1%, a reduction of 1.7% on October 2025 (73.8%). 	<ul style="list-style-type: none"> November 2025 was 77.5%, an improvement of 1.4% on October 2025 (76.1%).
A&E Attendances Type 1 [Site level]	<ul style="list-style-type: none"> 7,095 attendances during November 2025, 1 down against the previous month, but approximately 8 patients more per day in real terms. 	<ul style="list-style-type: none"> 11,452 attendances during November 2025, a decrease of 1.7% against the previous month, but a 19 patients per day increase in real terms.
4-hour Performance (%) Type 1 Paediatrics [Site level]	<ul style="list-style-type: none"> November 25 reported performance of 88.6%, an improvement of 1.1% on the previous month (87.5%). 	<ul style="list-style-type: none"> November 2025 reported performance of 79.9%, a reduction of 5.9% on the previous month (85.8%).
12-hour Performance Type 1 & 2 (%) [Provider level]	<ul style="list-style-type: none"> 14.4% of Types 1 & 2 attendances breached the 12-hour mark for 'Time in Department' in November 2025, no change on October 2025. 	<ul style="list-style-type: none"> 10.9% of Types 1 & 2 attendances breached the 12-hour mark for 'Time in Department' in November 2025, a reduction of 1.1% on October 2025
Bed Occupancy (%) - General & Acute (G&A) [Site level]	<ul style="list-style-type: none"> G&A Bed Occupancy increased marginally during November 2025 to 96.9% from 96.8% the previous month. 	<ul style="list-style-type: none"> G&A Bed Occupancy increased during November 2025 to 97.8% from 96.8% the previous month.
Virtual Wards [Provider level]	<ul style="list-style-type: none"> UHDB – 47 occupancy out of 40 bed capacity (118%) for last submission in month (20th November 2025). 	<ul style="list-style-type: none"> RWT – 272 occupancy out of reported 98 bed capacity (278%) for last submission in month (20th November 2025).
Average Ambulance Handover Time [Site level]	<ul style="list-style-type: none"> West Midlands Ambulance Service (WMAS) and East Midlands Ambulance Service (EMAS) combined average handover time for November 2025 was 33 minutes 55 seconds, 15 minutes 30 seconds better than October 2025. 	<ul style="list-style-type: none"> WMAS average handover time for November 2025 was 1hr 45 seconds, up 4 minutes 5 seconds on October 2025.
Ambulance Compliance % Handovers within 45 minutes [Site Level]	<ul style="list-style-type: none"> WMAS & EMAS combined handover compliance for November 2025 was 84.2%, up 10% on October 2025. 	<ul style="list-style-type: none"> WMAS handover compliance for November 2025 was 66%, down 1.4% on October 2025.
Time Lost due to handover delays > 15 mins [Site level]	<ul style="list-style-type: none"> 43% reduction in time lost due to handover delays during November 2025, dropping to a combined total of 470 hours between WMAS and EMAS. 	<ul style="list-style-type: none"> Increase of 14.4% during November 2025 in time lost, lifting the time lost by WMAS to 2,816 hours from 2,462 hours during October 2025.

Primary Care and Medicines Optimisation

Programme	Measure Name	Currency	ICB / Provider	Reporting period	Current Month & direction from previous month		Target	Variance	Plan / baseline	Variance	Trend from April 2024 to current month
Primary Care	Appointments in General Practice	Number	ICB	Oct-25	726,964	▲	n/a	-	779,258	-52,294	
	Unique patients seen by a NHS dentist - adult	% (quarterly)	ICB	Q2	43.2%	▼	n/a	-	43.0%	0.1%	
	Unique patients seen by a NHS dentist - children	% (quarterly)	ICB	Q2	64.8%	▲	n/a	-	61.8%	3.0%	
	Units of Dental Activity delivered	% (quarterly)	ICB	Q2	96.2%	▲	n/a	-	82.2%	13.9%	
	Urgent Dental Activity delivered	Number	ICB	Oct-25	5,324	▼	n/a	-	6,797	-1,473	
	Pharmacy First consultations	Number	ICB	Oct-25	20,847	▲	n/a	-	15,000	5,847	
Medicines Optimisation (Local Metrics)	Structured medication reviews (SMRs) conducted in general practice. (Year to Date Cumulative)	% (quarterly)	ICB	Q1	15.0%	▼	n/a	-	15.0%	0.0%	

Key to arrows showing direction from previous month		Key to variation Colour	
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▼	Improved with a lower value than the previous month	Green	Positive impact / desired variation
▲	Deteriorated with a higher value than the previous month	Yellow	No change / equal
▼	Deteriorated with a lower value than the previous month	Black	Not applicable / not available
⇒	Equal to the previous month		
n/a	not available		

Notes on data:

- Structured medication reviews (SMRs) conducted in general practice – Quarterly metric, no update this month.
- Unique patients seen by a NHS dentist (adults and children) – Quarterly metrics, no update this month
- Units of Dental Activity delivered – Quarterly metric, no update this month

Primary Care Metrics off Plan and Actions

Programme Area	Metric	Drivers for underperformance	Top 3 Planned actions provided by portfolio
<p style="text-align: center;">Dental</p>	<p>Urgent Dental Activity delivered</p> <p>October 2025 position: 5,324 units of urgent dental activity was delivered against the plan of 6,797 (78.3%).</p> <p>Year to date (YTD) position: 35,793 units of urgent dental activity against the plan of 46,105 (77.6%).</p>	<p>Drivers identified previously remain:</p> <ul style="list-style-type: none"> • 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. 	<p>Actions previously planned continue to address performance issues:</p> <ol style="list-style-type: none"> 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 continues to be shared in other healthcare settings e.g. GP practices, pharmacies, hospitals, A&E and via the internet. This will run to end of financial year to raise patient awareness of access to Urgent Dental Access. Healthwatch Staffordshire has also published a comprehensive local guide regarding access to NHS dental services; this includes details of how to access urgent dental care. 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. Urgent dental care incentive (UDCI) scheme will run between September 2025 and March 2026. The scheme is to encourage more urgent treatment, offering financial incentives to practices that deliver a higher volume of urgent care. 77 of 111 eligible practices have signed up to the scheme (scheme sign up extended to 19th December 2025).

Primary Care Metrics off Plan and Actions

Programme Area	Metric	Drivers for underperformance	Top 3 Planned actions provided by portfolio
<p>Primary Care</p>	<p><u>Appointments in General Practice</u> October 2025 position: there were 726,964 appointments against the plan of 779,258 (93.3%). YTD position: 3,945,555 against the plan of 3,950,130 (99.9%).</p>	<ul style="list-style-type: none"> • Covid-19 vaccination appointments were significantly below plan because of an unexpected change in eligibility criteria in autumn 2025 (over 59,000 were planned, around 6,500 took place); whereas standard appointments were over plan. • Eligible patients: adults aged 75 years and over, residents in care homes for older adults and individuals who are immunosuppressed aged 6 months and over. Autumn 2024 also included adults aged 65 to 74 and all those aged 6 months and over in a clinical risk group. 	<ol style="list-style-type: none"> 1. Primary Care Networks (PCNs) have submitted workforce plans in November 2025 for the remainder of 26/27, showing increases in WTE for Additional Roles to utilise available funding, which should result in increased appointments. 2. Access programme ongoing to improve patient experience and access to general practice. No capacity issues identified at this time in addition to the plans in place. 3. Appointment data is being reviewed on a regular basis at Practice and PCN level to determine variations and understand if there are any coding-related issues.

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	Nov-25	21	▼	n/a		-	4	17	
	Average length of stay for adult acute beds	Bed days	ICB	Oct-25	38	▼	41.1	2025/26	-3.1	40.3	-2.3	
	Number of people who are discharged having had at least 2 NHS talking therapy appointments	Number	ICB	Nov-25	1,089	▼	n/a		-	1,238	-149	
	Access to NHS talking therapies for anxiety and depression - reliable recovery	%	ICB	Nov-25	47.5%	▼	50.0%	March 2026	-2.5%	50.0%	-2.5%	
	Access to NHS talking therapies for anxiety and depression - reliable improvement	%	ICB	Nov-25	69.5%	▼	68.0%	2025/26	1.5%	68.0%	1.5%	
	Access to Specialist Community Perinatal Mental Health Services	Number, Rolling 12 months	ICB	Oct-25	1,340	▲	1,216	March 2026	124	1,200	140	
	Access to Children and Young People Mental Health Services	Number, Rolling 12 months	ICB	Oct-25	17,255	▲	17,273	March 2026	-18	16,195	1,060	
	Access to Individual Placement Support	Number, Rolling 12 months	ICB	Oct-25	820	▲	891	March 2026	-71	861	-41	
Learning Disabilities & Autism (LD&A)	Learning disability registers, Annual health checks delivered by GPs	% (YTD)	ICB	Q2	33.13%	▲	n/a		-	19.51%	13.6%	
	Reliance on MH inpatient care for adults with a learning disability	Number (quarterly)	ICB	Q2	16	▲	n/a		-	15	1	
	Reliance on MH inpatient care for autistic adults	Number (quarterly)	ICB	Q2	10	▲	n/a		-	7	3	
	Reliance on MH inpatient care for people with a learning disability and/or autism - children	Rate (quarterly)	ICB	Q2	17.7	▼	n/a		-	22.1	-4	
Learning Disabilities & Autism (LD&A) (Local Metrics)	Mean wait to complete autism assessment - Children and Young People (CYP) North	Weeks	ICB	Oct-25	132	▲	26	March 2026	106	30	102	
	Mean wait to complete autism assessment - Children and Young People (CYP) South	Weeks	ICB	Oct-25	114	▲	26	March 2026	88	30	84	
	Learning from Lives and Deaths Review (LeDeR) reviews within 6 months of notification of death.	%	ICB	Oct-25	100.0%	↔	100%	2025/26	0.0%	100%	0.0%	
	Oliver McGowan training - Tier 1 (NHS staff)	%	ICB	Nov-25	17.0%	▲	30%	2025/26	-13.0%	30%	-13.0%	
	Oliver McGowan training - Tier 2 (NHS staff)	%	ICB	Nov-25	31.0%	▲	30%	2025/26	1.0%	30%	1.0%	

Key to arrows showing direction from 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	
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Yellow	No change / equal
Black	Not applicable / not available

Notes on data:

- Reliance on MH inpatient care (3 metrics) and Learning disability Annual health checks – Quarterly metrics, no update due this month.

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
<p>Mental Health (MH)</p>	<p>Active inappropriate adult acute mental health Out of Area Placements (OAPs)</p> <p>21 OAPs were active at the end of November. Down from 28 last month.</p> <p>4 OAPs reported by Midlands Partnership University NHS Foundation Trust (MPFT) (no change on last month); 17 by North Staffordshire Combined Healthcare Trust (NSCHT) (down from 24 last month).</p>	<p>Drivers identified previously remain in place:</p> <p>NSCHT:</p> <ul style="list-style-type: none"> 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. <p>MPFT:</p> <ul style="list-style-type: none"> 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. <p>Capacity within the market is extremely stretched, including residential and nursing homes with skills around mental health, supported living and supported accommodation.</p>	<ol style="list-style-type: none"> The ICB is in attendance at the weekly discharge calls to provide support and escalate actions. The ICB have arranged for wider representation from Local Authority colleagues, including brokerage and commissioning to provide real time updates and sign-off. Continued focused work on reducing the number of patients who are CRfD, working with colleagues across the system <p>Actions planned previously continue:</p> <ol style="list-style-type: none"> Specific reporting to NHSE on increase.

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)	<p>Talking Therapy – reliable recovery</p> <p>Performance was 47.5% in November, and 49.3% year to date.</p> <p>In October 2025 (latest benchmarking data), the system (48%) benchmarked at position 16/42 amongst ICBs. England = 47%; Midlands = 46%.</p>	<p>Drivers identified previously remain:</p> <ul style="list-style-type: none"> • Performance against key metrics continues to fluctuate throughout the year, largely influenced by vacancies, staff sickness, and other workforce-related issues. • Reliable Recovery: the service initially operated under the assumption that the target was set at 49%, which led to misaligned focus. They have now adjusted their approach to align with the correct 50% target, but this initial misunderstanding has contributed to underperformance against expectations. 	<p>1. This remains a focus for team leaders through supervision with all practitioners.</p>
	<p>Talking Therapy – courses of treatment</p> <p>November 2025 position: there were 1,089 completed courses of treatment against the plan of 1,238 (88% of plan achieved).</p> <p>YTD position: 9,742 courses against the plan of 9,919 (98.2% of plan achieved).</p> <p>In October 2025 (latest benchmarking data), the system benchmarked at position 15/42 amongst ICBs (% of YTD plan achieved).</p> <p>It is expected that the target will be achieved by the end of the financial year.</p>		

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
<p>Mental Health (MH)</p>	<p>Access to Individual Placement Support (IPS)</p> <p>At 820 in October 2025, an improved position on the previous month (812) and the third consecutive month showing improvement. 41 patients below plan*.</p> <p>The rate of access varied between 55 and 81 patients per 100,000 population (6 sub ICBs). England rate = 80.3.</p> <p>* Please note: NHS England revised the System targets in December 2025 with a new 'Fair Shares' calculation. The annual System target now stands at 891 in place of the original 1,015.</p>	<p>Drivers identified previously remain:</p> <ul style="list-style-type: none"> • There is an identified need to increase service uptake, as current access levels are below expectations, impacting overall performance. • Sickness and vacancies within the team continue to affect service delivery and hinder achievement of performance targets. • The current workforce profile does not align with IPS Grow Tool calculations, indicating a mismatch in staffing levels. Collaborative work is underway with NHSE and IPS to better understand and address this gap. <p>Newly identified:</p> <ul style="list-style-type: none"> • There still remains a query regarding the service supporting several retention service users, IPS grow have advised that this number should be minimal or zero if a service is under-performing as this isn't what the service is commissioned for. 	<p>Current actions remain in place to continue supporting improvement efforts:</p> <ol style="list-style-type: none"> 1. The service has utilised funding in previous years to re band a cohort of staff (due to constant turnover as posts in other teams were being paid at a higher rate) this has resulted in the team now being under target for the number of employment specialists (the main post that contributes to access targets) a workshop to be arranged to model workforce over the next 3 years and establish any funding gaps for further discussion, modelling for the workshop underway 2. Work continues regarding promotion of the service, there are service stands at depots and self-referral has been introduced, alongside a new website established. 3. Recruitment underway and mitigating actions are being put into place. 4. 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	<p>Local Metrics: Autism assessment completion waits (CYP, North & South)</p> <p>The average wait at North Staffordshire Combined Healthcare (NSCHT) was 132 weeks (up from 108 weeks last month).</p> <p>The average wait at Midlands Partnership University Foundation Trust (MPFT) was 114 weeks (up from 77 weeks last month).</p>	<p>Drivers identified previously remain:</p> <ul style="list-style-type: none"> Increasing referrals and caseloads are placing significant pressure on services, contributing to delays and reduced responsiveness. These local trends reflect a national picture of rising demand, further compounding service pressures. 	<ol style="list-style-type: none"> The Portfolio has set up an ICS working group to work with an organisation based in North West - 'Capacity' to help to develop an action plan for Neurodiversity (including autism). A meeting took place in November with a range of stakeholders. Capacity have since produced a recommended systemwide action plan that is being consulted on in December and January. Action retained: By 31st January 2026, review and incorporate new NHS medium-term plan guidance into any pathway redesign.
	<p>Local Metrics: Oliver McGowan training - Tier 1 (NHS staff)</p> <p>November 2025: 17%</p>	<p>Driver identified previously remains:</p> <ul style="list-style-type: none"> Limited workforce capacity has affected delivery. For some time the system has relied on a single ICB trainer to deliver Tier 1 training across the entire footprint. It will take several months to realise the benefit of the newly trained provider based Tier 1 trainers. 	<p>Actions planned previously continue driving improvements:</p> <ol style="list-style-type: none"> University Hospitals of North Midlands NHS Trust (UHNM) have had 15 members of their team — including the facilitator, co-trainers with a learning disability, and autistic co-trainers — signed off and have started to deliver Tier 1. They are currently running approximately three to four sessions a week for all staff who are not patient-facing. MPFT have their train-the-trainer date scheduled for December 2025 and are planning to begin delivering Tier 1 from January 2026. Aiming to reach 30% completion for Tier 1 by the end of quarter 3, which in turn will hopefully enable additional funding from NHS England.

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	Oct-25	18	▼	n/a	-	22	-4	
	Epilepsy emergency admission (≤18)	Number	ICB	Oct-25	17	▼	n/a	-	13	4	
	Diabetes emergency admission (≤18)	Number	ICB	Oct-25	10	▼	n/a	-	10	0	
Maternity and Neonates	Stillbirth rate	rate per 1,000	UHNM	Nov-25	2.3	▼	n/a	-	4.1	-1.8	
	Neonate Mortality rate per 1000	rate per 1,000 (quarterly)	UHNM	Sep-25	6.1	▲	n/a	-	4.0	2.1	
	Brain injury rate per 1000	rate per 1,000 (quarterly)	UHNM	Sep-25	0.0	▼	n/a	-	2.0	-2.0	
	The % of full - term babies admitted to a neonatal unit	rate per 1,000 (quarterly)	UHNM	Sep-25	0	▼	n/a	-	0	0.0	

Key to arrows showing direction from previous month		Key to variation Colour	
▲	Improved with a higher value than the previous month,	Red	Negative impact / unwanted variation
▼	Improved with a lower value than the previous month	Green	Positive impact / desired variation
▲	Deteriorated with a higher value than the previous month	Yellow	No change / equal
▼	Deteriorated with a lower value than the previous month	Black	Not applicable / not available
⇔	Equal to the previous month		
n/a	not available		

Notes on data:

- Neonate Maternity data is provided quarterly for Mortality, Brain Injuries and Neonatal admissions. Data is provided for the preceding months, each quarter. No update this month.

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
<p style="text-align: center;">Children and Young People (CYP)</p>	<p>Local Metric: Epilepsy emergency admission (≤18) 17 emergency admissions against a local target of 13 in October 2025.</p>	<p>Drives unchanged from last month:</p> <p>Although numbers are small (a decrease to 17 compared to 13 in the same month last year) there are a number of factors that may be driving an increase in Epilepsy non-elective (NEL) admissions:</p> <ul style="list-style-type: none"> • Lack of Epilepsy Specialist Nursing (ESN) care post diagnosis. • Ongoing management via non-specialists meaning that CYPs are not receiving the specialist care they need to manage their condition with poorer outcomes. • Waiting times for appointments and review. 	<p>The portfolio is awaiting Executive approval to finalise the agreed actions.</p> <p>Exec level actions (ICB & Provider) to take place pending a decision. These actions remain open with updates awaited:</p> <ol style="list-style-type: none"> 1. A lack of ESN posts recorded within the risk register (score 16). This remains unchanged from last month. 2. A business case for investment was presented to Strategic Commissioning and Transformation Committee meeting during October 2025.

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	Oct-25	0.9%	▲	n/a	-	1.0%	-0.2%	
	Increase patients receiving all 8 care processes for Diabetes, receiving 3 treatment targets - Type 1 (Year to Date Cumulative)	%	ICB	Oct-25	25.6%	▲	n/a	-	22.5%	3.1%	
	Increase patients receiving all 8 care processes for Diabetes, receiving 3 treatment targets - Type 2 (Year to Date Cumulative)	%	ICB	Oct-25	33.9%	▲	n/a	-	30.8%	3.1%	
	Long-term conditions: Ensure referrals are made to the National Diabetic Prevention Programme – support for patients who are pre-diabetic	Number	ICB	Oct-25	580	▲	n/a	-	520	60	
	Urgent community response (LTC): Ensure patients commence on the National Diabetic Prevention Programme (NDPP) following referral	Number	ICB	Oct-25	365	▲	n/a	-	261	104	
	Reduction in number of conveyances for falls by WMAS	Number	ICB	Oct-25	672	▲	n/a	-	761	-89	
	Falls, Reduction in number of falls related emergency admissions - 65+	Number	ICB	Oct-25	156	▼	n/a	-	260	-104	
	Care Home, Reduction emergency admissions - 65+	Number	ICB	Oct-25	830	▲	n/a	-	839	-9	
	Reduction emergency admissions - all 65+	Number	ICB	Oct-25	6,839	▲	n/a	-	7,022	-183	

Key to arrows showing direction from previous month		Key to variation Colour	
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▼	Improved with a lower value than the previous month	Green	Positive impact / desired variation
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▼	Deteriorated with a lower value than the previous month	Black	Not applicable / not available
⇄	Equal to the previous month		
n/a	not available		

Community Transformation Local Metrics off Plan and Actions

Programme Area	Metric	Drivers for underperformance	Top 3 Planned actions provided by portfolio
<p>Community Transformation</p>	<p>Local Metrics: Prevalence rate of patients on palliative care registers to 1%.</p>	<p>Driver identified previously remains as below:</p> <ul style="list-style-type: none"> 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. 	<p>Action remains the same as last month:</p> <ol style="list-style-type: none"> 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	Jun-25	89.2%	▲	n/a	-	#N/A	-	
	Children and Young People Vaccination uptake - Pertussis maternal vaccination	%	ICB	Sep-25	79.4%	▲	n/a	-	62.9%	16.5%	
	Hypertension (CVDP007HYP): Patients treatment to recommended age specific thresholds	% (quarterly)	ICB	Jun-25	67.8%	▼	n/a	-	67.1%	0.7%	
	Cholesterol (CVDP003CHOL):Patients with QRISK 20% or more treated with lipid lowering therapy	% (quarterly)	ICB	Jun-25	65.7%	▲	n/a	-	64.0%	1.6%	
	Respiratory: Flu Vaccinations (65+years)	%	ICB	Nov-25	72.8%	▲	n/a	-	73.0%	-0.2%	
	Respiratory: COVID Vaccinations (65+years)	%	ICB	Nov-25	63.4%	▲	n/a	-	63.0%	0.4%	

Key to arrows showing direction from previous month	
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▼	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

Notes on data:

- Hypertension (CVDP007HYP) and Cholesterol (CVDP003CHOL) measures - Data published every 3 months, no update this month.

Improving Population Health Local Metrics, off Plan and Actions

Programme Area	Metric	Drivers for underperformance	Top 3 Planned actions provided by portfolio
<p>Improving Population Health</p>	<p>Local Metric: Respiratory: Flu Vaccinations (65+) 72.8% recorded in November 2025, 0.8% below the baseline (of 73%). Figures to 14th December 2025 show the vaccination percentage has increased to 74.1%, continuing to increase. The end of year target should be reached.</p>	<ul style="list-style-type: none"> • Later deliveries of flu vaccine to sites. • Difficult to quantify but higher incidence of early seasonal illness (flu and other respiratory conditions) has delayed vaccinations for affected poorly individuals by 1–2 weeks, reducing uptake within the planned timeframe. 	<ol style="list-style-type: none"> 1. The ICB has targeted media campaigns to improve low uptake demographics. 2. The ICB is supporting PCNs with low care home uptakes. 3. There are general press releases/media on countdown to Christmas and high flu activity to encourage individuals to come forward. 4. A Targeted Vaccination Team who are holding walk-in clinics for COVID and flu across the patch is in operation.

Staffordshire & Stoke on Trent ICS

Financial Position (November 25)

Finance & Performance Committee – 6th January



Executive Summary

This report details the aggregate financial position as at month 8 with high level metrics

Year to date position

At month 8, the system is reporting a £16.3m deficit, representing a £1.0m favourable variance against the planned £17.3m deficit (£0.7m favourable at month 7). Year-to-date, this includes deficits of £12.6m for the ICB, £8.2 at UHNM and off set by a surplus of £4.0m at MPFT and £0.5m NSCHT. While the overall position remains broadly on track, the key driver of variances continues to be lower than planned efficiency delivery, offset by a number of non-recurrent mitigations. Following the adverse variance reported at month 1, recovery trajectories were developed where appropriate. At month 8, the system is now £7.0m behind these recovery trajectories (£2.6m behind at Month 7).

Efficiency delivery

The reported system efficiency delivery YTD is £19.9m behind our submitted plan of £186.0m, this comprises of ICB (£11.2m), MPFT £0.1m, NSCHT (£0.2m) and UHNM (£8.7m). As a system this equates to 89% delivery YTD. We are continuing to monitor the development of the efficiency plans weekly with the month end position included in the pack.

Forecast and net risk

As a system we are forecasting to meet our year end financial plan of break even, subject to the receipt of £95m deficit support funding (DSF). Net risk has reduced to £6.7m at month 8 down from £12.9m at month 7. This net risk is primarily made up of efficiency risk (£0.4m), additional cost risk (£7.2m) and offset by non-recurrent mitigations and anticipated allocations. UHNM holds the remaining net risk of £6.7m aligned to the recovery plan, with all other partners having fully mitigated their positions.

Workforce

The system workforce numbers across providers and ICB (substantive + bank + agency) were 25,451 WTE in November 2025. This is an increase on month 7 of 178.5 WTE. Much of this increase can be attributed to UHNM bank (243WTE). Month 8 workforce numbers were 1,016 WTE above plan which was seen in substantive (653 WTE) and bank (379 WTE), offset by agency which is under plan by (15 WTE). The system is undertaking assurance on trajectories for remaining months including drivers and alignment to recovery plans.

Capital

The system submitted a compliant forecast at month 8, any deviations from this will potentially impact 2026/27 should there be material underspends in the remaining months. The freedom and flexibility funding will be locked down at month 9. Key movements in month include the disposal of land at former RI and COPD site has deferred into 2026/27 and the region have informed of an increased CDEL limit to cover the IFRS16 pressure at MPFT.

Month 8 Position

The System is reporting a YTD **favourable position to plan of £1.0m** against a planned deficit of £17.3m. The main drivers for the aggregate YTD position are efficiency slippage (£19.9m) offset with greater than planned use of flexibilities and underspends on vacancies and investment slippage. The efficiency programme phasing in response to the month 1 adverse variance, where appropriate organisations have developed recovery trajectories. At month 8 the system has fallen behind this recovery trajectory by £7.0m (£2.7m month 7).

System	Month 8		
	Plan	£m YTD	Variance
Income	3,673.8	3,675.2	1.4
Pay	(944.2)	(949.2)	(5.1)
Non Pay	(512.7)	(509.5)	3.2
Non Operating Items (exc gains on disposal)	(23.9)	(22.5)	1.4
ICB Expenditure	(2,210.4)	(2,210.3)	0.0
Total	(17.3)	(16.3)	1.0
			0.0%

	Month 7		
	Plan	£m YTD	Variance
Income	3,213.8	3,212.1	(1.8)
Pay	(828.5)	(831.2)	(2.7)
Non Pay	(449.1)	(445.4)	3.7
Non Operating Items (exc gains on disposal)	(20.8)	(19.4)	1.3
ICB Expenditure	(1,934.8)	(1,934.7)	0.1
Total	(19.4)	(18.7)	0.7
			0.0%

MPFT	Month 8		
	Plan	£m YTD	Variance
Income	480.0	487.4	7.4
Pay	(345.8)	(348.1)	(2.3)
Non-Pay	(132.6)	(137.5)	(4.9)
Non Operating Items (exc gains on disposal)	2.3	2.2	(0.1)
TOTAL Provider Surplus/(Deficit)	3.9	4.0	0.1
			0.0%

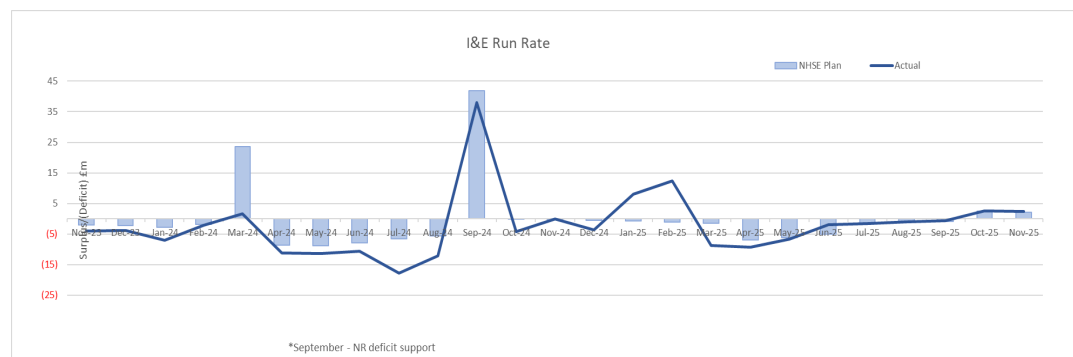
	Month 7		
	Plan	£m YTD	Variance
Income	420.2	425.7	5.6
Pay	(302.6)	(304.6)	(2.1)
Non-Pay	(115.8)	(119.2)	(3.4)
Non Operating Items (exc gains on disposal)	2.2	2.1	(0.1)
TOTAL Provider Surplus/(Deficit)	4.0	4.0	0.0
			0.0%

ICB	Month 8		
	Plan	£m YTD	Variance
Allocation	2,197.7	2,197.7	0.0
Expenditure	(2,210.4)	(2,210.3)	0.0
TOTAL ICB Surplus/(Deficit)	(12.7)	(12.6)	0.0
			0.0%

	Month 7		
	Plan	£m YTD	Variance
Allocation	1,922.2	1,922.2	0.0
Expenditure	(1,934.8)	(1,934.7)	0.1
TOTAL ICB Surplus/(Deficit)	(12.5)	(12.5)	0.1
			0.0%

NSCHT	Month 8		
	Plan	£m YTD	Variance
Income	119.9	118.9	(1.0)
Pay	(73.1)	(72.5)	0.6
Non-Pay	(46.5)	(45.1)	1.4
Non Operating Items (exc gains on disposal)	(0.6)	(0.8)	(0.2)
TOTAL Provider Surplus/(Deficit)	(0.3)	0.5	0.8
			-0.7%

	Month 7		
	Plan	£m YTD	Variance
Income	104.9	103.6	(1.3)
Pay	(64.0)	(63.3)	0.7
Non-Pay	(40.8)	(39.4)	1.4
Non Operating Items (exc gains on disposal)	(0.5)	(0.7)	(0.2)
TOTAL Provider Surplus/(Deficit)	(0.4)	0.2	0.6
			-0.6%



UHNM	Month 8		
	Plan	£m YTD	Variance
Income	876.1	871.2	(4.9)
Pay	(525.2)	(528.7)	(3.4)
Non-Pay	(333.5)	(326.9)	6.7
Non Operating Items (exc gains on disposal)	(25.6)	(23.9)	1.7
TOTAL Provider Surplus/(Deficit)	(8.2)	(8.2)	0.0
			0.0%

	Month 7		
	Plan	£m YTD	Variance
Income	766.5	760.5	(6.1)
Pay	(462.0)	(463.2)	(1.3)
Non-Pay	(292.6)	(286.8)	5.7
Non Operating Items (exc gains on disposal)	(22.4)	(20.8)	1.6
TOTAL Provider Surplus/(Deficit)	(10.4)	(10.4)	0.0
			0.0%

Key Performance Metrics

The tables below summarise the key variances and positions which are likely to be considered when reviewing eligibility for continued deficit support provision. The key point for the Committee to note is that the net risk at month 8 is £6.7m and a likely breach of the system bank cap.

Position	Run Rate		
	Income Extrapolated	Expenditure Extrapolated	Run rate difference to forecast
Staffordshire and Stoke On Trent ICB			
Midlands Partnership University NHS Foundation Trust	731.1	(725.1)	6.0
North Staffordshire Combined Healthcare NHS Trust	178.3	(177.5)	0.8
University Hospitals of North Midlands NHS Trust	1,306.9	(1,319.2)	(12.3)
Total	2,216.3	(2,221.8)	(5.6)

System Net Risk		
Planning Submission	Month 7	Month 8
(11.7)	(0.0)	0.0
(0.7)	0.0	(0.0)
(30.0)	0.0	(0.0)
(54.9)	(12.9)	(6.7)
(97.3)	(12.9)	(6.7)

Efficiency	Efficiency		
	YTD Actual	YTD Variance	YTD Variance %
Staffordshire and Stoke On Trent ICB	94.5	(11.2)	-11%
Midlands Partnership University NHS Foundation Trust	36.2	0.1	0%
North Staffordshire Combined Healthcare NHS Trust	4.6	(0.2)	-4%
University Hospitals of North Midlands NHS Trust	30.8	(8.7)	-22%
System	166.1	(19.9)	-12%

Efficiency FOT		
Efficiency FOT	Forecast Variance	YTD as % of FOT
169.9	0.0	56%
54.2	0.0	67%
7.4	0.0	63%
51.9	(23.0)	41%
283.4	(22.9)	54%

Workforce	Agency		
	YTD agency spend £m	FOT agency spend £m	YTD agency spend as % of FOT
Staffordshire and Stoke On Trent ICB			
Midlands Partnership University NHS Foundation Trust	3.9	5.8	68%
North Staffordshire Combined Healthcare NHS Trust	1.2	1.5	78%
University Hospitals of North Midlands NHS Trust	8.7	16.1	54%
System	13.7	23.4	59%

Bank		
YTD Bank spend £m	FOT Bank spend £m	YTD Bank spend as % of FOT
16.2	24.8	66%
4.4	6.0	74%
44.9	64.8	69%
65.6	95.6	69%

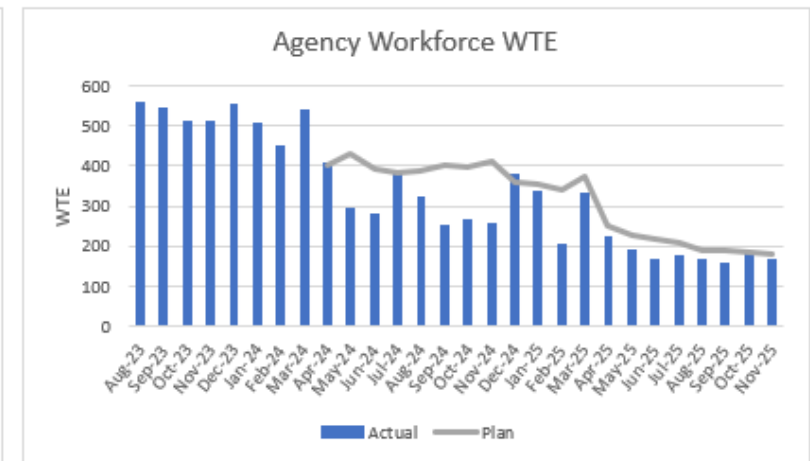
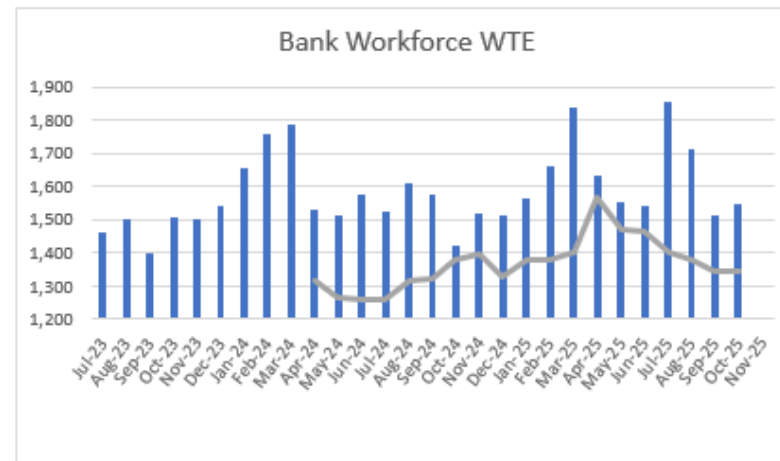
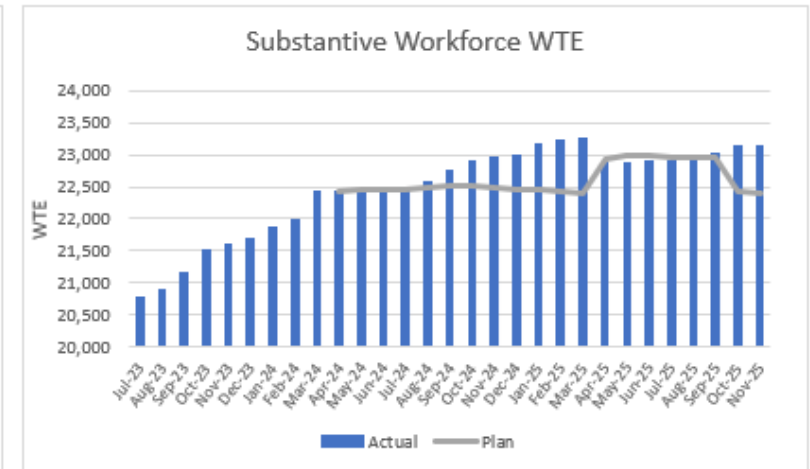
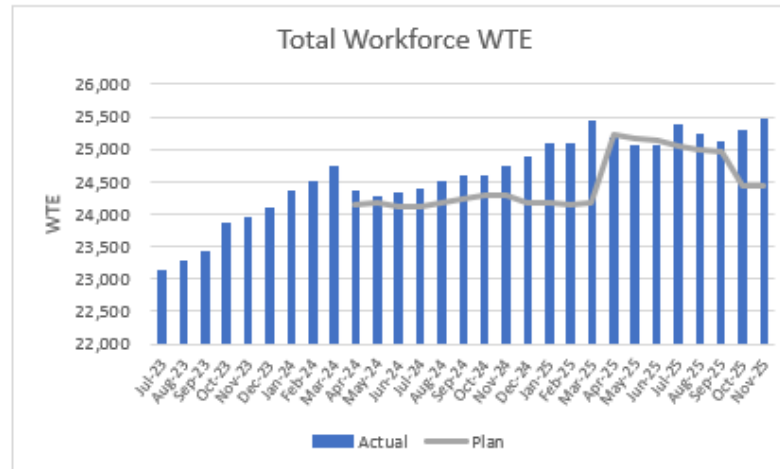
The NHS oversight framework rankings have been published with the system: UHNM ranked 83rd out of 134 acute providers and in segment 3. NSCHT ranked 1st of out 61 providers in the non-acute and in segment 1. MPFT ranked 2nd of out 61 providers in the non-acute, also in segment 1.

Workforce

The system workforce numbers across providers and ICB (substantive + bank + agency) were 25,451 WTE in November 2025. This is an increase on month 7 of 178.5 WTE. Much of this increase can be attributed to UHNM bank (243WTE). Month 8 workforce numbers were 1,016 WTE above plan which was seen in substantive (653 WTE) and bank (379 WTE), offset by agency which is under plan by (15 WTE).

- As a system we were within our agency ceiling by 21.2% (£3.7m), however we were over our bank ceiling metric by 27.8% (£14.3m).
- Agency spend was 1.4% of total staff spend therefore (1.8%) under the 3.2% ceiling/target.
- Since the start of the year there is a total increase (55 WTE). In 2025/26 to date, although bank reduced (88 WTE) and agency reduced (169 WTE) these remain above planned levels.
- When compared to Sep 25 (month 7), there has been an overall increase in the Workforce of 178 WTE.

The system is undertaking assurance on trajectories for remaining months including drivers and alignment to recovery plans.



Capital

- For Month 8 expenditure actuals were £5.3m 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 system submitted a compliant forecast at month 8, any deviations from this will potentially impact 2026/27 should there be material underspends in the remaining months. The freedom and flexibility funding will be locked down at month 9
- The system is still forecasting to be on plan against the capital plan will no escalations at present.

Category	YTD £000		
	Plan	Spend	Variance
Capital allocation	21,936	20,634	(1,302)
Return to Constitutional Standards	15,890	16,041	151
2025/26 Estates Safety	4,891	1,480	(3,411)
2025/26 Mental Health: Reducing Out of Area Placements	3,040	2,288	(752)
Total	45,757	40,443	(5,314)

By Organisation	YTD £000		
	Plan	Spend	Variance
MPFT	17,271	12,378	(4,893)
NSCHT	2,421	2,099	(322)
UHNM	26,065	25,966	(99)
System total	45,757	40,443	(5,314)

At month 8 key variances are:

- MPFT** – The main pressure on the forecast has been IFRS16 (£4.1m) due to timing of remeasurements review. The region have confirmed this will be supported with an increase to the system CDEL limit. It should also be noted that one of the 2025/26 Mental Health: Reducing Out of Area Placements schemes (Ellesmere in Patient Rehab £3.95m) was rejected post submission therefore the overall planned spend will be reduced to remain within allocation and potentially funded through the freedoms and flexibility confirmed funding.
- UHNM** – YTD is on track. The main forecast movement in month 8 is the disposal of land at former RI and COPD site has deferred into 2026/27. Total forecast expenditure is on plan with the Trust deferring funding on UTC and UEC schemes into 2026/27.
- NSCH** – Small YTD underspend on Chrysalis (replacement of Dormitory Wards) and £159k behind on leases. Both of these are timing issues and plan will be delivered.
- The ICB remains on track to deliver the capital spend on GPIT and Utilisation and Modernisation Funding. This sits outside the monthly reporting process as ICB capital is reported within NHSE accounts.

Appendices



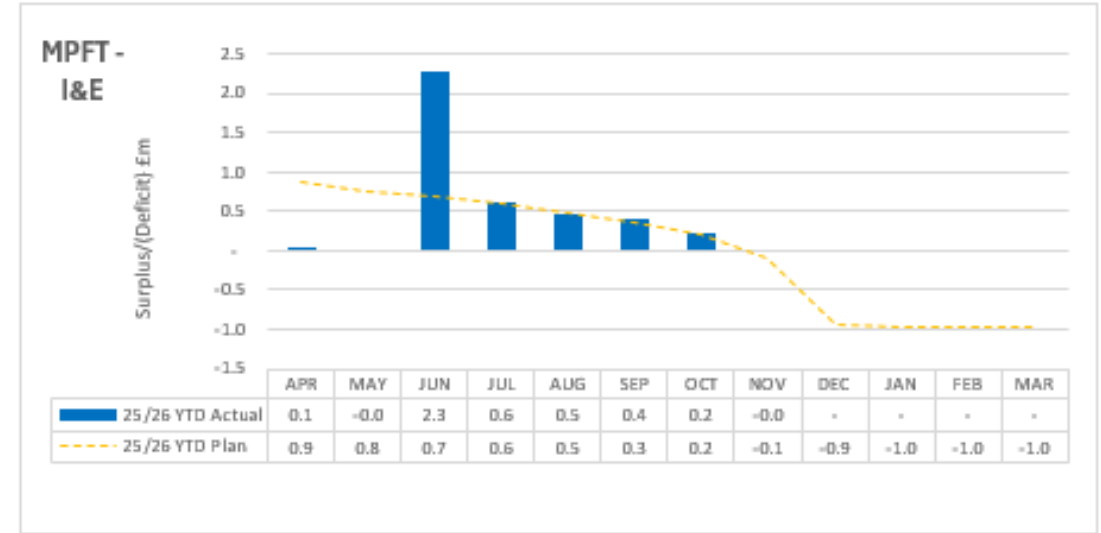
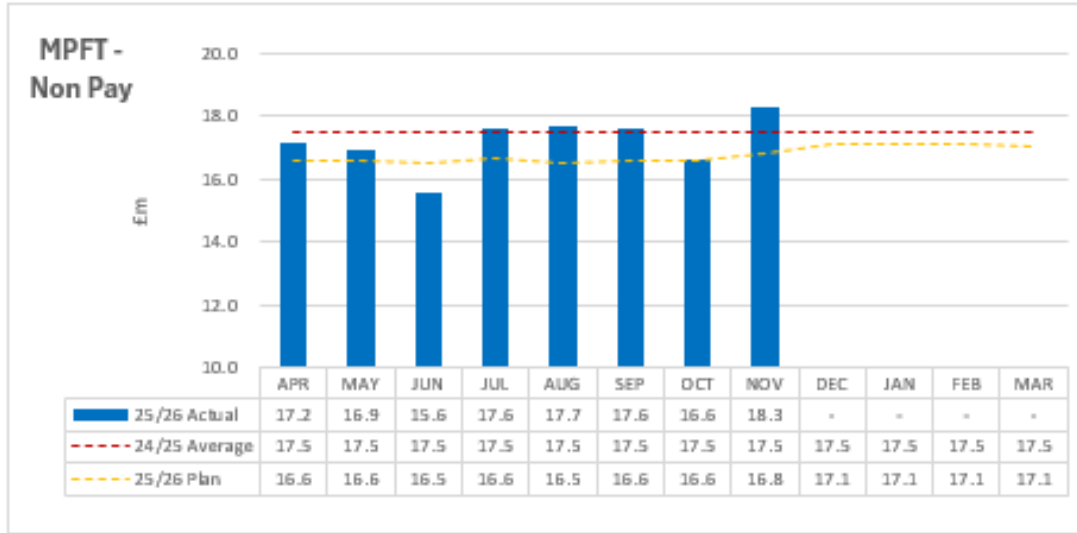
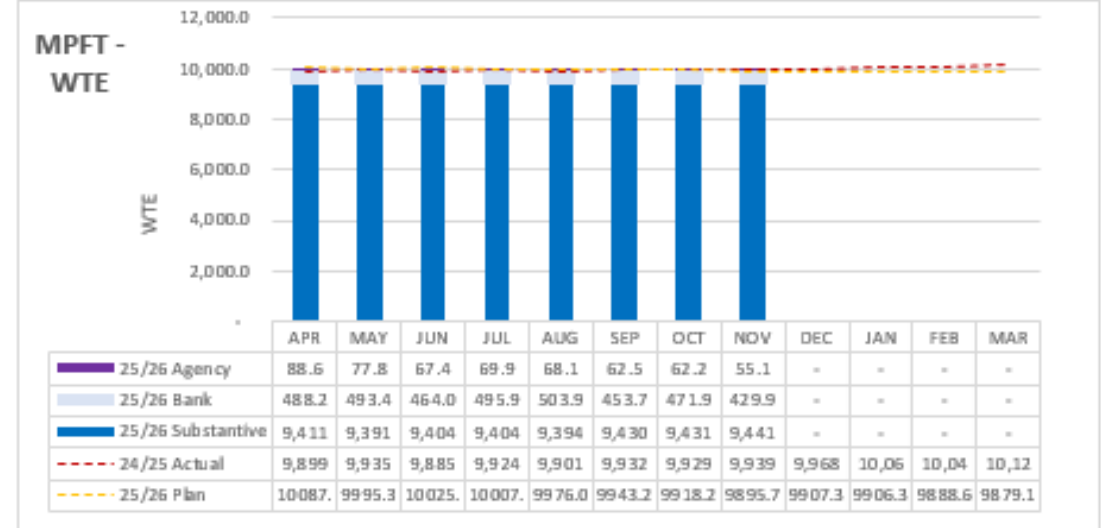
Underlying Position

The system underlying position reported at month 7 is £139.1m deficit. ULP was non mandatory in month 8 as it forms part of the planning submission. The drivers from the breakeven forecast to the underlying position is summarised below. The main drivers are the removal of the non recurrent deficit support funding and non-recurring efficiencies partially offset with FYE of recurring efficiencies.

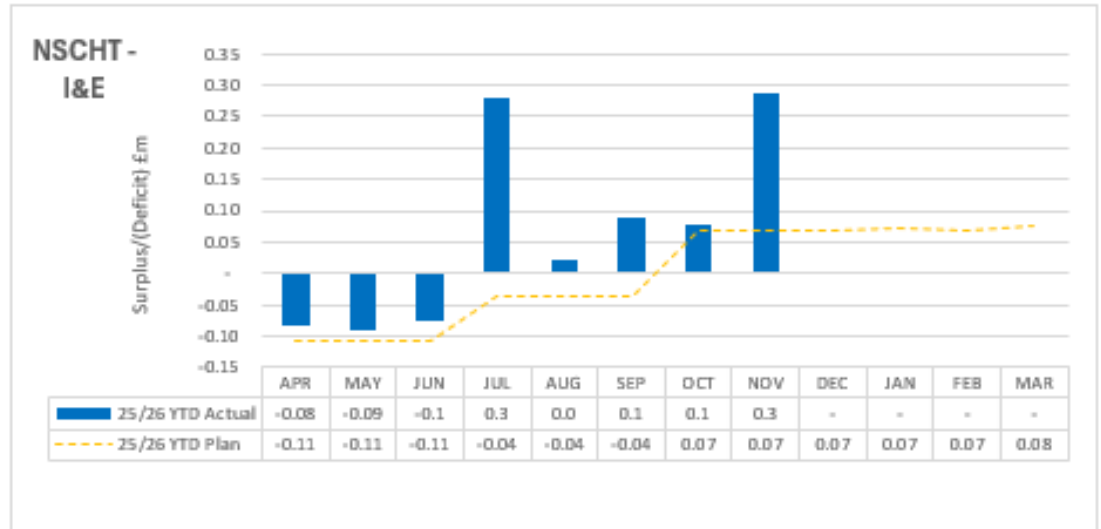
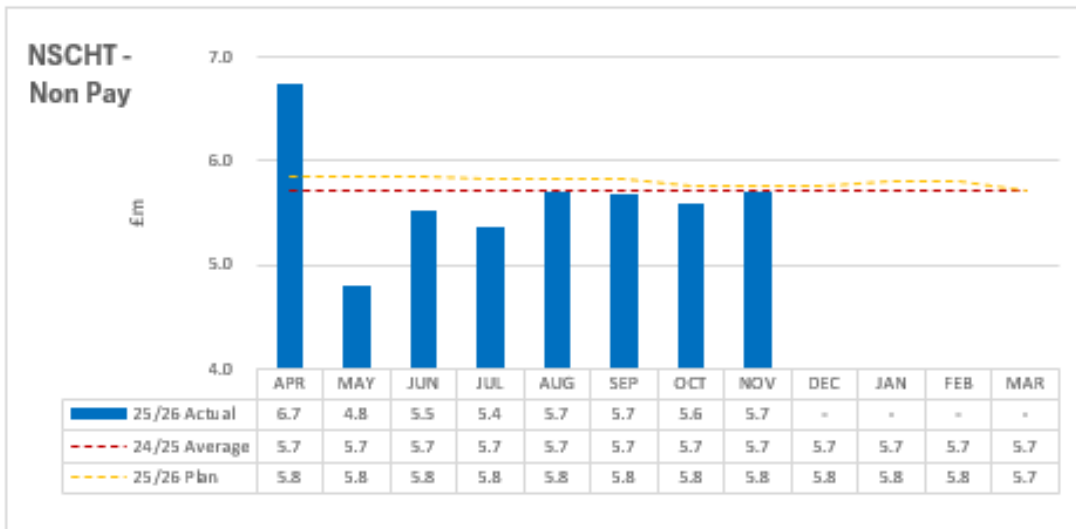
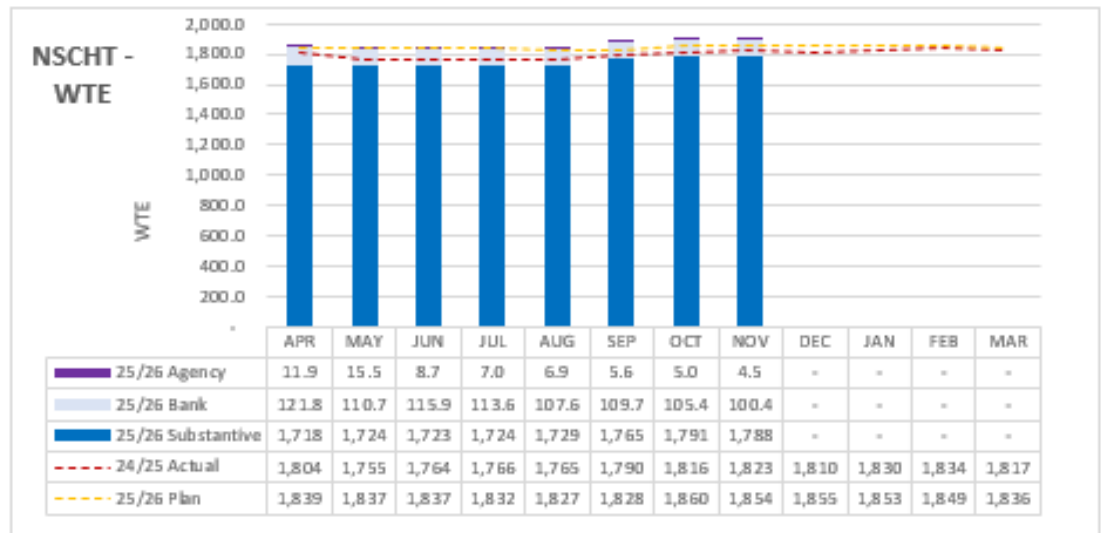
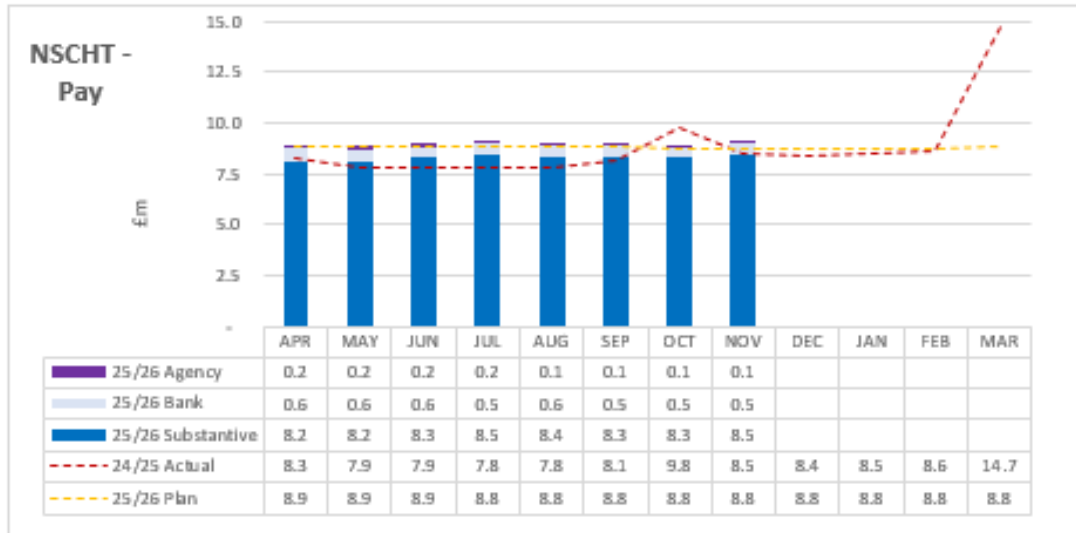
2025/26 Forecast	UHNM	NSCHT	MPFT	ICB	SSOT
	0.0	0.0	0.0	0.0	0.0
Forecast non-recurring efficiencies	(46.3)	(1.8)	(12.7)	(10.4)	(71.2)
FYE of forecast recurring efficiencies - cash releasing	43.9	0.5	4.8	18.2	67.5
Gains and losses and donations	(0.0)	0.1	(0.1)		0.0
Deficit Support	(37.2)		0.0	(57.8)	(95.0)
Full year effect of service developments	0.0	(0.1)			(0.1)
Deficit Repayment Allocation				11.6	11.6
Interest Receivable			(3.5)		(3.5)
Capital Charges FYE			(2.6)		(2.6)
Non Recurrent IT Slippage			(1.7)		(1.7)
NR Flexibility			(4.7)	(27.8)	(32.5)
Other NR				(11.2)	(11.2)
2025/26 Underlying Position (submitted)	(39.6)	(1.3)	(20.8)	(77.4)	(139.1)
Triangulation to be resolved	(16.5)			16.5	0.0
2025/26 Underlying Position	(56.1)	(1.3)	(20.8)	(60.9)	(139.1)

There is substantial regional oversight of the underlying position across all systems. Organisations have reviewed their positions against national principles to ensure consistency and robustness, and are sharing key drivers with one another, as these inputs will inform the 2026/27 planning process.

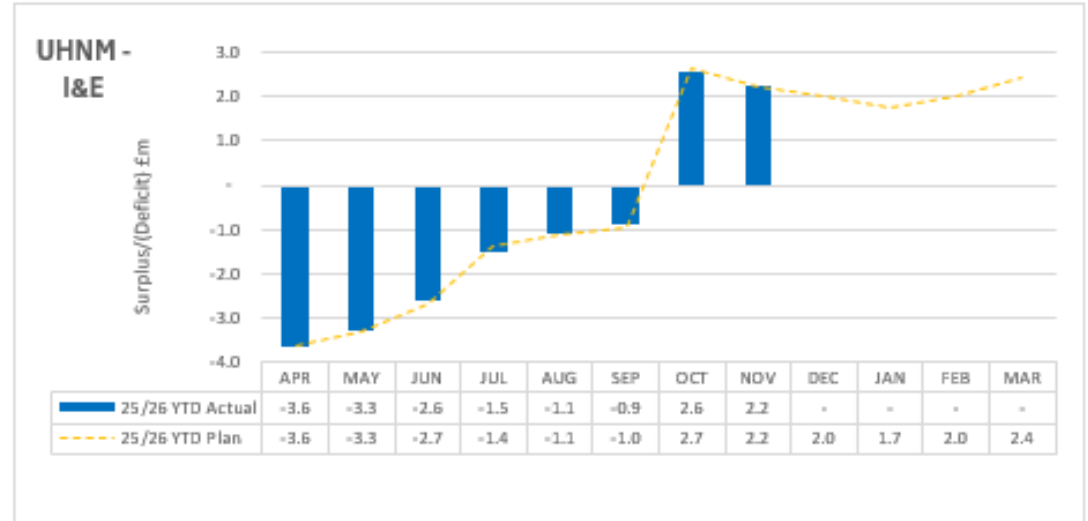
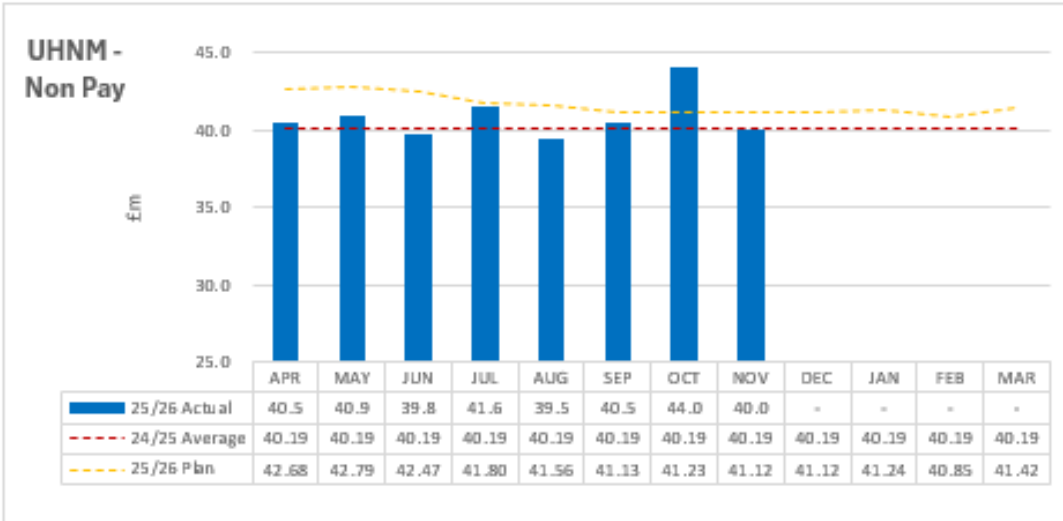
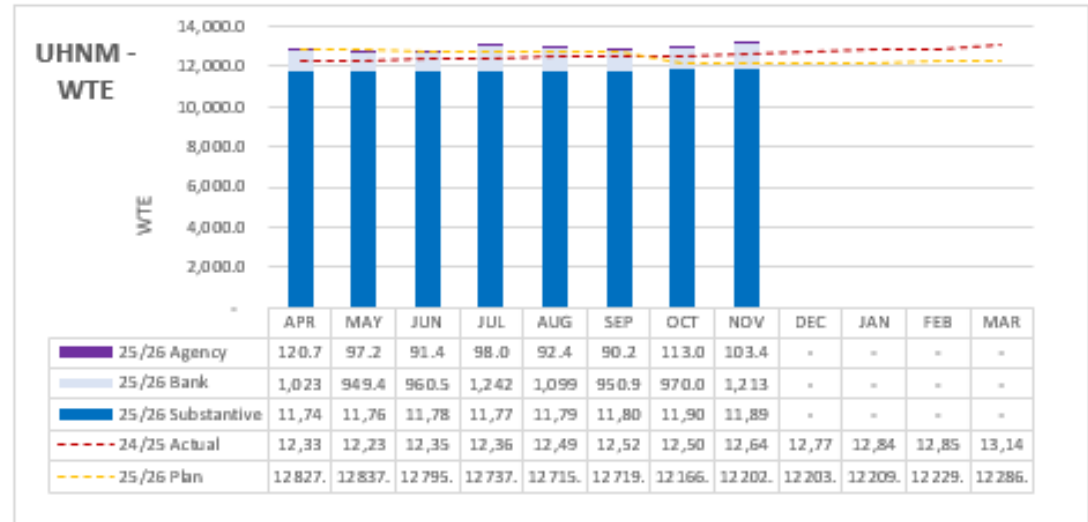
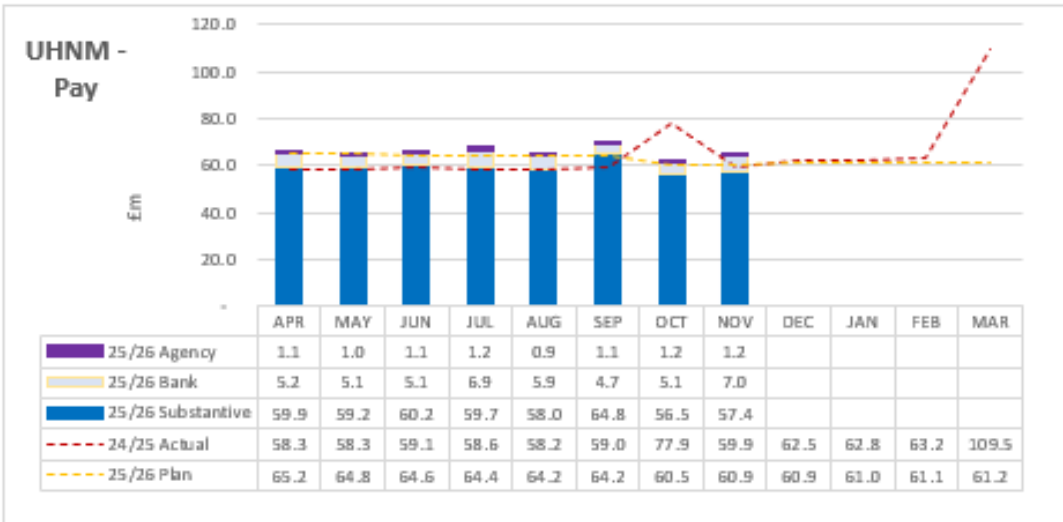
Provider – MPFT Run Rate



Provider – NSCHT Run Rate



Provider – UHNM Run Rate



AAA Escalation & Assurance Report from Committees

Report To:	Board
Date:	29 th January 2026
Reporting Committee / Group:	Finance and Performance Committee (System & ICB)
Date of Meeting:	26 th November 2025
Meeting Quorate Y/N?	Yes (both)
Presenter:	Mike Lawton, Non-Executive Member and Committee Chair
Author:	Kelly Weatherill, Executive Assistant

Key Escalation & Discussion Points from the Committee Meeting:

ALERT

There were no items to alert the ICB Board from the meeting.

ADVISE

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

Chief Finance Officer Update

The Committee received an update from the Chief Finance Officer, the purpose of which was to brief the Committee on national and regional context alongside emerging policies. The report covered:

- Regional and national financial position
- Changes to the NHS planning and financial regime to support Medium term financial planning
- Implementation of new financial ledger

System Performance Group - Summary Report

The Committee received a summary of key issues that had been discussed at the System Performance Group (SPG) on Tuesday 25th November, including updates on system finance, efficiency programme, workforce, performance, planning review and feedback from the System Capital Group which had taken place on 21st November.

The Committee was updated on the month 7 system financial position which is currently reporting a £18.7m deficit, representing a £0.7m favourable variance against the planned £19.4m deficit (£0.7m favourable at month 6), followed by a breakdown of individual provider positions. Overall, the Committee was assured by the SPG summary and associated reports on Month 7 Finance and Performance.

The Committee received the feedback letter from the Staffordshire and Stoke on Trent ICB (SSOT) and Shropshire, Telford and Wrekin (STW) ICB Joint Mid-Year Review Meeting held on 15th October 2025. The letter summarised the key points of the discussion including progress, risks, actions across finance, workforce, quality of care, access and outcomes.

Planning Update

The Committee received an update of the progress and actions as part of the planning process for 2026/27, ahead of the first planning submission due on 17th December. The update also included an overview of productivity and efficiency opportunities across SSOT ICB main providers (UHNM, UHDB, RWT), using data from the Model Health System and internal analytics.

Digital Strategy Progress Report

The Committee received an update on the evolving role of Digital within the context of strategic commissioning, the NHS 10-Year Plan and the medium-term plan, as well as proposed next steps in planning for this transition. The presentation included:-

- Short-term transitional planning and 2026/27 budgeting
- Current risks that require ongoing ownership and mitigations
- The sustainability and management of the shared care record (One Health and Care)
- The importance of digital as part of a strategic commissioning cycle including within contracting
- Risk management and clinical safety in the context of clinical IT systems

Provider Collaborative Assurance Update

The Committee noted the report and the ongoing work undertaken in the Provider Collaborative which consists of three priority areas agreed by system Chief Executives:

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

The update focussed specifically on the work underway in relation to Governance and Reporting, UEC / Community Transformation and Corporate Services.

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

Month 7 Finance Report & 2025/26 Efficiency Report

The Committee received the Month 7 ICB financial position which reported a year-to-date breakeven position against the £12.5m plan. Deficit support funding has been received by the system up to and including Q3 (£71.3m / £95.0m).

In terms of the Efficiency Programme update, year-to-date efficiency is £4.3m behind plan, primarily due to overperformance against Indicative Activity Plans within agreed secondary care contracts. Despite this variance, the ICB remains confident in meeting the £169.9m efficiency target. Current performance has been supported by £20.4m of non-recurrent items. A break-even forecast outturn position continues to be reported; however, the Committee noted the remaining risk and mitigations required to offset this.

ASSURE

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

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

The System Risk Register is a bi-monthly update to the Committee. The next update will be due at the next Committee meeting taking place on Tuesday 6th January 2026.

Policies Approved:

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

Decisions to be Escalated to ICB Board:

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

AAA Escalation & Assurance Report from Committees

Report To:	Board
Date:	29 th January 2026
Reporting Committee / Group:	Finance and Performance Committee (System & ICB)
Date of Meeting:	6 th January 2026
Meeting Quorate Y/N?	Yes (both)
Presenter:	Mike Lawton, Non-Executive Member and Committee Chair
Author:	Kelly Weatherill, Executive Assistant

Key Escalation & Discussion Points from the Committee Meeting:

ALERT

There were no items to alert the ICB Board from the meeting.

ADVISE

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

Chief Finance Officer Update

The Committee received an update from the Chief Finance Officer, the purpose of which was to brief the Committee on a national and regional context. The report covered:

- Regional and national financial position
- Additional updates on 25/26 post month 8 reporting
- Implementation of new financial ledger
- Update on NHS financial arrangements for 2026/27 and 2027/28

System Performance Group - Summary Report

The Committee received an update on the key headlines in relation to Finance, Performance and Workforce. This included specific updates on system finance, efficiency programme, the 2026/27 planning round, and feedback from the System Capital Group which had taken place on 12th December.

The Committee was updated on the month 8 system financial position which is currently reporting a £16.3m deficit, representing a £1.0m favourable variance against the planned £17.3m deficit (£0.7m

favourable at month 7). Year-to-date, this includes deficits of £12.6m for the ICB, £8.2m at UHNM and partial offset with surplus of £0.4m at NSCHT and £4.0m at MPFT.

Developing the medium term plan and 2026/27 operational planning

The Committee received an update on the ICB 2026/27 planning first submission made on 17th December 2025. The update also outlined the next steps required to meet the final submission deadline of 12th February 2026, including progress on the 5-Year Strategic Commissioning Plan. The Committee noted the areas where there is further work required to meet the national performance standards and the steps in place to address these.

Urgent Treatment Centre Designation

The Committee received an update on the proposed designation of Urgent Treatment Centres (UTCs) across Staffordshire and Stoke-on-Trent which had been presented to the Committee seeking approval. The recommendations had been formed from discussions undertaken as part of the extensive UEC transformation workstream and refined via a series of UTC Technical Event sessions, with representation from all system partners, neighbouring providers and other pivotal partner organisations. The Committee **approved** the recommendations and proposed approach.

Provider Collaborative Assurance Update

The Committee noted the report and the ongoing work undertaken in the Provider Collaborative which consists of three priority areas agreed by system Chief Executives:

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

The update focussed on the two priority areas for 2025/26 (Neighbourhood Health and UEC/Community and Corporate Services Transformation Programmes) as well as the plans for developing the programme of work for 2026/27.

ICB Finance and Performance Committee (formerly Part B)

Month 8 Finance Report & 2025/26 Efficiency Report

The Committee received the Month 8 ICB financial position which reported a YTD breakeven position against the £12.6m plan. Deficit support funding has been received by the system up to and including Q3 (£71.3m / £95.0m) with informal notification of Q4 receipt.

In terms of the Efficiency Programme update, the level of plans implemented or fully developed by the ICB reflects a positive position (£150.3m/88%) however, a £12.2m risk to delivery remains. The key driver being a £17.9m shortfall in developed schemes. Mitigations to offset this shortfall alongside any emerging risks continue to be identified via the monthly Portfolio Assurance Meetings.

Budget Setting Principles

The Committee were presented with the framework and principles that will be applied in setting the ICB statutory body budgets whilst working in conjunction to the developing Medium-Term Plan, to ensure that the management team is operating within the Standing Financial Instructions (SFIs). The purpose of the update was to outline the approach the ICB will take to establishing an approved budget which is aligned to the NHS Long Term Plan published in Autumn 2025 and promotes the delivery of best value for all stakeholders. The Committee were in support of the approach and therefore **approved**.

ASSURE

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

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

The Committee were presented with the System Board Assurance Framework (SBAF) for Q3 2025-26 for oversight and assurance. The Committee were also presented with updates relating to the ICB and System Risk Registers.

Policies Approved:

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

Decisions to be Escalated to ICB Board:

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

Report to:	Integrated Care Board					
Date:	29 January 2026					
Title:	Quality and Safety Report					
Presenting Officer:	Heather Johnstone, Interim Chief Nursing Officer - SSOT					
Author(s):	Lee George, Associate Director – Quality Assurance and Improvement					
Document Type:	Report	If Other: Click or tap here to enter text.				
Action Required (select):	Information (I)	<input checked="" type="checkbox"/>	Discussion (D)	<input type="checkbox"/>	Assurance (S)	<input type="checkbox"/>
	Approval (A)	<input type="checkbox"/>	Ratification (R)	<input type="checkbox"/>	<i>(check as necessary)</i>	
Is the decision within SOFD powers & limits	Yes / No	YES				
Any potential / actual Conflict of Interest?	Yes / No	NO <i>If Y, the mitigation recommendations –</i> Click or tap here to enter text.				
Any financial impacts: ICB or ICB?	Yes / No	NO <i>If Y, are those signed off by and date:</i> Click or tap here to enter text.				
Any impacts on ICB Undertakings?	Yes / No	NO <i>If Y, are those signed off by and date:</i> Click or tap here to enter text.				
Appendices:	Appendix A: Quality and Safety Report – Detail January 2026.					

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

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

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

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

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

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

(6) Executive Summary, incl. expansion on any of the preceding sections:
<p>The paper summarises key areas discussed by the Quality and Safety Committee (QSC) and the System Quality Group (SQG) at the meetings held in December 2025.</p> <p>Several key programmes of work were discussed, and the paper is intended to provide assurance to the Integrated Care Board in relation to:</p> <ul style="list-style-type: none"> • Home and Host Commissioner • Right Care Right Person • Looked After Children • Operation Anzu • Quality and Safety Through Transition

(7) Recommendations to Board / Committee:
<p>Members of the Integrated Care Board are asked to:</p> <ul style="list-style-type: none"> • Receive this report, seek clarification, and further action as appropriate. • Be assured in relation to key quality assurance and patient safety activity undertaken in respect of matters relevant to all parts of the Integrated Care System.

Appendix A: Quality and Safety Report – Detail January 2026

1.0 Home and Host Commissioner

1.1 On 13 November 2025 Elysium Healthcare announced its decision to close the Moorlands Neurological Centre, a neuro-behavioural hospital, by 31 December 2025. To ensure safe and timely transfers, the ICB in its role as Host Commissioner established weekly meetings with all placing commissioners and Elysium. These meetings, supported by NHS England's Mental Health, Learning Disability and Autism Quality Transformation Programme, focused on progress updates and collaboratively resolving any barriers to patient transfers. 12 patients were affected by the closure, and all were successfully and safely transferred before Christmas.

1.2 A 'lessons learned' workshop involving Elysium, placing commissioners, and NHS England will take place on 26 January 2026. The aim is to review what worked well, identify areas for improvement, and gather feedback on how patients have settled into their new placements.

2.0 Right Care Right Person (RCRP)

2.1 Concerns were raised by North Staffordshire Combined Healthcare NHS Trust (NSCHT) and Midlands Partnership Foundation NHS University Trust (MPFT) regarding adherence to the RCRP process. An initial review identified four cases where the process may not have been followed, and all four individuals were found deceased. Each provider has reviewed these incidents in line with national patient safety requirements.

2.2 Following discussions between the Police, the Police Fire and Crime Commissioner, the ICB, MPFT, and NSCHT, the ICB agreed to lead a joint thematic review of these incidents, focusing on the application of RCRP processes. Summary of key findings:

- System challenges and blockers contributed to delays in gaining access to properties to check on service users where there was concern for safety.
- Whilst a full launch of phase one and two of RCRP had been undertaken by all the three NHS Hospital providers and information shared within these organisations, there were apparent gaps in fully/robustly cascading the information to everyone relevant.
- Whilst the Right Care Right Person process had been fully launched across the system the stepping down of the governance meetings for the process meant that there was no opportunity or ongoing joint governance to identify deficiencies in understanding in a timely manner.

2.3 Providers have implemented multiple actions following their reviews. Since March 2025, no similar incidents have been reported. Summary of areas for improvement:

- Clear System Governance and Oversight for RCRP process and action plan.
- System approach to be designed and agreed so confusion and misunderstandings limited.
- Relaunch of RCRP across system to ensure well socialised and understood.

2.4 The action plan will be monitored through the System Quality Group. A full report has been presented to the Quality and Safety Committee and shared with NHS England for wider learning. Whilst we are confident that a thorough and comprehensive review has been completed, the ICB has commissioned an independent specialist to review the report and provide assurance regarding the learning and mitigations identified.

3.0 Looked After Children

3.1 The ICB has statutory responsibilities for Looked After Children, including responding to local authority requests for health assessments and ensuring timely access to appropriate services. A key risk remains around compliance with statutory timeframes for Initial Health Assessments (IHAs) and Review Health Assessments (RHAs), which have not consistently been met.

3.2 While RHA compliance remains below target due to a historic backlog, performance is improving, and average waiting times have reduced. MPFT has implemented a risk prioritisation process and increased workforce capacity using non-recurrent funding from the ICB. In addition, MPFT is applying a quality improvement approach to release further clinical capacity. This issue is recorded on MPFT's Trust Board risk register with a score of 16 (Red).

3.3 Cluster working arrangements are in place, and both MPFT and the ICB are reviewing the impact of quality improvement initiatives alongside demand and capacity analysis. This will inform a revised plan and trajectory, including how skilled capacity will be funded. Progress continues to be monitored through the System Quality Group and Corporate Parenting Boards in Staffordshire and Stoke-on-Trent.

4.0 Quality and Safety Through Transition

4.1 As part of the national ICB reform, progress on developing the Cluster with Shropshire, Telford and Wrekin ICB is advancing well. The ICB remains committed to fulfilling its statutory duties throughout this transition. A dedicated Quality & Safety workstream, co-chaired by both ICB Chief Nursing Officers, has been established to support governance during the process. Partnership meetings across the cluster have focused on shaping future functions, with a strong emphasis on strategic commissioning and maintaining compliance with statutory responsibilities, ensuring that quality and patient safety remain key priorities.

AAA Escalation & Assurance Report from Committees

Report To:	Board
Date:	29 th January 2026
Reporting Committee / Group:	Quality & Safety Committee
Date of Meeting:	17 th December 2025
Meeting Quorate Y/N?	Quorate for part meeting only
Presenter:	Siobhan Heafield, Non-Executive Member and Committee Chair
Author:	Tracey Finney, Executive Assistant

Key Escalation & Discussion Points from the Committee Meeting:

ALERT
No items of alert were identified.

ADVISE
<p>UHNM Non-Obstetric Ultrasound (NOUS) Review</p> <p>The committee received an update on the NOUS service at UHNM following a review of long diagnostic waits and the steps that have been undertaken to reduce waiting times for patients.</p> <p>A full waiting list review and triage of all referrals had been undertaken by UHNM, and it was identified that not all referrals were triaged appropriately in line with best practice guidelines. Where NOUS was not appropriate referrals were rejected back to primary care or forwarded to another more appropriate diagnostic service. Assurance was given that patient harm had been considered throughout the review process, and both referrers and patients were written to and informed of the rejection. To date no harm has been identified to any individuals.</p> <p>A complaint was sent by the LMC to the CQC regarding the triage rejection process. The CQC were satisfied with the response from UHNM, and the complaint closed.</p> <p>UHNM have implemented a recovery plan to reduce the backlog of patients. This is monitored at SSOT/UHNM Tier 2 meetings with NHSE, and assurance was given the recovery plan is currently ahead of trajectory.</p>

The committee were assured a process is in place to look at diagnostic services and patient symptomatic pathways are being developed and approved through the Health and Care Senate.

All Age Continuing Care

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

The total AACC caseload has decreased by 1.9% since April 2025, the reduction can be seen across all cohorts with the exception of funded nursing care (FNC). The CHC caseload stood at 689 at the end of November.

Joint working is taking place with Staffordshire County Council and Stoke-on-Trent City Council. This includes FNC and joint funded review projects, and production of an Integrated Support Protocol.

The committee heard two patient stories that demonstrated the work carried out from a quality improvement and personalisation perspective.

System Quality Group

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

Staffordshire and Stoke-on-Trent ICB as host commissioner were advised by Elysium Healthcare the Moorlands Neurological Centre would close on the 31st of December. Assurance was given that meetings were taking place with the provider, placing commissioners and NHSE to ensure all individuals were safely transferred to suitable alternative placements.

An update was provided on review health assessments (RHAs). The improvement trajectory was recorded as 15% against a trajectory of 85% in November, however delays have improved to six weeks from six months earlier in the year and are improving month on month. MPFT have put in place a number of actions including a risk management process to ensure the most vulnerable children are prioritised at every opportunity and children are kept safe whilst waiting for an assessment. The committee were asked to note a number of multifaceted factors need to be considered when looking at the trajectory remaining on track, however assurance was given that processes have been reviewed including reviewing from a quality improvement viewpoint.

ASSURE

Infection, Prevention and Control

The committee received an update on infection, prevention and control activity across the system.

The committee were assured by the information presented, however did request more detail be included in future reports on the 'so what' aspects of the work taking place.

The committee were assured that UHNM have been working with the Regional Infection, Prevention & Control Lead to carry out a review of cases with nothing new identified the Trust needed to do around infection rates.

An update was provided on the 'Act now: protect our present, secure our future' letter received from the National Medical Director & AMR Senior Responsible Officer, National Chief Nursing Officer and Interim Chief Medical Advisor for the UK Health Security Agency. The letter is a call to action to make the changes required to meet the targets in the national action plan for antimicrobial resistance (AMR). The committee were assured the objectives set out in the letter will be taken forward by the AMR board.

Perinatal Quality Surveillance

The committee received an update on maternity and neonatal services accessed by women and babies from Staffordshire and Stoke-on-Trent

Work is continuing on the system review of infant mortality. Actions are being progressed through a steering group, with a number of working groups developed to focus on high impact priorities.

Two cases from UHNM were heard by the coroner in October and November. The first case concluded a neglect verdict following the death of a baby in 2023 due to a gross failure of care during labour. The Trust has confirmed all actions have been completed. A Prevention of Future Deaths notice was not issued as the coroner felt this was not appropriate due to the improvement that had been demonstrated. The second case concluded a rare complication of delivery with no care issues identified.

The interim findings from the national maternity inquiry have been published and these are similar to those from previous reviews. The review identified a need to ensure a holistic approach is taken to care provided during the postnatal period. Assurance was provided that work has taken place across the system to standardise postnatal guidance which will be published in the new year.

Quality Oversight Dashboard

The committee received the quality oversight dashboard 2025-26.

A remedial action plan for the wheelchair service was agreed in November with a number of clear objectives to reduce waits. Weekly monitoring is taking place and the latest data showed a week-on-week reduction and an overperformance on the trajectory.

An increase in bank spend at UHNM was highlighted. However, the committee were assured by the Trust that bank spend is being scrutinised carefully to ensure it is being used appropriately.

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

Risk Register

The committee received and noted the Risk Register.

The committee:

- Discussed the proposal to add new risk 1609 Infant and Neonatal Mortality and **Approved** inclusion on the register.
- Discussed the proposal to increase the residual risk score from nine to twelve for Risk 1457 Gaps in AHP Workforce on UHNM Neonatal Unit. The proposed increase was **Not Approved** and the committee asked for further information before approval could be given.
- Discussed the proposed closure of issue 1407 Urgent Care Sepsis Management and **Approved** the closure of this issue.
- Was informed of a potential new risk or issue around the large-scale recall taking place within an acute community dermatology provider and recommended that consideration be given to adding this to the issues log or risk register.

As the committee was not quorate during this agenda item the Chair agreed virtual approval should be sought for all of the recommendations contained within the risk report.

Policies Approved:

None discussed.

Decisions to be Escalated to ICB Board:

No decisions to be escalated.

Report to:	Integrated Care Board			
Date:	29 January 2026			
Title:	Assurance and Performance Report – M08/Nov 2025 Position			
Presenting Officer:	Mish Irvine, Chief of Staff			
Author(s):	Matthew Bewick – ICS Principal Workforce Information & Systems Manager Sarah Machin – Workforce Planning & Information Analyst			
Document Type:	Report	If Other: Click or tap here to enter text.		
Action Required (select):	Information (I)	<input checked="" type="checkbox"/>	Discussion (D)	<input checked="" type="checkbox"/>
	Assurance (S)			<input checked="" type="checkbox"/>
	Approval (A)	<input type="checkbox"/>	Ratification (R)	<input type="checkbox"/>
	<i>(check as necessary)</i>			
Is the decision within SOFD powers & limits	Yes / No	Choose an item.		
Any potential / actual Conflict of Interest?	Yes / No	NO If Y, the mitigation recommendations – Click or tap here to enter text.		
Any financial impacts: ICB or ICB?	Yes / No	YES If Y, are those signed off by and date: Click or tap here to enter text.		
Any impacts on ICB Undertakings?	Yes / No	YES If Y, are those signed off by and date: Click or tap here to enter text.		
Appendices:	Click or tap here to enter text.			
(1) Purpose of the Paper:				(2)
This summary paper provides an update on FY25-26 in year workforce position, position to plan FY25-26 plan and associated risks, challenges and mitigations.				
(3) History of the Paper & Whether for I-D-S-A-R (as above):			Date	
			Click or tap to enter a date.	
(4) Implications:				(5)
Legal or Regulatory	There are several conflicts to the workforce agenda at a national level, i.e. financial control and long term workforce plan.			

CQC or Patient Safety	Workforce has a direct impact on patients and the care they receive. In response to previous wider workforce challenges, Francis report, a number of mitigations have been developed since the report to ensure safer staffing tools and professional judgement are incorporated into staffing level decisions.	
Financial (CFO-assured)	Workforce is the majority of NHS operating costs.	
Sustainability	Need to ensure that workforce levels are safe, sufficiently resourced to deliver patient care.	
Workforce or Training	As detailed in the exec summary below.	
Equality & Diversity	Yes, workforce demographic should be representative of the population served.	
Due Regard: Inequalities	As per Equality and Diversity.	
Due Regard: wider effect	Our workforce is the means in which our patients receive care and is also our biggest asset.	

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

(7) Integration with the System Board Assurance Framework & Key Risks:						
SBAF1	Responsive Patient Care - Elective	<input checked="" type="checkbox"/>		SBAF5	High Quality, Safe Outcomes	<input checked="" type="checkbox"/>
SBAF2	Responsive Patient Care - UEC	<input checked="" type="checkbox"/>		SBAF6	Sustainable Finances	<input checked="" type="checkbox"/>
SBAF3	Proactive Integrated Community Services	<input type="checkbox"/>		SBAF7	Improving Productivity	<input checked="" type="checkbox"/>
SBAF4	Reducing Health Inequalities	<input checked="" type="checkbox"/>		SBAF8	Sustainable Workforce	<input checked="" type="checkbox"/>

(8) Executive Summary, incl. expansion on any of the preceding sections:
<p>All references to position against WTE plan below, pertain to position against the current understanding of the 2025/26 Operational plan. It is acknowledged that, as part of the 2026/27 MTP, work is underway within Providers to recalibrate existing plans. When completed, the outcomes of this work will impact the following positions.</p> <p>Total workforce levels, as at M08, equated to 25,033 WTE which is currently +1,079 WTE (+5%) above the operational workforce plan. This represents a +179 WTE increases from M07 and an overall -56 WTE (-0.2%) reduction since the start of 2025/26.</p> <p>Substantive Workforce (23,127 WTE) is currently at its highest monthly level recorded in data spanning to Mar-19 and +721 WTE (+3%) above plan. Respectively, all staff groups, except for Support to Clinical, are above their corresponding Substantive plans.</p>

Bank Workforce, like Substantive, has seen all staff groups exceed respective plans. Collectively, with 1,743 WTE utilised in M08, Bank is +373 WTE (+27%) above planned levels. In addition, Year To Date (YTD) usage is +848 WTE higher than it was by M08 2024/25 with an additional £7.5m spent.

Agency Workforce, in contract to Bank, continues to remain below planned levels; with the 180 WTE utilised in M08, level remain 15 WTE below plan. The net result is that, for 2025/26 YTD, 1,423 WTE has been utilised; 1,020 WTE (-42%) lower than the same period in 2024/25 and with £7.6m less spent. Agency spend constitutes 1.4% of Total Staffing spend; significantly within the 3.2% target range.

Temporary Staffing overall, in 2025/26 YTD, has seen a -172 (-1.2%) WTE decrease but just a £50k (<0.5%) reduction when compared to the same period of 2024/25. This is because the decrease in Agency spend has been offset by an almost identical increase in Bank spend.

M03

(9) Recommendations to Board / Committee:

People Metrics

November 2025



SSOT Workforce Variance to Plan by Provider NHS Trust (M08)

	SSoT	MPFT	NSCHT	UHNM
Total Workforce (wte)	+1,079 (+5%)	+31 (0%)	+38 (+2%)	+1,010 (+8%) <small>*UHNM are currently +1,092 wte above Funded Establishment</small>
Substantive (wte)	+721 (+3%)	+102 (+1%)	+28 (+2%)	+592 (+5%)
Bank (wte)	+373 (+27%)	-52 (-11%)	+14 (+16%)	+411 (+51%)
Agency (wte)	-15 (-8%)	-19 (-25%)	-4 (-45%)	+8 (+8%)
Reasons for Variation	Position to plan will be addressed, by each Provider, as part of a recalibration process ahead of the 2026/27 Medium Term Plan.			

People Metrics Appendices

- System Monthly Position
- System Trend
- Provider Summary



Staffordshire & Stoke-on-Trent NHS: November 2025

NHS Workforce

Total Workforce

25,033 wte



Substantive

23,127 wte



Bank

1,743 wte



Agency

163 wte



Other Health and Care Workforce

SSOT ICB Workforce

429 wte

Primary Care Workforce

3,524 wte

Social Care Workforce

21,000 wte

Dentistry Workforce

610 Headcount



Temporary Workforce

7.6%

In Month Agency Spend

£1.7M (1.4% of total spend)



Vacancies

1,380 wte (5.6%)

Joiners

155 wte



Leavers

136 wte



12 Month Rolling KPI's (%)

8.3%*

Turnover
Rate



5.6%*

Sickness
Absence Rate



94.3%

Mandatory
Training



87.9%

AFC
Appraisal
Rate



71.5%

Medical
Appraisal Rate



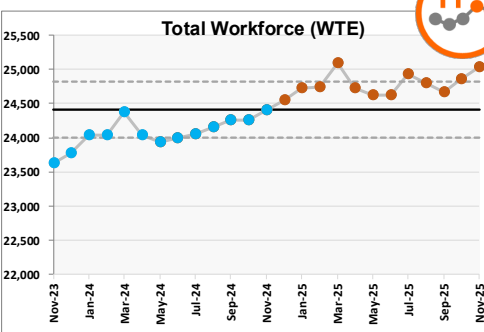
*Oct-25 position shown due to unavailability of Nov-25 Data



Current Workforce Position: November 2025

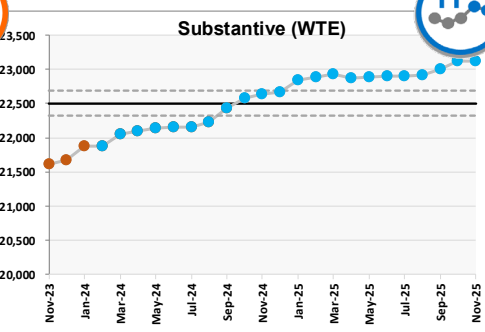
Staff in Post (Total Workforce wte)

Current Month: **25,033**
 Position to Plan: **+1,079**
 12M Change: **+624**
 FYTD Change: **- 56**



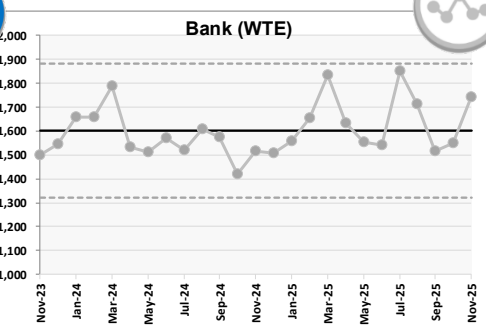
Staff in Post (Substantive wte)

Current Month: **23,127**
 Position to Plan: **+721**
 12M Change: **+486**
 FYTD Change: **+202**



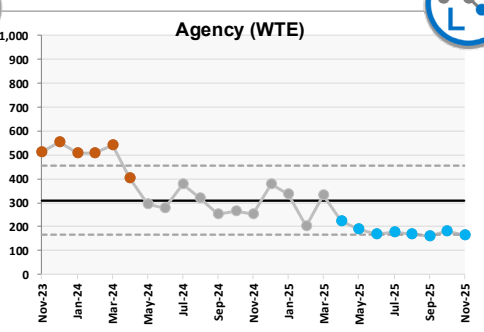
Bank Workforce (Bank wte)

Current Month: **1,743**
 Position to Plan: **+373**
 12M Change: **+ 228**
 FYTD Change: **- 88**



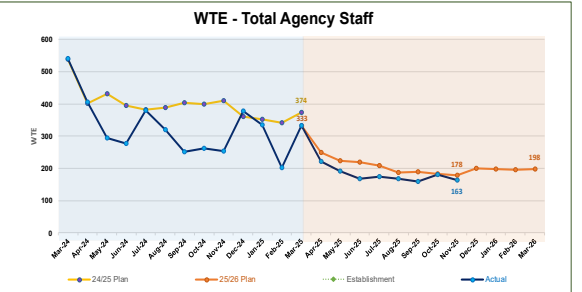
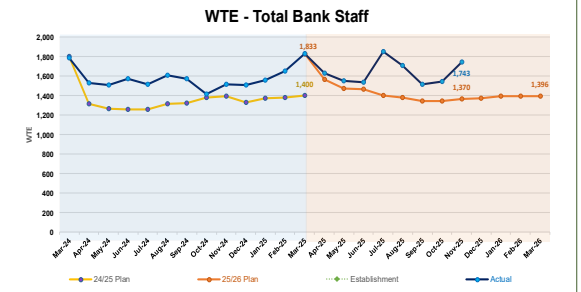
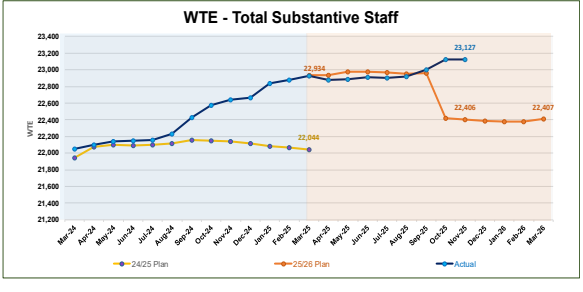
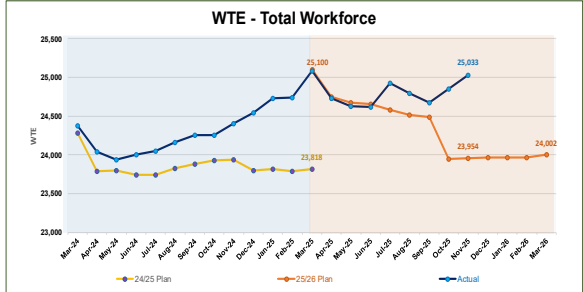
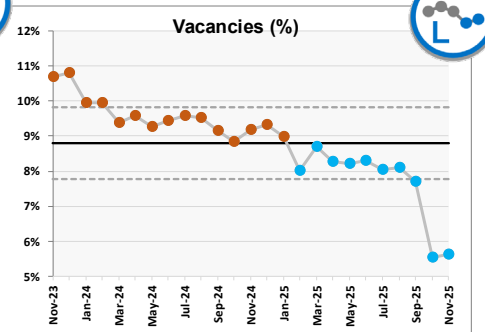
Agency Workforce (Agency wte)

Current Month: **163**
 Position to Plan: **-15**
 12M Change: **-90**
 FYTD Change: **-169**



Vacancies (%)

Current Month: **5.6%**
 12M Change: **-3.5%**
 FYTD Change: **-3.1%**



Total WF - Actual vs Plan
 Overall: **+1,079 wte** above plan
 Registered Nursing: **+359 wte** above
 Registered S,T&T: **+203 wte** above
 Support to Clinical: **+40 wte** above
 NHS Infrastructure: **+174 wte** above
 Medical and Dental: **+305 wte** above

Substantive - Actual vs Plan
 Overall: **+721 wte** below plan
 Registered Nursing: **+315 wte** above
 Registered S,T&T: **+187 wte** above
 Support to Clinical: **-23 wte** below
 NHS Infrastructure: **+173 wte** above
 Medical and Dental: **+71 wte** above

Bank - Actual vs Plan
 Overall: **+373 wte** above plan
 Registered Nursing: **+73 wte** above
 Registered S,T&T: **+15 wte** above
 Support to Clinical: **+94 wte** above
 NHS Infrastructure: **+7 wte** above
 Medical and Dental: **+184 wte** above

Agency - Actual vs Plan
 Overall: **-15 wte** below plan
 Registered Nursing: **-28 wte** below
 Registered S,T&T: **+1 wte** above
 Support to Clinical: **-32 wte** below
 NHS Infrastructure: **-6 wte** below
 Medical and Dental: **+50 wte** above

AAA Escalation & Assurance Report from Committees

Report To:	ICB Board
Date:	29 th January 2026
Reporting Committee / Group:	People, Culture, and Inclusion Committee (PCI) (Part1)
Date of Meeting:	18 th December 2025
Meeting Quorate Y/N?	N (MPFT absent)
Presenter:	Shokat Lal, Non-Executive Director & Committee Chair
Author:	Helen Conway – System Strategic Workforce Planning Lead

Key Escalation & Discussion Points from the Committee Meeting:

ALERT
No escalations.

ADVISE

Quoracy

Although there was no attendance from MPFT, there were no planned decision-making requirements to be confirmed during the meeting which would have impacted on the outputs of the committee.

Strategic System updates (CPO's):

ICB:

The Committee discussed the ongoing developments of the reform activities that continue since the launch of the ICB Model Blueprint and subsequent activities to implement this locally. The Committee was notified of the confirmation of several cluster executive team appointments that have now been confirmed:

- **Claire Skidmore – Chief Financial Officer**
- **Phil Smith – Chief Officer System Development and Integration**
- **Dr Lorna Clarson – Chief Officer of Strategy and Improving Outcomes**
- **Mish Irvine – Chief of Staff**
- **Dr Rachel Gallyot – Interim Chief Medical Officer**
- **Heather Johnstone – Interim Chief Nursing and Therapies Officer.**

Alongside this a voluntary redundancy window has been opened to enable all employees at all levels of the ICB opportunity to exit the organisation electively. This is ahead of a planned management of change programme.

A number of activities are underway, not least, the development of a system redeployment process which will support those at risk in obtaining other opportunities within the NHS, enabling redundancy to be the last resort. It was however acknowledged these opportunities are somewhat limited due to the management of change activities underway in our providers also and the sheer extent of change underway within the NHS.

Providers:

All providers shared the significant pressures due to seasonality and the impact of the immediate challenges of resident doctor industrial action commencing 17th Dec for a period of 5 days. All organisations are focused on efficiency and given that provider workforce accounts for 70% of overall costs, all providers are working through workforce approaches which have so far exhausted options such as Mutually Agreed Resignation (MARs) and are now embarking/in process of management change of activity.

NHS England update

Although present for the meeting, the representative advised that there was no update to be provided to the committee.

ASSURE

Performance, Planning and Finance:

The Committee was updated on the workforce position, performance to 25/26 operational plan and people metrics.

2025/26 Operational Plan

Workforce

The Committee were reminded of the FY25-26 planning intent which planned for a reduction in workforce by Mar-26 of circa 1,100 wte overall which is a reduction of 4.4% which was and continues to remain a significant challenge.

The system workforce wte (substantive + bank + agency) was 24,853 wte in Oct-25. This is a reduction since FY25-26 month 1 of 235 wte. Month 7 workforce numbers were +908.5 WTE above plan respectively in both substantive (+720.9 wte) and bank (+373.4 wte) and below plan for agency (-14.9 wte). This is also in context of an action which is being overseen by the Finance and Performance Committee (FPC) via the System Performance Group (SPG) in which providers have been asked to reprofile the FY25-26 (M8-12) based on M7 actuals. This was recognised to also be an ongoing action to inform the Medium-Term Plan (MTP).

Finance

An overview of the MTP activity was provided and the changing context of the reform activities on the respective partner organisation obligations of planning, i.e. the role of the system in the process itself and an aggregated provider position will be developed now planning submissions have been received. At the point the meeting was held and appreciating the development of the plans and submission is a developing and live position, further work will be completed ahead of the final submission of MTP planned for Feb-26.

People Metrics

The people metrics were noted and assurance received by the Committee regarding ongoing monitoring and mitigation to improve metrics.

Sickness Absence Deep Dive

The committee were shared an overview on the sickness absence focused activities which shared an overview of the position on sickness absence and the support efforts which are underway to target the sickness absence drivers which are continuing to contribute to a heightened sickness absence position. The Committee was assured that a robust deep dive was undertaken, and work was ongoing within Providers and at System to monitor and improve the health and wellbeing of our workforce.

Inclusion Journey

Some variation in the indicators and although there has been significant progress made, there continues to remain a continued focus on this area required. Concern was raised in terms of the reform piece and a need to maintain focus on this area going forward.

Winter Surge Plan

An update on the winter surge plan was provided following an update to the last PCI in respect of the sign off, of the plan. This included an update on the winter position hitting earlier in September and October, which has posed some significant challenges in terms of winter effectively hitting earlier. These challenges are relating specifically to ambulance handover delays. From a workforce perspective there was a stretch target set from NHSE in respect of improving vaccination take up by 5% and at the time of the meeting this had been exceeded at 8%, however it is vital work continues to increase this uptake. The Committee recognised the challenge in meeting the operational plan targets against the context of a challenging Winter and workforce availability and gained assurance around Providers actions in place to mitigate.

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

Risk Register

The Committee received the people risk register. There was discussion concerning the alignment of the frequency of the PCI (bi-monthly) and reporting of risk which is required monthly. It is recommended that consideration be given to the frequency of the update of the risk register.

Whilst the risk report identifies alerts and reduced assurance in management of risks, it is recognised that the PCI Sub-Committees and CPOs continue to monitor and implement the mitigating actions. Further review of the risks is currently being undertaken with all mitigating actions in place clearly articulated. The Committee was assured that a robust review will be undertaken and acknowledged the current context around meeting frequency.

Policies Approved:

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

Decisions to be Escalated to ICB Board:

Nothing for escalation to ICB Board or other Committees.

AAA Escalation & Assurance Report from Committees

Report To:	Integrated Care Board
Date:	29 th January 2026
Reporting Committee / Group:	Staffordshire and Stoke-on-Trent Health and Care Senate
Date of Meeting:	13 th November 2025
Meeting Quorate Y/N?	Yes
Presenter:	Rachel Gallyot, Interim Chief Medical Officer and Senate Chair
Author:	Rachel Gallyot

Key Escalation & Discussion Points from the Committee Meeting:

ALERT
None.

ADVISE
<p>1) Integrated Medicines Optimisation Group (IMOG) Approvals – September 2025</p> <p>a) One NICE TA for the specialist NHSE funded drug Fruquintinib was considered and recommended for entry onto the formulary as a RED drug.</p> <p>NICE TAs for ICB funded drugs were summarised and it was noted that all of them were specialist drugs for conditions such as severe eczema, ulcerative colitis and Crohn’s disease and were all recommended for entry onto the formulary as RED specialist only drugs.</p> <p>b) IMOG approved the updated clinical pathway for Ulcerative Colitis disease to include Guselkumab.</p>

- c) IMOG approved the updated clinical pathway for Crohn's disease to include Guselkumab.
- d) IMOG approved the clinical pathways for use of biological drugs:-
 - SSOT moderate to severe psoriasis biological pathway.
 - SSOT psoriatic arthritis biological pathway.
 - SOT axial spondylarthritis biological pathway.
- e) IMOG approved local asthma treatment guidelines. These local guidelines supplement NICE guidance by specifying preferred local inhalers and practical advice. The local guidelines are split into 4 age groups: Under 5 years; 5 to 11 years; Age 12 years to 17 years. Key changes include reduced reliance on bronchodilators, earlier introduction of steroids for younger patients and wider use of MART therapy (long-acting beta antagonist (LABA) with an inhaled corticosteroid (ICS)), for older groups.
- f) The COPD guidelines were presented, reflecting West Midlands consensus and removing previous recommendations for LABA-ICS dual therapy in favour of triple therapy long acting antimuscarinic agent (LAMA)/LABA/ICS, where ICS is needed. The team modelled the costs impacts of the new Asthma and COPD prescribing patterns and concluded that increased costs should be managed as normal inflationary pressures, within routine budgeting.
- g) IMOG approved the Emollient Formulary Choices Guide, which is to assist prescribers in recommending and prescribing emollients for patients and has been developed with input from UHNM dermatologists.
- h) IMOG approved the reclassification of high strength aflibercept from BLUE to RED, following publication of a national pathway on the treatment of age-related macular degeneration (AMD).
- i) Medicines shortage guidance was shared for information and did not require approval. The guidance has been developed after a fatality linked to an anti-epileptic medicine shortage.

Following the presentation the following clarification points were provided: -

- Asthma patients should not be treated with SABA alone and such cases require clinical review.
- Communication practices to be reviewed in respect of the biological drugs pathways and the Senate to have oversight of this work.
- Guidance will be circulated to frontline clinicians. There will be a broader implementation strategy including webinars and Tier 3 training, incorporating guideline review and practical workshops on inhalers and formulary aligned products.

The Senate **approved** IMOG decisions a) – h) from the meeting held on 3rd September 2025.

2) Management of Dry Eye in Primary Care: Guidance for Clinicians

The new Dry Eye Guidance was presented. The Guidance aims to help clinicians stratify patients, by severity, and direct them to appropriate treatments, including clear pathways for both new and existing presentations. Supporting materials include a patient leaflet, on self-care and over the counter options, and a template letter for practices. The Quality Improvement Framework (QIF) 2025/2026, will be used to incentivise deprescribing, where appropriate. There has been systemwide engagement in development of the guidance,

including collaboration with the Local Optical Committee (LOC) who provided advice on ensuring alignment, with the existing community urgent eyecare service (CUES). The guidance was also reviewed by Planned Care and amendments made based on feedback.

Following the presentation the following clarification points were provided: -

- Conjunctivitis is part of national self-care guidelines, and the LOC will remind optometrists to avoid unnecessary GP prescription requests.
- It is accepted that secondary care prescribing is a major factor, and the guidance represents an essential first step towards wider pathway redesign.
- It was suggested that wording should be added to clarify that the list of over-the-counter examples are not exhaustive and that the formulary process should be reviewed to ensure that governance is followed. It was agreed that these points would be addressed outside of the meeting.
- The work undertaken was commended. It was noted that there was a need for full alignment with secondary care to complete the pathway.

The Senate **approved** the Primary Care Dry Eye Management Guidance with caveats noted regarding formulary governance and secondary care alignment.

3) System Elective Strategy

The development of the System Elective Strategy commenced in May 2025, and it has been reviewed by the Elective Programme Board on 23/09/2025 and the Planned Care, Cancer and Diagnostics Board on 23/10/2025. The strategy involved extensive engagement, across multiple portfolios, including Planned Care, Communications, Digital, Workforce, Children and Young People and Sustainability. The strategy also involved engagement with providers including UHNM, MPFT, UHDB and RWT as well as NHSE and the upper tier Local Authorities. The strategy spans adult and paediatric populations and aims to deliver timely, equitable, high quality, patient centred care across Staffordshire and Stoke-on-Trent. There are 5 key objectives including population health and inequalities, innovation and digital technology, high quality patient centred services, optimising capacity and reducing waiting times, and system resilience and sustainability. The delivery of the strategy will be overseen by the Planned Care Portfolio Board and individual delivery plans will be developed for implementation. The strategy is 5 years in duration with an annual review, to ensure alignment with the evolving national guidance and operational planning.

Following the presentation the following clarification points were provided: -

- Work on Waiting Well initiatives is already underway and a stocktake will be undertaken to identify gaps and actions.
- The importance of recognising mental health and wellbeing support for patients, with chronic conditions, was discussed. The strategy broadly addresses long term conditions and psychosocial support will be considered further, during delivery planning.
- High risk cohorts where elective procedures may not improve quality of life will be taken into consideration within the implementation plans.
- The strategy should evolve, with the strategic commissioning context, and clustering arrangements. Regular updates will be provided to the Senate, around implementation, and progress will be reviewed annually, or as significant changes occur.

The Senate **approved** the System Elective Strategy.

4) Pneumonia Management Pathways

A systemwide working group was established in 2024, as part of the Recovery Programme, to address pneumonia management, due to high readmission rates and pathway issues across primary and acute care. The group developed pathways for primary and acute care management, a discharge bundle and public facing resources, for prevention and self-management. Collaboration has been undertaken, with the provider collaborative and clinical interest group, to ensure coordinated implementation and behaviour change interventions. The Senate was asked to approve the pathways to progress to the delivery phase, noting that the Quality Impact Assessments and Equality Impact Assessments are underway but not yet approved.

Following the presentation the following clarification points were provided: -

- The inclusion of mental health considerations in the discharge plan was noted. The importance of supporting vulnerable patients with Chronic Obstructive Pulmonary Disease (COPD) and other chronic illnesses, with preventative care, including prophylactic antibiotics, was raised. Assurances were provided that the pathway incorporates British Thoracic Society (BTS) guidelines on prevention and that a learning module is being developed to address pneumonia prevention in vulnerable cohorts including those with mental health, learning difficulties, dementia and neurological conditions.
- The importance of finalisation of the QIA process, for governance purposes, was discussed and assistance was offered in completing the QIA process by the Deputy Chief Nurse.

The Senate **approved** the Pneumonia Management Pathways and evidence based active implementation, subject to completion of the QIA and formal governance checks.

ASSURE

None.

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

The Senate received the Q2 update of the SBAF and Risk Register for information.

Policies Approved:

None discussed.

Decisions to be Escalated to ICB Board:

- a) The Senate **approved** IMOG decisions a) – h) from the meeting held on 3rd September 2025.
- b) The Senate **approved** the Primary Care Dry Eye Management Guidance with caveats noted regarding formulary governance and secondary care alignment.
- c) The Senate **approved** the System Elective Strategy.
- d) The Senate **approved** the Pneumonia Management Pathways and evidence based active implementation, subject to completion of the QIA and formal governance checks.

AAA Escalation & Assurance Report from Committees

Report To:	Board
Date:	29 th January 2026
Reporting Committee / Group:	Remuneration Committee
Date of Meeting:	11 th November 2025
Meeting Quorate Y/N?	Yes
Presenter:	Shokat Lal
Author:	Stacey Robinson

Key Escalation & Discussion Points from the Committee Meeting:

ALERT
ADVISE
ASSURE
<p>Appointment of Cluster Executive Team Committee members received and approved a report providing assurance around the creation of the new cluster executive team roles, the pay and terms and conditions framework for those roles, the pay principles and pay ranges applicable to each new cluster role. The Committee also approved the appointment of the successful candidates, approved the exit and redundancy process for the candidates who were unsuccessful in obtaining a role, approved the extension of the interim SSOT Medical Director arrangements and approved the pay parameters for the payment of the cluster Deputy Chief Executive.</p> <p>Following the Committee’s approval of the exit and redundancy process for those who were unsuccessful in obtaining a role, individual redundancy business cases have been submitted to NHSE for their approval prior to notice being issued.</p>

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

N/A

Policies Approved:

N/A

Decisions to be Escalated to ICB Board:

N/A

Accessibility Hints and Tips ****DELETE BEFORE FINALISING****

Use the Accessibility Checker

Why is this important?

Helps catch issues that might impact accessibility.

Tips:

1. Go to the **Review** tab in the Ribbon.
2. Click **Check Accessibility**.
3. A pane will appear on the right side of the screen labelled **Accessibility**.

Use Headings Properly

Why is this important?

Screen readers use heading levels to navigate documents.

Tips:

Use built-in styles like **Heading 1**, **Heading 2**, etc., for structure.
Avoid using bold or larger font sizes to simulate headings.
Maintain a logical order (e.g., Heading 1 > Heading 2, not Heading 1 > Heading 3).

Make Tables Accessible

Why is this important?

Screen readers rely on proper structure to read tables accurately. Poorly constructed tables can confuse users and prevent them from understanding your data.

• Tips:

Use simple table structures
Avoid merged or split cells, especially in header rows.
Keep tables as simple as possible - complex nested tables or multi-level headers can cause issues with accessibility tools.
Avoid leaving blank rows or columns
If the table spans multiple pages, go to Table Layout > **Repeat Header Rows** so headers appear on each page.

Test Table Navigation:

Try navigating your table using only the keyboard:

Use **Tab** and **Arrow keys** to move through cells.
Ensure the reading order makes sense.

Merging PDFs

When merging with other supporting materials ensure content owners have checked each individual PDF is fully accessible *before* merging.

For further guidance see our 'Accessibility Hints and Tips Sheet for Microsoft Word'.

AAA Escalation & Assurance Report from Committees¹

Report To:	ICB Board
Date:	29 January 2026
Reporting Committee / Group:	Strategic Commissioning & Transformation Committee (SCTC)
Date of Meeting:	14 January 2026
Meeting Quorate Y/N?	Yes
Presenter:	Mike Lawton, ICB NEM and SCTC Chair
Author:	Vanessa Ridout, Executive Assistant

Key Escalation & Discussion Points from the Committee Meeting:

ALERT

There were no alerts for the Committee.

ADVISE

Betley Surgery Options Paper (for approval)

The Committee was presented with a report which detailed the options available to the ICB regarding the future commissioning arrangements of Betley Surgery. The Committee was asked to approve Option 1 – List Dispersal.

It was noted that both Dr Lorna Clarson and Elizabeth Mellor declared an interest in this report due to connections with the Keele Practice so would not be involved in the decision making.

The GP Partners handed back their GMS contract on 12 October 2025 with 6 months' notice, the contract will come to an end on 31 March 2026.

The paper detailed two options for future provision:

- 1) List Dispersal
- 2) Competitive Tender for a new APMS contract.

Two further options were explored by the partners prior to handing back the contract: to bring a new partner onto the contract and to look at a merger with a nearby practice. Neither of these options were viable due to estate and financial constraints.

The paper sets out the advantages, risks and mitigations for both options and following a QIA and EHIA process and makes the recommendation to disperse the list.

The Committee **approved** the recommendation – List Dispersal.

Urgent Treatment Centre Designation (for Approval)

SCTC were asked to approve the proposed designation of Urgent Treatment Centres (UTCs) across Staffordshire and Stoke-on-Trent.

SSoT ICS designates the following sites as standalone UTCs

- Haywood Hospital
- Sir Robert Peel hospital

- Samuel Jonso Hospital
- Leek Moorlands Hospital

Furthermore, co-located UTC are designated at

- Royal Stoke Hospital
- Queens Hospital Burton

A co-located UTC at County Hospital is planned but deferred until 2026/27

Cannock MIU does not meet UTC criteria presently and remains temporarily closed. The Cannock service will be assessed via alternative service change forums to agree plans/next steps

The recommendations have been formed from discussions undertaken as part of the extensive UEC transformation workstream and have been refined via a series of UTC Technical Event sessions, with representation from all system partners, neighbouring providers and other pivotal partner organisations.

The revenue cost implications have been reviewed at System Finance and Performance Committee and revenue funding for the Royal Stoke UTC site has been approved. A further business case in relation to County Hospital UTC is expected in quarter 4 and will be progressed via the appropriate governance once assessed.

Each of the proposed UTCs are assessed individually and relevant points to consider are presented to add context to the decisions required to ensure designation. In addition, the next steps within the process are outlined, giving a clear roadmap to full designation and the further work and assurance required to ensure that proposals are taken forward safely and in line with regional and national NHSE processes

The Committee **approved** the proposed designation of UTCs across Staffordshire and Stoke-on-Trent.

ASSURE

ICB Five Year Commissioning Plan (for information/assurance)

The Committee received an update on the 5 Year Strategic commissioning plan which sets out how national and local ambitions will be delivered. Development of the plan is underway using a cluster-based approach across the cluster while allowing flexibility for Staffordshire and Stoke on Trent's specific requirements. This approach supports coherence in overarching themes and collaborative working.

Portfolios and relevant directorates are responsible for drafting their respective sections, which will include health and population context, commissioning intentions, finance and workforce plans, transformation and new care models, digital and infrastructure enablers, and risks and mitigations. The first draft of the plan is currently in progress and will be completed as a draft by 16th January. The development process is on track and compliant with national guidance. The cluster-based approach and portfolio ownership model provide assurance that the plan will deliver a consistent narrative where appropriate while maintaining flexibility for local priorities.

A detailed discussion took place on this item.

Governance and Meeting Structures (for information/discussion)

The Committee received a verbal update in respect of the future direction of travel for meetings. Cluster ICBs will work increasing more as 'one in common' but will remain two statutory organisations in terms of annual accounts and annual reports. The first Board meeting in Comon will take place on 29 January 2026.

Areas of concern raised were around the delegated responsibilities of committee and the remit of individual sub committees.

Work will take place to bring together the SCTC (SSoT) and the Strategic Commissioning & Productivity Committee (SCPC) (STW).

ICS Green Plan Quarterly Update (for information and assurance)

The Committee received the report which provides an update on the work ongoing within the system to deliver the ICS Green Plan against the following ambitions.

- Green Delivery Plan and System Objective/Ambition
- Primary Care
- Sustainability Impact Assessment (SIA)
- Travel and Transport Surveys
- Net Zero Clinical Transformation
- Heat Decarbonisation Plans
- ICS Clear Air Framework

The Committee was **assured** of the progress being made by the system to deliver the local green plan and performance against regional targets.

Public consultation Update – Birthing services previously provided at county Hospital and Samuel Johnson Community Hospital (for assurance)

The Committee received an update on the formal public consultation on birthing services previously provided at County Hospital Stafford and Samuel Johnson Community Hospital in Lichfield. The formal consultation took place between 12 May 2025 and 3 August 2025. During the public consultation it was highlighted that there were elements of antenatal care that were in place prior to COVID-19 at Samuel Johnson Community Hospital that have not been reinstated. As this was not included within the PCBC, the recommendation from the technical group is to complete an additional 4-week engagement piece targeted at UHDB to gather the views of women and their families on this element of the pathway.

The Committee **noted** the contents of the report.

Primary Care Contract Change (for Information)

The Committee received a presentation on the new contact changes for general practices which came into effect on 1 October 2025. This included

- Online consultations – practices are required to keep their online consultation tool open from 8.00am until 6.30pm for all non-urgent requests. 95% compliant.
- GP Connect – this functionality connects read only access to patients care records for the purposes of direct patient care by other NHS commissioned providers. Private providers need to have explicit permission from the patient to access their NHS care record. Record access – 100% Structured access 87%
- You and Your General Practice – This refers to the Patient Charter which must be displayed on each practice websites. 100% compliant
- Doors and Phones Open for Core Hours – Must be open between the core hours of 8.00 am and 6.30 pm. Doors 98% compliant. Phones 100% compliant.

The Committee **received** the update.

Primary Care Forum (PCF) Triple A report (for information)

There were no alerts for the SCTC.

Key points from the PCF included:

Primary Care Financial Position – Month 8

Still reporting understand on the primary care budgets. These underspends are all non-recurrent.

Additional Space Requests – Trent Meadows Medical Centre

An application was made for additional rent re-imburement for 3 clinical rooms that Midlands Partnership NHS Trust have recently vacated. The space is now void and therefore a cost pressure to the ICB. The recommendation is to support the application as the practice has recently increased their boundary due to population growth and new housing developments that surround the practice. This was approved.

Pharmacy, Optometry and Dental Services

An update was provided to the PCF. SJ suggested exploring at a future meeting an update on progress on dental activity. ML agreed for this to be brought back to a future meeting.

GP Quality Variation Dashboard

Was considered in a lot of detail and a confidential update has been sent to the confidential members of the Committee.

The Committee **received** the update.

Health Literacy (for information)

SCTC received a presentation on Health Literacy. As part of the Health Inequalities Strategy a lot of engagement has taken place with communities and partners. Some of the feedback received was about people understanding information about their own health and being able to access and act on that. A health literacy programme has been developed and feedback from the local authorities locally was that this was probably the most impactful thing to do as a system together to help people understand the information that is available.

The Committee **received** the update.

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

The SBAF had been circulated off line prior to the meeting for any comments or feedback. No comments or feedback were received and therefore the SBAF was signed off by the Committee and would be submitted to the Boards in Common on 29 January 2026.

Policies Approved:

There were no policies submitted to the Committee for approval.

Decisions to be Escalated to ICB Board:

There were no decisions to be escalated to the Board.

AAA Escalation & Assurance Report from Committees

Report To:	STW/SSOT Board "In Common"
Date:	29th January 2025
Reporting Committee / Group:	Remuneration Committee
Date of Meeting:	20 th November 2025
Meeting Quorate Y/N?	Yes
Presenter:	Shokat Lal
Author:	Stacey Robinson

Key Escalation & Discussion Points from the Committee Meeting:

ALERT
ADVISE
ASSURE
<p>The Staffordshire and Stoke-on-Trent Remuneration Committee held a meeting in common with Shropshire, Telford and Wrekin Integrated Care Board Remuneration Committee to discuss the following:</p> <p>Voluntary Redundancy Scheme The Committee considered the nationally approved voluntary redundancy scheme, noting the scheme will allow staff to make their own decisions about their future. Committee members acknowledged the sensitivity in relation to this subject and the impact on the wellbeing of staff. The proposal to proceed with the VR Scheme was approved.</p> <p>Interim Chief Medical Officer Arrangements The Committee received a proposal around the interim arrangements for the Cluster Chief Medical Officer role noting the salary offer is aligned to the VSM pay framework. The Committee approved the proposal.</p>

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

Policies Approved:

N/A

Decisions to be Escalated to ICB Board:

N/A

AAA Assurance Report to Board – Transition Committees in Common

Report To:	SSOT ICB Board – January 2026, ‘In-Common’
Date:	29th January 2026
Reporting Committee:	NHS Staffs & Stoke-on-Trent (SSOT) and NHS Shropshire Telford & Wrekin (STW) Transition Committees in Common
Date of Meetings:	Meeting 1 (25th November) and Meeting 2 (23rd December)
Meetings Quorate Y/N?	YES
Presenter:	Ian Green, Committees in Common Chair & ICBs Cluster Chair
Author:	Paul Winter, Associate Director of Corporate Governance

Key Escalation & Discussion Points from the Meetings:

ALERT

Principal ALERT Escalations to ICB Board =

- **Our new “In-Common” approach to Committee Operations:**

Members welcomed the first two meetings held in common of the SSOT-STW Transition Committees. This approach had been agreed back in late summer by the then 2 separate ICB Chairs. This underpins a wider Cluster joint working model – as agreed by both Boards in November. With “Cluster” Boards & Committees governance structures developing and refining prior to April 1st, 2026, full implementation of joined up ‘two-into-one’ meetings supporting the NHS Reset Transition.

Members discussed and reviewed the generally understood governance requirements for any meetings held ‘in common’ style, noting that two separate sets of minutes and action lists are typically required. It was instead agreed to adopt a pragmatic, streamlined approach by maintaining a single combined Action Log and using one set of paperwork / minutes, featuring joint logos.

In this way, keeping administration and work programme duplication risks to a minimum while still protecting the sovereignty of the two ICBs. [SSOT members had also approved a proposed draft set of Terms of Reference for a more substantive replacement ‘Joint Committee’ version – essentially the same as agreed for in-common yet with single versions of everything, including memberships.]

- **People Update – ICBs’ Management of Change (MOC) and Voluntary Redundancy (VR):**

A VR Scheme proposal was approved at Cluster Remuneration Committees on 20th November, running from December 1st-22nd across both ICBs. Exec & HR Panels initially assess business continuity and eligibility. Then a VR Moderation Panel reviews outcomes to ensure consistency, with recommendations submitted to Remuneration Committees (subsequently to NHSE) with applicants expected to be notified week commencing 26th January.

Successful applicants will receive written confirmation and meet with their Line Manager to discuss notice periods. Staff will also receive a national template settlement agreement, which must be signed within ten working days. Notice periods will vary between 4-12 weeks, starting from the date of approval. With most agreements anticipated to be finalised between mid / late February.

The scheme is nationally governed and therefore its terms cannot be amended locally. However, adjustments to eligibility criteria are permitted and will be applied. There is ongoing engagement with Staff / Staff-side colleagues, including detailed Frequently Asked Questions. Members acknowledged this matter is beyond local control and requested a clear commitment to fairness, consistency, transparency and support throughout, recognising the challenges faced by staff.

MOC Phase One is complete, with newly appointed Execs commencing their new roles from 1st December following approval from NHS England. Phase Two commences for the remaining Senior Leadership Team (SLT) + Exec Direct Reports from early/mid-January.

ALERT (continued)

- **People Update – ICBs’ Management of Change (MOC) and Voluntary Redundancy (VR):**
Members noted the complexity of running multiple processes in parallel and stressed the need to clarify high-level timelines, while remaining true to the £19 per head allocation challenge and ensuring that outcomes are both fit for purpose and financially sustainable. Colleagues noted that the high volume of VR applications may make a significant contribution to meeting the required savings; and could reduce the need for compulsory redundancies, while also potentially helping staff morale by giving individuals greater choice and control over their outcomes.

The development of integrated staff / function structures are being worked on during MOC Phase Two with SLT colleagues to ensure their input and support. A robust HR Framework outlines the process; and is supported by Equality & Quality Impact Assessments to ensure equity and fairness. The individual ICB accounts remain in place and redundancy costs / accruals will be managed and reported separately for each ICB, with oversight provided by the respective Audit Committees.

ADVISE

Principal ADVISE Items for ICB Board Awareness =

- **Operating Model per NHS ‘Blueprints’:**
Cluster ICB organisational charts are currently being drafted, with the emphasis on the existing structures being transitional and will evolve as Phase Two of the MOC progresses. The final timeline for the structure will be communicated once confirmed.
- **Accommodation / Office Working:**
Staff within SSOT ICB will be consulted regarding their base of work later in 2026, with an expectation of being “hybrid” (office based) for 40% of their time. Significant work is required in relation to Estates and is ongoing. The next steps will be communicated once finalised.
- **ICB Transition Workstream ‘Feeder Groups’ Updates:**
A single-page ‘SITREP’ sets out the four key workstreams’ updates to the Committees in Common - ref. Transition Programme Group / Workforce & People Function / ICB Governance & Merger / CSU Task & Finish Group. Matters of concern are escalated through the SITREP, the latest covering - Potential destabilisation arising from the NHSE VR scheme; the implications of implementing the ‘Regional Blueprint’; and ICB Model Blueprint changes relating to EPRR & SCC functions.
- **ICB Governance Update:**
NHSE is working with both ICBs on making certain Cluster-facing ICB Constitution changes in order to align with the wider intent of NHS Transition Reset guidance per ICB Blueprint & Strategic Commissioner Framework. Principally on Cluster Board Composition and roles, though also including how the ICB Standing Orders should be harmonised.

The January Boards in Common meeting will receive a detailed paper that signals an early intent to merge, while engaging with NHSE on clarifying the wider process, timeline and preparatory steps required. As needed for Clustering first, then with potential future ICB merger options that build on Cluster Governance. Including alternative structures (e.g. Joint Boards Committee, Partnership Board, expanded ICB Board development sessions to address ICS Partner concerns prior to any formal consultations to be held after a decision to merge has been taken).

- **Update on CSU / Shared Services:**
CSU Commissioning Support service lines (functions) are RAG-rated for areas reflecting possibly fragile services or areas of business continuity risk, as a result of CSU’s own VR processes and the re-procurement timelines for payroll, employment services and Transforming Care. Potential staff transfers are being developed, where some staff may transfer earlier than others depending on the

service line. CSU costs are already included within financial baselines, meaning that NHS Transition primarily changes employment status rather than introducing additional costs. Future reports will include indicative financial data for both incoming and outgoing services.

ADVISE (continued)

- **Update on CSU / Shared Services:**

A brief update on the status of 18 potential ICB services marked for future transfer was provided, outlining the ongoing moderation process with regional oversight. The Transition Programme Group continues to conduct operational diligence assessments, with the Committees providing assurance to their Boards. The Programme Workstream committed to bringing more detailed financial and operational updates in future meetings.

ASSURE

Principal ASSURE Items for ICB Board Assurance =

- **Transition Committees – future Governance, including Committee Membership:**

All Non-Executive Members will continue to attend Transition Committee meetings in common to ensure comprehensive oversight and shared understanding of all transition activities, while providing for one space where these detailed internal assurance discussions are being held. Colleagues remain aware that the pace is very fast moving and highlights the need to have the appropriate level of governance in place and pre-Cluster circumstances are not unduly slowing things down.

Additional or more frequent meetings may be necessary to respond to the fast-moving nature of the transition, ensuring timely decision-making and governance. Including the merging of operational / organisational plans, particularly as planning cycles progress, to ensure that streamlined governance structures support delivery across both ICBs. Acknowledging the significant demands placed on Execs / Staff and committing to avoiding unnecessarily added workloads.

- **Proposals for Transition Committees to move to a Full Joint Committee:**

As reported, both Boards agreed in November to move to an In-Common then Joint Committee model, with a Governance Plan created to implement this across all Committees (noting that some may transition more quickly than others, depending on complexity and level of readiness). This remains a significant programme of work and emphasises the need to correctly sequence committees and the timing of transitions from single to In-Common to Joint basis. The medium term strategic direction is to progress toward ICB merger; and stresses the importance of following a clear and orderly pathway, implementing the changes correctly rather than rapidly, ensuring that governance arrangements are well managed throughout. Governance Team capacity remains crucial, particularly during the VR process, highlighting the need to co-ordinate timing and prioritise business-critical elements to avoid overextending resources during Transition.

Risk Management Assurances:

- **ICB Transition Risk Register:**

This is now aligned to individual Workstreams; with each required to report on risk mitigations via their routine SITREP and with their escalations updating the Risk Register.

Policies Approved:

Not Applicable

Decisions to be Escalated to ICB Board:

- ☑ **To ASSURE the Board** of the latest meetings of the Transition Committee; and those governance items it has agreed & approved;
- ☑ **To ASSURE the Board** of the continued reporting beyond the Committee in terms of proactive engagement with ICB staff and the need to keep staff informed / involved to maintain morale and deliver a smooth transition through usual engagement methods.