NHS STW/SSOT Integrated Care Board

PUBLIC

Agenda Papers

MEETING
25 June 2026 13:30

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Shared Agenda for Meetings in common of:

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

Integrated Care Board

Thursday, 25 June 2026 / 1:30pm

Room 1, Wellington Civic Offices, Larkin Way, Tan Bank, Wellington, Telford, TF1 1LX

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

	Agenda Item	Lead	Purpose	Format	Time
OPENING MATTERS					
(1)	Welcome and Apologies	Chair	I	Verbal	1:30
(2)	Declarations of Interest: To declare any new interests or existing interests that conflict with an agenda item	Chair	I	Verbal	
(3)	Minutes from previous meetings	Chair	A	Enc.01 Enc.02	
(4)	Matters Arising / Actions from previous meeting	Chair	I/D	Enc.03	
(5)	Questions from members of the public	Chair	I	Verbal	
(6)	Resident Experience	Comms Team	I/D	Enc.04	
STRATEGIC DEVELOPMENT AND OVERSIGHT					
(A)	**ICB Cluster:**				
(7)	Chair's Report	Chair	I/D	Verbal	2:00
(8)	Chief Executive Report	Simon Whitehouse	I/D	Enc.05	2:05
(9)	EPRR Annual Assurance 2025-26	Phil Smith	A/R	Enc.06	2:15
(10)	Annual FTSU and Whistleblowing Review (NHSE Report) 2025-26	Mish Irvine	S	Enc.07	2:25
(11)	Fit and Proper Person Test annual declarations / attestations	Chair	S	Enc.08	2:30
(12)	The Involvement Strategy (Working with People and Communities)	Mish Irvine/Adele Edmonson	D/A	Enc.09	2:35

(13)	The PSED reports for the population across the cluster	Mish Irvine	I/S	Enc.10	2:45
(14)	Workwell and Widening Access Demonstrator Programme	Mish Irvine	I/S	Enc.11	2:55
(15)	Urgent and Emergency Care – Urgent Treatment Centre Designation	Phil Smith	R	Enc.12	3:05
BREAK 10 MINUTES 3:15					
GOVERNANCE AND PERFORMANCE					
(16)	Integrated Performance Report	Claire Skidmore	S/D/I	Enc.13	3:25
(17)	'Triple A' Board Committee Highlights Reports				3:35
	a) In Common:				
	Finance Committee	Mike Lawton	S	Enc.14	
	Transition Committee	Paul Edmonson-Jones	S	Enc.15	
	Audit Committee	Roger Dunshea	S	Verbal	
	Remuneration Committee	Shokat Lal	S	Enc.16	
	Strategic Commissioning & Transformation Committee	Trevor McMillan	S/R	Enc.17	
	Quality and Performance Committee	Cheryl Etches	S/A	Enc.18	
	People, Culture and Inclusion Committee	Mish Irvine	S	Enc.19	
	b) STW:				
	Shropshire Place Partnership Committee	Tanya Miles	S/D	Enc.20	
	Telford & Wrekin Place Partnership Committee	David Sidaway	S/D/A	Enc.21	
	c) SSOT:				
	Staffordshire & Stoke-on-Trent Health and Care Senate	Rachel Gallyot	S/R	Enc.22	
(18)	Any Other Business – notified in advance to Chair	Chair	D	Verbal	3:45
(19)	Review of new or amended risks following discussions in the meeting	Chair	D/A	Verbal	
(20)	Meeting Effectiveness: • Have we upheld the behaviours agreed in the Leadership Compact? • Has there been any learning and how we can improve going forward?	Chair	S	Verbal	
Date and time of next meeting: Thursday, 24th September 2026 at 1:30pm					

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

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

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

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

Present:

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

In Attendance:

Leanne Walker (LW)	Presenter (virtually)
Dr Tony Ahmed (TA)	GP Partner (Dental), NHS SSOT
Tanya Miles (TMS)	Interim Chief Executive Officer, Shropshire Council (Virtually)
Andrew Morgan (AM)	Chair in Common, Shropshire Community Health NHS Trust and Shrewsbury & Telford Hospital NHS Trust
Terry Gee (TG)	Healthwatch, Telford and Wrekin
Lynn Cawley (LCY)	Healthwatch Shropshire
Paul Winter (PW)	Associate Director of Corporate Governance, NHS STW & SSOT
Adele Edmonson (AE)	Communication
Claire Colcombe (CC)	Board Secretary, NHS STW

Apologies:

Neil Carr OBE	Midlands Partnership University NHS Foundation Trust
Trevor McMillan OBE	Non-Executive Director, NHS STW
Dr Paul Edmonson-Jones MBE	Transformation Director, NHS SSOT

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

Minute No. ICB-26-04-001 – Welcome & Apologies

001.1 ML formally opened the meeting and welcomed members, partners and attendees. It was confirmed the meeting was being held in public in line with governance requirements.

001.2 ML clarified that the meeting was being conducted in public rather than as a public meeting and confirmed that questions received from members of the public would be responded to in writing following the meeting.

001.3 Apologies were received as listed in the attendance register. Additional apologies were noted from members unable to attend.

Minute No. ICB-26-04-002 – Members' Declarations of Interests

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

NHS STW/SSOT Cluster Board Register of Interests

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

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

Minute No. ICB-26-04-003 – Minutes of Previous Meeting

003.1 The minutes of the previous meeting, held on 26th March 2026, were reviewed by the Board.

003.2 Members were invited to identify any inaccuracies; no issues were raised.

RESOLVE: **The NHS Shropshire, Telford and Wrekin Integrated Care Board and NHS Staffordshire, Stoke-on-Trent Integrated Care Board APPROVED the minutes of the meeting held on 26th March 2026 as an accurate record.**

Minute No. ICB-26-04-004 – Matters Arising/Actions from previous meeting

004.1 The Board reviewed the action log and received updates on outstanding items.

004.2 In relation to neighbourhood development, it was confirmed that further discussion would be brought back through future Board and strategy sessions.

004.3 Members queried progress on the Patient and Public Involvement strategy; officers confirmed this remained in development and would be returned to the Board.

004.4 An update was provided on the development of the cluster-wide risk appetite; it was confirmed this would be progressed further through a scheduled Board development session.

004.5 Completed actions were formally noted and closed.

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

Minute No. ICB-26-04-005 – Questions from members of the public

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

005.2 It was confirmed that responses would be prepared and published on the ICB websites in line with policy, with links included in the final published minutes.

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

Minute No. ICB-26-04-006 – Resident Story

006.1 ML introduced the item and reflected that, in recent meetings, the Board had received a number of impactful and engaging resident stories which had effectively illustrated the impact of the work of the Integrated Care Board on individuals. It was noted that the story to be presented at this meeting continued this theme and provided further valuable insight into lived experience.

006.2 ML introduced the resident story, advising that it had been provided by LW, who contributes to the system as an expert by experience. It was noted that Leanne draws on her personal experience of accessing both Child and Adolescent Mental Health Services (CAMHS) and Adult Mental Health Services (AMHS). ML highlighted that the story included a recorded poem, reflecting LW's perspectives on lived experience roles, including the expectations placed on individuals and the importance of recognising and valuing that contribution, including appropriate remuneration.

006.3 The Board viewed the recorded presentation. The poem highlighted the complexity and emotional impact of lived experience roles, noting that such experience cannot be "switched off" and requires individuals to bring personal history and vulnerability into professional environments. It emphasised the importance of recognising lived experience as central to service design, rather than as a procedural requirement, and explored themes of stigma, resilience, and the responsibility carried by individuals sharing personal experiences.

006.4 LW was welcomed by ML. Members thanked LW for the powerful and engaging presentation, noting both its emotional impact and accessibility.

006.5 LW reflected that the core message of the presentation was that services exist because of the needs of individuals accessing them, and therefore systems should remain focused on the purpose of care and those they serve. She encouraged members to reflect on how systems can remain connected to the population and avoid becoming overly driven by process.

006.6 Members invited further comment from LW on how the system could strengthen engagement with people with lived experience. In response, LW highlighted that organisations often expect individuals to attend formal settings, which may be inaccessible or associated with negative experiences, and suggested that greater effort should be made to engage proactively within

communities. The importance of accessibility, including location, language and communication was emphasised, and it was noted that jargon and organisational complexity can act as barriers to engagement.

006.7 LW further highlighted that building trust with marginalised groups, including those with protected characteristics and seldom-heard voices, should be a priority, recognising that meaningful engagement is dependent on establishing trust before expecting participation in service development.

006.8 Members reflected on the themes raised, noting the importance of lived experience in informing commissioning and the opportunity to strengthen engagement approaches. It was recognised that lived experience roles can influence organisational culture, reduce stigma and support more open and inclusive working environments.

006.9 A question was raised regarding how learning from lived experience could be embedded into workforce development. It was suggested that incorporating lived experience into leadership and management training would support greater understanding and cultural change across organisations.

006.10 Members also explored how insights from lived experience could inform wider population engagement strategies. ML advised that this aligned with ongoing work to strengthen patient and public involvement and to develop more interactive approaches to engagement, including identifying populations that are not currently being reached.

006.11 The Board acknowledged the courage and vulnerability required to share lived experience, noting that such contributions provide valuable insight that cannot be replicated through data alone.

006.12 ML thanked LW for her contribution, noting that the story provided a clear and impactful reminder of the importance of maintaining focus on individuals and outcomes within system decision-making.

Minute No. ICB-26-04-007 – Chair's Report

007.1 ML introduced the item and invited the IG, who was attending remotely, to present his report.

007.2 IG thanked ML for chairing the meeting and provided an update on recent activity. IG reported that he had undertaken a series of visits to provider organisations across the system, including Shrewsbury and Telford Hospital NHS Trust and Midlands Partnership University NHS Foundation Trust, with further visits planned to other providers and primary care. He reflected positively on the commitment and dedication of staff and noted the strong focus on responding to changing health needs, delivering the 10-year plan, and working collaboratively across the system. IG emphasised the importance of ensuring that ICB leadership remains visible and supportive to providers delivering commissioned services.

007.3 IG provided an update on engagement with local authority leaders, noting positive meetings with Stoke-on-Trent City Council and Staffordshire County Council, with ongoing engagement with Shropshire Council and a planned meeting with Telford and Wrekin Council. IG highlighted the importance of strengthening relationships, not only at officer level, but also with political leadership, particularly in the context of neighbourhood development.

007.4 IG further advised that he had met with the newly appointed NHS Midlands Regional Chair, Russell Hardy. It was noted that the introduction of regional chair roles is a national development aimed at supporting Chairs, Non-Executive Directors and organisations in delivering the NHS 10-year plan. IG confirmed that the meeting had been positive and that the Regional Chair had committed to being visible and accessible across the region despite the scale of the role.

007.5 No questions were raised by members, and the report was noted.

RESOLVE: **The NHS Shropshire, Telford and Wrekin Integrated Care Board and NHS Staffordshire, Stoke-on-Trent Integrated Care Board RECEIVED the report and were ASSURED on progress**

Minute No. ICB-26-04-008 – Chief Executive Report

008.1 The Chief Executive's report was taken as read, with key updates highlighted for assurance.

008.2 SW provided an update on the ICB reset and change programme, advising that a significant number of colleagues had left the organisation during April as part of the Management of Change process. SW formally placed on record his thanks, on behalf of the Board and Executive Team, for the contributions of those colleagues and extended best wishes for the future.

008.3 The Board noted that the organisation was now transitioning into the next phase of development, with a focus on establishing the future operating model and organisational structure. Members were advised that appointments to the senior leadership team would be progressed during May, enabling the development of a single leadership structure aligned to the strategic commissioning role.

008.4 SW recognised the impact of the change programme on staff, noting that colleagues were managing multiple competing priorities, including maintaining operational delivery, planning future services, adapting to new ways of working and supporting organisational transition. The Board acknowledged the complexity of the environment and the importance of supporting staff through this period.

008.5 Members were advised that further detail on the five-year strategic commissioning plans and the response to national requirements would be discussed later in the agenda, including the ICB response to guidance from NHS England regarding neighbourhood development, strategic commissioning and system engagement.

008.6 SW highlighted the scale of activity across the system, including work within the WORKWELL programme, noting that significant external resource had been brought into the system to support delivery. It was suggested that a more detailed update be provided to a future meeting to ensure the Board had sufficient oversight of this programme.

Action: Provide a detailed update on the WORKWELL programme to a future Board meeting.

008.7 Additional updates were referenced within the report, including progress on primary care developments, urgent and emergency care, and service optimisation across the system. It was noted that the report was intended to provide visibility of the breadth of system activity rather than a comprehensive overview of each area.

008.8 SW emphasised that all activity remained focused on improving outcomes for the population, supported through partnership working with providers, local authorities and the voluntary and community sector. He highlighted the importance of clinical and professional engagement in delivering sustainable improvements.

008.9 Members reflected on the report and noted the complexity of the current system environment, acknowledging the scale of change for staff and organisations. The Chair highlighted the transition from a period of stabilisation to a rebuilding phase, recognising the progress made in establishing the foundations for the future organisation.

008.10 A further reflection noted the positive impact of developments such as the Community Diagnostic Centre in Hanley, recognising this as a significant step forward for the system.

008.11 No further questions were raised.

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

Minute No. ICB-26-04-009 – Operational Plans

009.1 CS introduced the Operational Plans, reminding members that the five-year narrative plan had been presented at the previous meeting. It was noted that, at that time, approval had not been received from NHS England to present the detailed operational plan in public, however confirmation had now been received and the full plan, including financial and performance information, was being presented.

009.2 Members were advised that the plans covered revenue, capital and performance targets across both systems. CS confirmed that both ICBs had submitted compliant financial plans and were able to meet break-even targets across the multi-year period. It was noted that both systems would utilise agreed deficit support funding as part of the glidepath to achieving underlying financial sustainability.

009.3 The Board noted that capital plans had been developed to maximise available funding and ensure both systems were well positioned to respond to any additional capital allocations. It was emphasised that the approach taken was to make best use of all available resources to support delivery priorities.

009.4 CS highlighted that a small number of performance targets were not currently forecast to be met over the three-year period. Members were advised that NHS England had confirmed the plans as “compliant with conditions”, with those conditions focusing on continued system effort to improve trajectories. It was recognised that plans reflected realistic assumptions and that ongoing work with providers and partners would be required to close performance gaps.

009.5 Members noted that, while some targets may not yet be achieved, the three-year planning timeframe provided opportunity to review trajectories and implement improvement actions.

009.6 In discussion, PH emphasised that the performance trajectories presented represented a credible position based on current plans and operational realities. It was noted that these were not fixed positions and that work was ongoing with providers and partners to improve delivery, whilst maintaining realism in planning assumptions.

009.7 RD asked whether the plans provided sufficient flexibility to support the significant transformation required in future years, particularly in relation to the delivery of the three strategic shifts. In response, CS confirmed that multi-year allocations provided greater certainty and flexibility for planning. It was noted that while year one was more clearly defined, future years included estimated investment aligned to strategic priorities and the anticipated 'left shift' in care.

009.8 SW reinforced that the question of transformation was fundamental, noting that the current plans represented a transition from stabilisation to transformation. He emphasised that while the plans for 2026/27 were not fully transformative, they established the direction of travel and provided the foundation for more significant change from 2027/28 onwards. It was highlighted that the Board would need to continue to scrutinise whether plans were beginning to demonstrate a shift in resource allocation and service delivery.

009.9 SW further noted that national changes to the financial regime and oversight framework were intended to support this shift, but alignment between national expectations and system planning would be critical to enable transformation.

009.10 TM reflected that transformation would be an ongoing process across the duration of the 10-year plan and emphasised the need for realism regarding the timescales required to deliver financial and service change. It was noted that some benefits may not be realised until later years and that maintaining ambition alongside realistic expectations would be essential.

009.11 Additional discussion highlighted the need to accelerate delivery where possible, with members emphasising the importance of making early progress to demonstrate impact, particularly ahead of winter pressures.

009.12 The Board recognised the complexity of planning within a changing system environment and acknowledged the need to maintain focus on both delivery and longer-term transformation.

009.13 No further questions were raised.

RESOLVE: **The NHS Shropshire, Telford and Wrekin Integrated Care Board and NHS Staffordshire, Stoke-on-Trent Integrated Care Board NOTED the final multi-year financial and performance metrics for the two Integrated Care Boards. These had previously been agreed in private session and are now confirmed by NHSE.**

Minute No. ICB-26-04-010 – Operating Model

010.1 ML introduced the item and invited LC to present the proposed ICB Operating Model.

010.2 LC outlined the context for the operating model, noting that ICBs had been required, as part of the NHS reset, to significantly reduce organisational size and work in clusters to deliver at scale. It was highlighted that this required a fundamental shift in how ICBs operate, moving fully into their role as strategic commissioners.

010.3 Members were advised that while initial expectations suggested ICBs would cease certain activities, in reality many responsibilities remained but would need to be delivered in a fundamentally different way. The operating model was therefore intended to provide clarity and transparency on the future role of the ICB, including priorities, ways of working and leadership approach.

010.4 LC confirmed that the four statutory objectives of ICBs remained unchanged, alongside alignment with the NHS 10-year plan and the three transformation shifts: hospital to community, treatment to prevention, and analogue to digital. It was noted that the operating model also incorporated the development of the neighbourhood health approach.

010.5 The Board noted that the ICB would operate through three core roles: strategic commissioner, system steward and system partner. It was highlighted that commissioning would be driven by population need, supported by strong partnerships and a focus on transformation and improvement.

010.6 LC outlined the commissioning cycle, emphasising the need for robust population health intelligence, triangulated with clinical insight and lived experience, to inform strategy and decision-making. It was noted that this would support a move towards outcomes-based commissioning, improved value for money and greater focus on evaluation, including scaling effective interventions and decommissioning where benefit was not demonstrated.

010.7 Members discussed the proposed system architecture, noting that delivery would be driven through place-based partnerships and neighbourhood teams, with the ICB working alongside local authorities and partners to set population outcomes and priorities. It was emphasised that healthcare services must be considered alongside wider determinants of health, including housing, education and employment.

010.8 LC highlighted the importance of clinical and professional leadership as a core component of the operating model, noting that this would ensure decision-making was clinically credible, deliverable and grounded in frontline experience.

010.9 Members acknowledged that the operating model represented a significant shift in approach and noted that organisational plans, including financial, workforce, clinical and engagement strategies, would align to support delivery.

010.10 In discussion, the Deputy Chair reflected on the importance of culture, highlighting the need for agility, data-driven decision-making and the confidence to make difficult decisions, including disinvestment where appropriate.

010.11 SL welcomed the model but highlighted the importance of clearly articulating what will be different from a patient perspective. He also raised the challenge of achieving alignment across a wide range of stakeholders, noting that successful delivery would require shared understanding, ownership and engagement across all partners.

010.12 LC acknowledged the complexity of system engagement and noted that multiple levels of engagement already existed across the system. It was recognised that future ways of working would need to reflect reduced ICB capacity while ensuring partners were clear on roles, responsibilities and expectations.

010.13 A representative from Healthwatch highlighted the importance of ensuring frontline staff understand and communicate the changes effectively to the public, noting that staff are key to providing assurance and building confidence within communities. Concerns were also raised regarding potential perceptions of postcode variation and the importance of clear communication where services may change.

010.14 In response, SW emphasised that the focus should be on improving population outcomes based on need rather than geography, noting that variation in provision reflects differences in population need. He further highlighted that effective commissioning should focus on integrated care pathways rather than individual services, noting that clear communication of the overall service offer would be essential when changes are implemented.

010.15 RD raised a question regarding prioritisation and statutory duties, particularly in the context of reduced resource. SW confirmed that statutory responsibilities would continue to be met and highlighted that strategic commissioning plans would provide clarity on priorities, with a strong focus on delivering within resource constraints.

010.16 CE welcomed the operating model, noting that it provided a clear direction of travel and an opportunity to embed new ways of working, including a more structured approach to disinvestment and reinvestment.

010.17 SL emphasised the importance of clarity of roles and responsibilities across partners, noting that strong communication and shared understanding would be critical to successful implementation.

010.18 RG highlighted the importance of focusing on value, noting that commissioning decisions should consider not only financial efficiency but also clinical effectiveness and outcomes for patients. It was emphasised that engaging clinical professionals in this process would be essential.

010.19 NH reinforced the importance of data, analytics and shared system capability, noting that improved access to and use of data would support more informed decision-making and enable the system to prioritise effectively.

010.20 LC confirmed that investment in digital, data and analytics capability was being progressed, including development of enhanced modelling and evaluation approaches to support decision-making.

010.21 CW asked how quickly the operating model could be implemented, noting the importance of maintaining pace. LC advised that elements of the model were already in progress, with further implementation aligned to the organisational change programme, noting that full implementation would develop over time, with acceleration expected as the new structure is established.

010.22 SW reinforced that implementation should not be delayed, noting that work was already underway across the system and that it was important to maintain momentum while the organisational model continues to develop.

010.23 IG reflected that the model must be transformational and enable meaningful change for the population. He emphasised the need for collective leadership and clear action to translate the model into delivery.

010.24 ML highlighted the importance of communication and engagement, noting that workforce understanding and system-wide alignment would be critical. It was confirmed that engagement activity and stakeholder workshops were planned to support implementation.

010.25 The Board recognised that the operating model provides a clear strategic framework but acknowledged that further work would be required to fully embed the approach across the system.

010.26 No further questions were raised.

RESOLVE: **The NHS Shropshire, Telford and Wrekin Integrated Care Board and NHS Staffordshire, Stoke-on-Trent Integrated Care Board RECEIVED and APPROVED the Operating Model and ACKNOWLEDGED that the model will evolve over time as it matures into its role as the strategic commissioner.**

Minute No. ICB-26-04-011 – Neighbourhoods and Place

011.1 ML introduced the item and invited PS to present the Neighbourhoods and Place paper.

011.2 PS outlined that the proposal built directly on the previously discussed Operating Model and focused on how the system would practically deliver improved population health outcomes. It was emphasised that the system was not starting from a low baseline, with examples of strong existing practice highlighted, including dementia multidisciplinary teams, integrated community working and family hubs, and frailty models across Staffordshire and Stoke-on-Trent.

011.3 It was noted that the primary aim of the paper was to establish a consistent strategic approach across the cluster, with clear roles, responsibilities and priorities. PS highlighted the importance of balancing immediate delivery priorities with longer-term transformation, including the future direction for delegated budgets and provider delivery models.

011.4 Members were advised that the vision for the system was to establish a neighbourhood health service as the default model of care delivery, designed around population needs and co-produced with communities. It was emphasised that this approach should support prevention, early intervention, improved outcomes and reduced inequalities.

011.5 The Board noted that place-based partnerships would act as the primary delivery mechanism, with Place Boards operating as formal sub-committees of the ICB and progressing towards increased delegation of responsibility and resources. It was further highlighted that neighbourhood teams would form the core delivery model, working across organisational boundaries.

011.6 PS emphasised that the next 12 months were critical for delivery, particularly in ensuring that tangible improvements were realised. It was noted that failure to progress key interventions at pace would limit the system's ability to deliver benefits ahead of winter pressures.

011.7 The paper identified priority population groups, including frail older people, people with long-term conditions, children and young people, and those with mental health needs. It was noted that delivery would need to be tailored to local context while maintaining a consistent overall strategy.

011.8 In discussion, DS supported the overall direction of travel and emphasised the importance of pace, highlighting the significant inequalities experienced across places. He noted that delays in implementation would result in continued inequity of outcomes and urged accelerated progress. Concerns were also raised regarding timescales for national submission and the need for strong co-production with local authorities.

011.9 DS further queried the approach to delegated funding, noting that significant funding was already managed at place level, and requested further clarity on the proposed approach. He also highlighted a specific example of a neighbourhood health centre scheme in Telford, emphasising the need to align capital investment decisions with local opportunities.

011.10 In response, PS acknowledged the importance of pace and confirmed that work was underway to align system inputs ahead of national submission deadlines. It was noted that the intention for delegated funding was to increase control at place over time, alongside corresponding accountability, and that further detail would be developed with partners. PS confirmed that capital allocation processes were being aligned to population need and would be progressed collaboratively with local authorities.

011.11 JW reflected on the challenges faced by providers in balancing immediate operational pressures with longer-term transformation, but reaffirmed commitment to the agenda. JW emphasised the importance of clear communication with frontline staff and supporting them to understand and articulate changes, noting that language and clarity would be critical.

011.12 JW also highlighted the importance of acting with pace and flexibility, suggesting that the system should be willing to test and scale innovative approaches, whilst maintaining focus on outcomes. It was noted that successful delivery would require strong participation at place level and active engagement from providers.

011.13 PS responded by emphasising the importance of evaluation and accountability, noting that the system must avoid progressing pilots without clear assessment of impact and scalability. It was agreed that robust evaluation would underpin decision-making on continuation or disinvestment.

011.14 Members discussed the importance of maintaining pace while ensuring that relationships, engagement and communication were not compromised. It was emphasised that successful delivery required both speed and alignment across partners.

011.15 RD highlighted the importance of consistent governance arrangements across the cluster and sought assurance on financial governance, delegation and accountability. In response, PS confirmed that work was underway to develop proportionate governance frameworks, ensuring transparency and value for money while avoiding unnecessary bureaucracy.

011.16 CS added that contractual mechanisms and financial levers would play a key role in supporting delivery, including developing appropriate incentive structures and risk-sharing arrangements. It was acknowledged that further work was required in this area and that this was a national challenge across the NHS.

011.17 Members also emphasised the importance of clinical leadership and engagement, with RG highlighting that clinical and professional staff were critical to driving change and improving outcomes. It was noted that focusing on value, rather than activity alone, would be central to successful commissioning.

011.18 Discussion also highlighted the importance of data and analytics in supporting decision-making, with members noting the need for shared system capability and improved use of intelligence to inform priorities.

011.19 Members raised the importance of learning from existing programmes and ensuring that good practice was shared and sustained across the system. It was emphasised that Place Boards would need to act as forums for sharing learning, evaluation and improvement.

011.20 SW concluded the discussion by emphasising that all activity must align with the national neighbourhood health framework and its defined goals. It was noted that while local innovation should be encouraged, it must contribute to delivery of agreed system outcomes.

011.21 ML thanked PS and members for a comprehensive and constructive discussion and noted the strength of alignment across the Board.

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

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

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

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

Minute No. ICB-26-04-012 – Risk and SBAF Strategy

012.1 MI introduced the item and emphasised the importance of risk management and the System Board Assurance Framework (SBAF), noting that effective risk management underpins Board assurance and the effectiveness of committee structures. It was highlighted that failure to establish a robust approach would limit the Board’s ability to understand risk and provide appropriate oversight.

012.2 MI noted that the development of a shared risk management strategy across the two ICBs was timely, particularly in the context of organisational change and the significant transformation agenda discussed throughout the meeting. It was highlighted that the strategy aimed to support clarity on what risks the organisation should take, how those risks should be managed and how the Board could be assured that risks were being effectively controlled.

012.3 PW presented the detail of the strategy, advising that it had been developed to support the transition to a new operating model and a strategic commissioning role. It was emphasised that risk management is a core component of the governance framework and provides the foundation for internal control, assurance and decision-making.

012.4 The Board was advised that the strategy sought to strengthen organisational culture, processes and systems for managing risk, while ensuring that the approach remained proportionate and not overly bureaucratic. It was noted that this was particularly important given the reduced organisational size and the need to maintain agility.

012.5 PW confirmed that the strategy incorporated learning from internal audit recommendations and good practice from other systems, including the development of draft risk appetite statements. It was noted that these would be further developed and refined through a Board development session scheduled for May, aligned to wider strategic discussions.

012.6 Members were advised that the approach aimed to balance the need for innovation and transformation with a clear understanding of risk, ensuring that risks were identified, articulated and actively managed rather than avoided.

012.7 RD, as Audit Committee Chair, welcomed the report and noted that it provided a strong foundation for the development of a consistent risk management framework. It was emphasised that the key test would be ensuring that the framework operated as a live and meaningful process rather than a compliance exercise.

012.8 IG commended the work undertaken to develop the strategy within a short timeframe and reinforced the importance of ensuring that risk management and the SBAF become embedded as dynamic tools that inform Board decision-making. He emphasised the need to continue refining risk appetite and articulation of risks over time.

012.9 VW highlighted the importance of ensuring that clinical quality and patient safety risks remain clearly reflected within the framework, particularly in the context of organisational change and system transformation.

012.10 ML reinforced that the organisation was operating in a complex and dynamic environment, with multiple concurrent changes, and therefore it was essential that risks were clearly understood, actively managed and regularly reviewed to ensure patient safety and service delivery were not adversely impacted.

012.11 Members agreed that further development work would be required to refine the framework, including strengthening alignment to strategic priorities and ensuring that risk management supported effective governance and assurance processes.

Action: Progress development of the risk appetite statements and framework through the planned Board development session.

012.12 No further questions were raised.

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

Minute No. ICB-26-04-013 – Equality, Diversity and inclusion Update

013.1 ML introduced the item, noting that two reports were presented: one relating to ongoing anti-racism and community engagement work within Shropshire, Telford and Wrekin, and the second relating to workforce equality and Public Sector Equality Duty (PSED) requirements across both ICBs.

013.2 VW introduced the first report, outlining the continued system-wide actions in response to previous work exploring experiences and perceptions of racism within the workforce and wider population. It was noted that, while the initial action plan had been completed, focus had shifted to sustaining progress and embedding long-term cultural and community change.

013.3 The Board was advised that work had increasingly focused on engagement with communities, including rural and seldom-heard populations, and strengthening relationships across the system. It was noted that a system-wide partnership group had been established, led collaboratively by organisational EDI leads, to coordinate activity, share good practice and respond to feedback from both staff and communities.

013.4 Members noted that lived experience had played a central role in shaping the programme, with individuals contributing directly to system learning and providing valuable insight. It was recognised that this aligned with themes raised earlier in the meeting regarding the importance of engaging meaningfully with people and communities.

013.5 VW further highlighted collaborative work with partners, including research undertaken with the University of Leicester into experiences of ethnic minority communities in rural and coastal settings. It was noted that the system had committed to supporting the recommendations arising from this work.

013.6 It was also highlighted that a communications campaign developed following a system workshop had been successful in raising awareness and engagement, with potential to be expanded into broader inclusion programmes.

013.7 The Board was advised that, in light of organisational change and the evolving role of the ICB, work would now focus on aligning anti-racism activity within a broader, integrated EDI approach, while enabling system partners to take forward elements of delivery collaboratively.

013.8 MI introduced the second report, outlining the workforce equality position across both ICBs and the requirements of the Public Sector Equality Duty. It was noted that, while detailed data had been presented, further work was required to analyse this collectively and define clear system actions.

013.9 MI emphasised that EDI must be driven by leadership and culture, noting that while training and initiatives were important, sustainable change would depend on leadership behaviours, psychological safety and organisational culture.

013.10 Members were advised of five key areas of focus for action: strengthening Board accountability, embedding EDI within leadership and organisational objectives, improving recruitment and career progression, expanding staff engagement and networks, and addressing inequalities in workforce experience, including bullying and pay gaps.

013.11 It was noted that a Board development programme on EDI would be implemented, including a mix of learning, engagement with communities and reflection to build understanding and capability across Board members and senior leaders.

013.12 MI highlighted the need to strengthen engagement with staff, including expanding networks and forums to better understand lived experiences within the workforce and inform targeted interventions.

013.13 Members were advised that targeted organisational development activity would be implemented to address areas identified through staff feedback, alongside continued development of leadership capability and inclusive practices.

013.14 IG emphasised the importance of leadership in driving this agenda and highlighted the need for the organisation to be proactive and action-oriented, particularly in reaching communities that are traditionally underrepresented or less engaged.

013.15 DS welcomed the progress made and recognised the significant cultural shift that had occurred, noting the importance of continuing momentum and leadership commitment.

013.16 SL highlighted the opportunity to align EDI work with wider system priorities, including neighbourhood working and co-production, emphasising the importance of engaging directly with communities to shape services.

013.17 SW reinforced the importance of leadership, listening and learning, noting the need for both proactive action and humility in understanding the experiences of staff and communities. He confirmed his commitment, as Chief Executive, to leading and embedding this agenda across the organisation.

013.18 ML reflected that EDI must be embedded across all aspects of the organisation and system, not treated as a standalone workstream, emphasising the importance of listening, learning and inclusive engagement.

013.19 No further questions were raised.

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

- **NOTED the first report and were ASSURED on the progress being made in strengthening Equality, Diversity and Inclusion (EDI) in response to the report on the Perceptions and experience of racism in the workplace by health and social care staff in Shropshire Telford and Wrekin (2023).**
- **ENDORSED the strategic direction of travel, including the development of a cluster-based approach to EDI, and SUPPORTED the integration of insights from this programme of work into a coherent, system-wide EDI framework that drives sustained improvement and impact.**
- **NOTED the second report and were ASSURED on the progress being made in strengthening Equality, Diversity and Inclusion (EDI) in response to the report on the Perceptions and experience of racism in the workplace by health and social care staff in Shropshire Telford and Wrekin (2023).**
- **ENDORSED the strategic direction of travel, including the development of a cluster based approach to EDI, and SUPPORTED the integration of**

insights from this programme of work into a coherent, system wide EDI framework that drives sustained improvement and impact.

Minute No. ICB-26-04-014 – Integrated Performance Report

014.1 CS introduced the Integrated Performance Report, noting that this represented a near year-end position, with some indicators subject to reporting lag. It was confirmed that the overall position remained positive and consistent with previously reported trajectories.

014.2 The Board was advised that the report reflected both improvements and ongoing challenges across performance domains; however, no new or material risks were identified beyond those already known and subject to active management.

014.3 CS provided assurance that, despite the scale of organisational transition and changes to governance arrangements, the ICB continued to maintain oversight of risks and performance issues. It was emphasised that maintaining delivery and system grip remained a priority during this period of change.

014.4 Members were advised that performance reporting would evolve in future months in response to updated NHS England requirements. It was noted that reporting would be refined to ensure the Board and its committees receive clear, relevant and actionable information to support effective oversight and decision-making.

014.5 CS confirmed that both systems had achieved their financial targets for the year, subject to final audit validation. It was noted that this represented a significant achievement, reflecting considerable collective effort across provider organisations, partners and ICB teams.

014.6 Members recognised the scale of system effort required to deliver the financial position and the importance of sustaining this discipline going into the next financial year.

014.7 SW formally thanked provider organisations, GP colleagues, partners and finance teams for their contributions, noting that the achievement of the financial position reflected strong collaboration, robust planning and sustained focus throughout the year. It was highlighted that this delivery had enabled both systems to reach a position of relative stability.

014.8 ML reflected on the scale of the financial challenge at the start of the year and acknowledged the significant progress made, noting that lessons learned should inform future planning and delivery.

014.9 TM highlighted the importance of maintaining momentum and discipline into the new financial year, noting that the current position required continued focus and acknowledging that the system may be at an earlier stage of delivery readiness compared to the same point in the previous year.

014.10 SW acknowledged this challenge and confirmed that ongoing monitoring through Finance Committee and governance processes would be essential. It was noted that a continued focus on incremental delivery and system discipline would support achievement of future objectives.

014.11 No further questions were raised.

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

Minute No. ICB-26-04-015 – 'Triple A' Board Committee Highlights Reports

015.1 The Deputy Chair introduced the committee highlight reports and invited updates from committee leads.

Finance Committee (in common)

015.2 ML advised that there were no material concerns or exceptions to highlight. Members noted the significant level of work undertaken across the system to achieve the year-end financial position and recognised the collective effort required to deliver this outcome.

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

Quality and Performance Committee

015.3 CE presented the report, noting that performance pressures remained within urgent and emergency care, particularly in relation to 12-hour performance.

015.4 Members were advised that, in recognition of improvements in assurance, evidence of progress and the quality of care being delivered, the risk rating had been reduced from 20 to 16. It was emphasised that this reflected progress but did not indicate that all challenges had been resolved.

015.5 CE also noted that this was the final meeting of the Committee in its previous format and that new arrangements would commence from May. It was recognised that the Committee would operate in a transitional phase over the next year, with further evolution expected as governance and reporting arrangements are embedded.

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

People, Culture and Inclusion Committee

015.6 ML presented the report and highlighted concerns regarding the reduction in senior capacity within the organisation. It was noted that this remained a key risk and was being actively managed by the Executive Team.

015.7 Members were advised that the Committee was considering future priorities in light of the evolving role of the ICB, including workforce development and system-wide collaboration.

015.8 ML highlighted the importance of progressing the anti-racism, anti-Semitism and Islamophobia statement, noting recent events reinforcing the need for visible leadership.

Action: Finalise and publish a joint leadership statement on anti-racism, anti-Semitism and Islamophobia, with co-signature from system leadership.

015.9 ML confirmed that while some workforce responsibilities had shifted, the ICB would continue to influence workforce development through partnership working, with further clarity to be developed and brought back to the Board.

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

Strategic Commissioning and Transformation Committee

015.10 No matters were raised under this item.

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

Health Care Senate

015.11 RG provided an update from the Health Care Senate, advising that the Senate had reviewed and approved amendments to the Assisted Conception Policy and had endorsed the Restricted Procedures Policy, subject to completion of a Quality Impact Assessment.

015.12 Members noted that the amendments focused on improving clarity and alignment across systems.

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

Audit Committee

015.13 RD provided a verbal update, advising that year-end processes were progressing well and that provisional audit opinions were positive, with no significant issues identified.

015.14 Members noted that final sign-off was anticipated in June, subject to completion of external audit processes.

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

- **Clinical approval of amendments to Excluded and Restricted Procedures (ERP) Policy V.2.3.**
- **Clinical approval of updates to the Assisted Conception for Fertility Policy.**

015.15 ML thanked committee chairs and members for their contributions and emphasised the importance of committee assurance in supporting effective governance.

Minute No. ICB-26-04-016 – Any Other Business

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

016.2 No further business was raised.

Minute No. ICB-26-04-017 – Review of new or amended risks following discussions in the meeting

017.1 ML introduced the item and invited PW to reflect on any new or amended risks arising from discussions during the meeting.

017.2 PW advised that a number of themes had emerged during the meeting which would be reviewed in the context of the developing risk framework and System Board Assurance Framework, particularly in relation to organisational transition, delivery of the operating model and the pace of transformation.

017.3 It was noted that these would be considered as part of the ongoing refinement of the risk register and risk appetite, ensuring alignment with strategic priorities and Board discussions.

017.4 No specific new risks were formally added at the meeting.

RESOLVE: The NHS Shropshire, Telford and Wrekin Integrated Care Board and NHS Staffordshire and Stoke-on-Trent Integrated Care Board NOTED the position and AGREED that risks identified through discussion will be reflected in the developing risk framework.

Minute No. ICB-26-04-018 – Meeting Effectiveness

018.1 ML confirmed that all business had been concluded and thanked members for their contributions.

16:17 – Meeting Closed

Date and Time of Next Meeting

Date: 25th June 2026
Time: 1.30pm
Location: Room 1, Wellington Civic Centre, Larkin Way, Telford, TF1 1LX

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

Friday, 12th June 2026 at 9.30am
Via Teams

Present:

Mike Lawton (ML) (Chair)	Deputy Chair, Non-Executive Member, NHS SSOT
Simon Whitehouse (SW)	Chief Executive Officer, NHS STW & NHS SSOT
Claire Skidmore (CS)	Deputy Chief Executive Officer and Chief Finance Officer, NHS STW & NHS SSOT
Cheryl Etches OBE (CE)	Non-Executive Member, NHS STW
Dr Buki Adeyemo (BA)	Trust Partner Member and Chief Executive Officer, North Staffordshire Combined Healthcare NHS Trust
Roger Dunshea (RD)	Non-Executive Member, NHS STW
Vanessa Whatley (VW)	Chief Nursing Officer, NHS STW
Dr Rachel Gallyot (RG)	Interim Chief Medical Officer, NHS STW & NHS SSOT
Dr. Ian Chan (IC)	Primary Care Partner Member, NHS STW
Dr Joanna Chan (JC)	Primary Care Partner Member, NHS SSOT
David Sidaway (DS)	Local Authority Partner Member and Chief Executive Officer, Telford and Wrekin Council
Dr. Simon Constable	Trust Partner Member & Chief Executive, University Hospitals of North Midlands (virtually)
Dr. Lorna Clarson (LC)	Chief Officer of Strategy and Improving Outcomes, NHS STW & NHS SSOT
Mish Irvine (MI)	Chief of Staff, NHS STW & NHS SSOT
Neil Carr OBE (NC)	Trust Partner Member and Chief Executive Officer, Midlands Partnership University NHS Foundation Trust
Jon Rouse (JR)	Local Authority Partner Member and Chief Executive Officer, Stoke-on-Trent City Council
Phil Smith (PS)	Chief Delivery Officer, NHS STW & NHS SSOT

In Attendance:

Paul Winter (PW)	Associate Director of Corporate Governance, NHS STW & SSOT
Claire Colcombe (CC)	Board Secretary, NHS STW

Apologies:

Ian Green OBE	Chair (Meeting Chair), NHS STW & NHS SSOT
Trevor McMillan OBE	Non-Executive Member, NHS STW
Shokat Lal	Non-Executive Member, NHS SSOT
Joanne Williams	Trust Partner Member and Chief Executive Officer, The Shrewsbury and Telford Hospital NHS Trust and Shropshire Community Health NHS Trust
Patrick Flaherty	Local Authority Partner Member and Chief Executive Officer, Staffordshire County Council

Minute No. EICB-12-06-001 – Welcome & Apologies

001.1 ML welcomed members to the Extraordinary Integrated Care Board meeting. It was noted that the meeting was quorate.

001.2 Apologies were noted above.

Minute No. ICB-12-06-002 – Members' Declarations of Interests

002.1 Members were invited to declare any interests in relation to the business of the meeting. No new declarations were made. The Board noted that all interests were recorded within the ICB's published Register of Interests.

NHS STW/SSOT Cluster Board Register of Interests

Minute No. ICB-12-06-003 – NHS Staffordshire and Stoke-on-Trent Integrated Care Board Undertakings Update

003.1 The Board received a report presented by CS providing assurance that the NHS Staffordshire and Stoke-on-Trent Integrated Care Board (NHS STW ICB) legal undertakings, in place since April 2024, had been substantively met and that appropriate arrangements were in place to sustain progress.

003.2 It was noted that the undertakings had originally been imposed following concerns regarding the ICB's ability to meet its statutory duties, particularly in relation to financial grip and control. Since that time, significant work had been undertaken to deliver the required improvements, with evidence collated and submitted to NHS England in early June 2026 to support a request for formal discharge of the undertakings.

003.3 The Board heard that delivery had been achieved through strengthened governance, improved financial management, and enhanced oversight arrangements, now embedded into business-as-usual processes. The submission to NHS England included a detailed narrative, supporting evidence, and a dashboard demonstrating delivery against each undertaking.

003.4 Members acknowledged that removal of the undertakings would represent a significant milestone for the organisation, demonstrating strengthened organisational grip and control and positively impacting the ICB's oversight framework rating.

003.5 In discussion, members:

- Reflected on the significant progress made since the undertakings were introduced, recognising the scale of the challenge and the collective effort required to achieve improvement.
- Placed on record their thanks to executive teams, past and present, and system partners for their leadership, collaboration and contribution to delivery.
- Noted that the progress had not been without difficult decisions and recognised the ongoing financial risks facing the system.
- Emphasised the importance of maintaining strong relationships, transparency and continued financial discipline to sustain improvements going forward.

003.6 The Board also considered key learning from the process, including the importance of early identification of financial risk, decisive action, and consistent system-wide collaboration to maintain grip and control.

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

- **RECEIVED and REVIEWED the information and evidence provided;**

- **SUPPORTED the view that the required improvements have been delivered and embedded and appropriate controls and oversight arrangements are in place to sustain progress;**
- **AGREED that it believes that the undertakings have therefore been substantively met and that the organisation is ready to move forward without the continued need for formal undertakings**

Minute No. ICB-12-06-004 – Any Other Business

004.1 SW informed the Board that communications had been issued confirming the appointment of Vanessa Whatley as Chief Nursing Officer for the cluster across both Integrated Care Boards. The Board congratulated VW on her appointment.

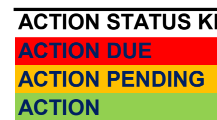
004.2 It was also noted that Heather Johnstone would be leaving the organisation. The Board placed on record its thanks to Heather for her significant contribution and leadership during her time with the Integrated Care Board. It was confirmed that a more formal opportunity to recognise her contribution, alongside other departing colleagues, would take place at the forthcoming public Board meeting.

Minute No. ICB-12-06-005 – Meeting Effectiveness

005.1 Members agreed that the meeting had been effective, with a clear focus on the single agenda item and appropriate opportunity for discussion and assurance.

005.2 In closing the meeting, ML thanked members for their time and contributions, noting that the discussion had reflected a positive and important milestone for the organisation. ML also reminded members of the importance of continuing to work in line with the leadership compact, ensuring a supportive, inclusive environment where all contributions are valued.

09:44 – Meeting Closed



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

Meeting Date	Agenda Item	Action	Due Date	Responsible Officer	Outcome/update
29/01/2026	Minute No. ICB 29-01.008 – Residents/Community Story – NHS Staffordshire, Stoke on Trent – End of Life Care	Provide an update on end of life care and neighbourhood development at a future public Board meeting. IG confirmed that there remained strategic and system interest in this area and that it was important the Board considered the topic in the context of place based development and partnership working. It was therefore agreed that a substantive discussion would be scheduled for a future Board meeting.	**TBC**	**Simon Whitehouse/Board Strategy Session**	30.04.26: Further discussion would be brought back through future Board and strategy sessions
26/03/2026	Minute No. ICB-26-03-010 – Involvement Update	Develop and return a joint patient and public involvement strategy and framework to the Board.	**TBC**	**Mish Irvine / Adele Edmonson**	30.04.26: This remained in development and would be returned to the Board.
26/03/2026 30/04/2026	Minute No. ICB-26-03-015 – ICB Cluster – Joint SBAF and Risk Register Report	A further development of the consolidated framework and cluster wide risk appetite to be progressed through a future Board development session. Progress development of the risk appetite statements and framework through the planned Board development session.	**Completed**	**Mish Irvine / Paul Winter**	25.06.26: Risk appetite session was conducted at May's Board Development Session

Enclosure No: 04

Report to:	Integrated Care Board
Date:	25 June 2026
Title:	Resident experience: Urgent care and Virtual Ward - Duncan's story
Presenting Officer:	Vanessa Whatley, Interim Chief Nursing Officer for NHS STW
Author(s):	Harriet Hopkins, Communications and Engagement Lead

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

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

(1) Purpose of the Paper:

To share Duncan's story gathered by Healthwatch Shropshire, highlighting the impact of the Virtual Ward model on patient care, recovery and system flow, and to inform Board discussion on the future development and potential expansion of Virtual Ward services, including into paediatrics.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	**Date**
E.g. First Review today or E.g. Q&P Committee [insert date →]	
E.g. First Review today or E.g. Q&P Committee [insert date →]	
Expand as necessary if the report went to multiple meetings	

(3) Implications:	
Legal / Regulatory	The areas discussed reflect ICB Statutory Duties and Functions
CQC / Patient Safety	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*
Workforce / 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:					
	Completed?			**If N - N/A, Rationale**	**If Y, Outcome / Date Reported & Signed off**
DPIA	**Yes** ☐	**No** ☐	**N/A** ☒	Click or tap here to enter text.	*Reported to IG Committee:* Click or tap to enter a date.
EIA	**Yes** ☐	**No** ☐	**N/A** ☒	Click or tap here to enter text.	*Outcome and date of completion:* Click or tap here to enter text.
QIA	**Yes** ☐	**No** ☐	**N/A** ☒	*E.g. per QIA Policy, that it doesn't impact quality of services* Click or tap here to enter text.	*SRO sign-off, outcome & date of completion:* Click or tap here to enter text.
Has there been Public / Patient Involvement?				**Yes** ☒ **No** ☐ **N/A** ☐	*Click or tap here to enter text.*

(5) Integration with SBAF (for NHS SSOT) / Strategic Risks (SR, for NHS STW)					
SBAF1	Responsive Patient Care - Elective	☒	**SBAF5**	High Quality, Safe Outcomes	☒
SBAF2	Responsive Patient Care - UEC	☐	**SBAF6**	Sustainable Finances	☐
SBAF3	Transforming Community Services	☒	**SBAF7**	Improving Productivity	☐
SBAF4	Reducing Health Inequalities	☒	**SBAF8**	Sustainable Workforce	☐
SR1	Strategic Collaboration & Partnership	☐	**SR4**	ICS Workforce (retention/wellbeing)	☐
SR2a	ICB & System Financial Balance	☐	**SR5**	Digital & Data Systems / Strategy	☐

SR2b	ICB & System RRL / CRL Plans	☐	**SR6**	ICS Strategic Response (e.g. EPRR)	☐
SR3	Reducing Health Inequalities	☒	**SR7**	ICS Socio-Economic Development	☐
			SR8	Patient & Public Involvement	☒

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

Duncan shares his experience of care across A&E, inpatient services and the Virtual Ward following treatment for a severe infection. He will attend the meeting to present his story and answer questions.

Duncan describes the Virtual Ward as a highly positive and reassuring service, with regular home visits, strong clinical oversight and coordinated support enabling recovery at home.

His experience also highlights some challenges in the discharge process, including delays and communication issues.

(7) Recommendations to Board:

To consider Duncan's experience and insights and reflect these in the continued development and expansion of the Virtual Ward model, including improvements to discharge processes and patient communication, and in the context of plans to expand the service to new pathways (including paediatrics).

Enclosure No: 05

Report to:	Integrated Care Board
Date:	25 June 2026
Title:	CEO Report
Presenting Officer:	Simon Whitehouse, CEO
Author(s):	Imogen Hyde and Harriet Hopkins

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

Is the decision within SOFD powers & limits	**Yes**	☐	**No**	☒
Any potential / actual Conflict of Interest?	**Yes**	☒	**No**	☒
Any financial impacts: ICB or ICS?	**Yes**	☐	**No**	☒
Any impacts on ICB Undertakings?	**Yes**	☐	**No**	☒
Appendices:	Appendix A – ICB Merger Correspondence			

(1) Purpose of the Paper:

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

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

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

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

(4) Statutory Dependencies & Impact Assessments:					
	Completed?			If N - N/A, Rationale	If Y, Outcome / Date Reported & Signed off
DPIA	Yes ☐	No ☐	N/A ☒	Click or tap here to enter text.	
EIA	Yes ☐	No ☐	N/A ☒	Click or tap here to enter text.	
QIA	Yes ☐	No ☐	N/A ☒	*E.g. per QIA Policy, that it doesn't impact quality of services* Click or tap here to enter text.	
Has there been Public / Patient Involvement?	Yes ☐	No ☐	N/A ☒		Click or tap here to enter text.

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

		SR8	Patient & Public Involvement	☒

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

(7) Recommendations to Board:

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

General Update

1.1 NHS Government Reset Programme

The implementation of the Senior Leadership Management of Change process is progressing in line with the agreed timetable, with good momentum maintained across the programme. The Clinical and Professional Leadership Management of Change process has been temporarily paused to enable the conclusion of a related HR process, ensuring that all subsequent steps are undertaken on a robust and equitable basis.

Consultation on the proposed structures and roles across the wider clustered ICBs closed on 17 May. We received 356 individual submissions from colleagues, many of which included multiple points of feedback. This level of engagement is both welcome and immensely valuable as we move to the next stage of this process. Submissions are currently being carefully reviewed by members of the Executive Team and the Senior Leadership Teams, with the intention of finalising structures and roles over the coming weeks in a way that reflects the insights shared. A comprehensive outcome report will be produced and shared with all staff across both ICBs.

Consultation regarding changes to base locations and hybrid working arrangements also concluded on 17 May, generating 131 individual responses. These contributions are similarly being considered in detail by the Executive Team, ensuring that future decisions are informed by colleague feedback and aligned with organisational priorities.

From an organisational development perspective, we remain focused on supporting colleagues throughout this period of change. A new toolkit has been introduced to support transitions, including handovers, role endings, and those remaining in post. In addition, we continue to evolve our employee support offer in response to feedback, and anticipate introducing further resources in June, drawing on materials from NHS Elect and national NHS England programmes. The quarterly Pulse Surveys and the annual Staff Survey will be instrumental in supporting the next stages of the organisation development programme and we will use feedback from those sources to inform our future development plans.

Finally, our ICB employee forums have come together to form a single, unified body. The former STW People Forum and SSOT Staff Engagement Group are now operating as the Cluster Staff Voice Forum. This development represents an important step in strengthening colleague voice, and the forum will continue to grow its role in supporting engagement and partnership working across the clustered ICBs in the months ahead. This is a positive step and one that the executive team fully supports.

1.2 ICB merger

NHS England is proposing that current ICB clusters transition into fully merged Integrated Care Boards by 1 April 2027, each serving populations of at least 1.5 million. This change is intended to improve efficiency and strengthen strategic commissioning, and it aligns with wider government reforms such as the 10 Year Health Plan, the English Devolution and Community Empowerment Act 2026, and forthcoming decisions on unitary authority footprints. NHS England is consulting with clustering ICBs on merged ICB footprints (a letter from Sir Glen Burley, Deputy CEO of NHS England, is attached ahead of a decision in September on final ICB boundaries that will be implemented on 1 April 2027. ICBs are encouraged to engage with local MPs, local authorities, and any emerging strategic authorities, before submitting their response by 14 July 2026, to ensure that local priorities and views on future governance are properly reflected.

Each ICB must confirm whether its current cluster footprint aligns with confirmed or reasonably anticipated strategic authority boundaries, propose minimal boundary changes to achieve alignment, or provide evidence explaining why alignment is not "feasibly possible." Where alignment with strategic or upper-tier authorities is not possible, ICBs must demonstrate why this is in the best interests of local people and outline mitigations developed with local authority partners. The ICB cluster has established a process for developing its submission to NHS England and is currently inviting input from key stakeholders. We have written to all our Cluster MP's and our LA Leaders and CEO's. Several informal conversations on this issue have already taken place.

We are of the view that the current Cluster footprint across the 2 ICB's makes sense and meets the national ask of being coterminous with any future Strategic Authority. Given the progress made with the management of change, it would also be supportive for our staff and provide clarity for them. The NHS provider footprints also make sense with the footprint of the proposed merged ICB and would enable a sensible / pragmatic shift to strategic commissioning.

In order to meet the submission deadline for the cluster ICBs response to NHS England by 14th July 2026, the Boards are asked to approve delegation of the submission sign off to the Joint Transition Committee.

In parallel, the cluster will begin developing a merger project plan and timeline, alongside a review of the existing transition governance and reporting framework. This will ensure that early preparatory work can commence where possible ahead of the technical transition processes beginning in September, but subject to a decision in the same period on ICB mergers by NHS England. The Board are asked to confirm their outline support, subject to the completion of the engagement processes set out above, for the direction of travel towards a full merger on the current Cluster footprint by April 2027.

1.3 Cluster Chief Nursing Officer Appointment Update and Executive Farewells

Following NHS England approval for NHS Shropshire, Telford and Wrekin and NHS Staffordshire and Stoke-on-Trent to operate under a clustered arrangement, the process to establish a single, shared Executive Team is now nearing completion.

I am pleased to confirm the appointment of Vanessa Whatley as Chief Nursing Officer following a robust external recruitment process. Vanessa has been serving as Interim Chief Nursing Officer for NHS Shropshire, Telford and Wrekin and brings a wealth of clinical leadership experience, alongside a strong commitment to quality improvement, patient safety and compassionate care. Her appointment represents an important step in strengthening leadership across our clustered arrangements as we continue to develop a more integrated approach to serving our populations.

The Board is also invited to recognise and thank colleagues who will be leaving their executive roles at the end of June.

We would like to place on record our appreciation and thanks to Paul Edmondson-Jones, Heather Johnstone, Chris Ibell and Tracey Shewan for the significant contribution each has made during their time in post. Collectively and individually, they have provided experienced, thoughtful and steadfast leadership through a period of significant change, helping to guide the organisation with professionalism, commitment and care while advancing our shared ambition to improve outcomes for the people and communities we serve. Their contribution has been substantial, their influence has been widely felt across the organisation and beyond, and their dedication to public service has left a lasting and valued mark. They will be greatly missed.

On behalf of the Board, I would like to offer our sincere and warmest thanks to all departing colleagues for their dedication, professionalism and the enduring contribution they have made to our organisation and to the people and communities we are privileged to serve. We wish them every success and happiness for the future and thank them again for all they have given in service.

1.4 NHS Excellence Awards

I am delighted to highlight the national recognition received by Dr Jess Harvey, local GP, Clinical Director for the South-East Shropshire Primary Care Network (PCN), and Co-Chair of the GP Board in Shropshire, Telford and Wrekin, at the inaugural NHS Excellence Awards.

The awards were presented at NHS ConfedExpo in Manchester on 10 June, bringing together leaders and colleagues from across the country to celebrate outstanding achievement within the NHS. Dr Harvey was awarded the national title in the Leadership category in recognition of her exceptional leadership, innovation and commitment to improving patient care.

This recognition reflects Jess's ability to inspire and empower others, build strong collaborative partnerships, and support teams to deliver high-quality services for the communities they serve. Her achievement exemplifies the values that underpin the NHS Excellence Awards and demonstrates the significant impact that strong clinical leadership can have in driving improvement and sharing best practice across the health and care system.

On behalf of the organisation, I would like to congratulate Jess on this well-deserved achievement and thank her for her continued leadership and contribution to improving outcomes for patients and communities.

1.5 Recognition: King's Birthday Honours

I am pleased to recognise Dr Karen Juggins, Consultant Orthodontist at University Hospitals of North Midlands NHS Trust, who has been awarded an MBE in the King's Birthday Honours List for services to dentistry.

This national honour reflects Karen's outstanding contribution to improving oral health, particularly for children and young people, and her sustained commitment to reducing health inequalities. Alongside her clinical leadership, she has led the development of the *Keep Stoke Smiling* and *Keep Britain Smiling* initiatives, which have achieved national reach through partnership working across health, education and community sectors.

Karen's achievement highlights the impact of clinical leadership in driving prevention, improving population health outcomes and engaging communities effectively.

On behalf of the organisation, I would like to offer my congratulations on this well-deserved recognition.

1.6 Long Service Awards

This month we celebrate a significant long service milestone across the cluster, with awards recognising staff who collectively represent over 900 years of service. This reflects the sustained commitment, expertise and contribution of colleagues to our shared purpose and the communities we serve. In recognition of the exceptional organisational change taking place, a more flexible

approach has been adopted to include those reaching milestones within the current financial year, ensuring colleagues leaving the organisation are appropriately acknowledged.

The report also recognises the ongoing contribution of former colleagues, whose legacy remains part of the organisation's success. As we transition to a new operating model, work is underway to develop a single, consistent long service awards policy across the cluster, aligned to best practice. We are committed to recognising the service that our colleagues have achieved and to thank them for their efforts and their service.

1.7 Lord Mann Review

On 4 June Lord Mann published his review into tackling racism and antisemitism within the NHS with recommendations to support our shared goal of making our services safe for all patients, communities, and colleagues.

The review demonstrates that while the NHS often creates an environment where every person, patient or colleague feels treated with dignity, compassion, and respect, we are not achieving that consistently and as effectively as we should be.

Lord Mann's review set out a range of recommendations for NHS England, NHS organisations and leaders, the Department of Health and Social Care, as well as arm's-length-bodies (ALBs) and regulators.

As a cluster of ICBs, we fully accept the findings of the review and will work to develop an approach that enables us to deliver its 36 recommendations, seeking assurances from our provider and primary care partners around this important agenda.

We are expecting further guidance and requirements but, as an immediate action, we will ensure regular board oversight of antisemitism, racism, religious hatred and staff experience and set clear expectations and accountability for leaders and managers across the cluster.

We will take ownership of addressing racism locally, including antisemitism, acting early and decisively, and embed established anti-racism principles into our organisational culture and practice.

NHS England has asked Boards to have oversight of some immediate actions. These are set out below-

- To join NHS England in signing up to the NHS Race and Health Observatory Seven Anti-Racism Principles
- Ensure implementation of the Violence Prevention and Reduction Standard, including data capture and use to target improvement with affected groups, this will be monitored via the NHS Oversight Framework
- Prepare to implement the forthcoming NHS Staff Standards
- Adopt the new government definition of anti-Muslim hostility
- Ensure all staff have completed the NHS Core Skills Framework module on Equality, Diversity and Human Rights (EDHR), which includes content on antisemitism and Islamophobia
- Ensure all staff complete the new bitesize module co-created with faith leaders in the NHS when it becomes available (with the exception of those who have completed EDHR mandatory training in the last 6 months)

- Ensure Board agreement to undertake new anti-racism training when it becomes available.
- Ensure colleagues, staff representatives, patients and communities are aware of your actions through your internal and external communications channels and are appropriately engaged in further developments to address antisemitism and all forms of racism locally
- Ensure your Board and its relevant committees fully understand your staff survey data on the experience of racism in your organisation and are taking appropriate action on key problem areas related to this issue and monitoring progress.

In addition, following on from NHSE communications in October 2025, we have been asked to confirm that we have adopted the International Holocaust Remembrance Alliance (IHRA) definition of antisemitism and the Government definition of anti-Muslim hostility.

The ICBs will build on the range of mechanisms we have in place to increase our understanding of the experiences and perspectives of our ethnically diverse workforce and populations, including our Public Sector Equality Duty (PSED) Reports (Workforce & Patients/Populations) and our annual Staff Survey.

We adopt the principles of Workforce Race Equality Scheme (WRES) in our PSED (Workforce) reporting and have adopted cluster equality objectives to address inequalities and health inequalities identified through our PSED reporting.

In addition to our statutory and mandatory requirements, the SSOT system developed a System Anti-Racism Toolkit which the ICBs are signed up to SSOT Anti Racist Toolkit and all ICB staff have been encouraged to engage with. We are clear that this agenda is much more than signing up to a definition or an action plan. It is fundamental to how we work, how we support all of our colleagues and how we actively set a culture and a tone that supports everyone to be their best. Antisemitism and all forms of racism have no place in the NHS. Patients should never feel anxious when receiving care in our system and no member of staff should ever feel isolated, intimidated or unwelcome in their workplace.

The Board are asked to confirm their commitment to this agenda and to gain the assurance of the delivery of the NHSE asks as detailed above.

1.8 Five-Year Commissioning Plans (2026–2031)

The summary versions of the Five-Year Strategic Commissioning Plans have now been published on both ICB websites, with links provided for ease of access:

- STW-Five-Year-Plan-Summary.pdf
- SSOT ICB Joint Forward Plan Update 2025-26

1.9 NHS Spring COVID-19 Vaccination Programme

The Spring COVID-19 vaccination programme continues to perform strongly across both Shropshire, Telford and Wrekin and Staffordshire and Stoke-on-Trent, with uptake remaining above both the Midlands and England averages.

It is particularly encouraging that uptake among people under 75 who are immunosuppressed or otherwise at increased risk is performing above regional and national averages. This reflects the

continued efforts of partners across the system to support those who are most vulnerable and to maintain confidence in vaccination.

Alongside programme delivery, there remains a strong focus on identifying areas where uptake is lower and working with local partners to better understand barriers, operational factors and community insight. This is enabling more targeted and responsive engagement across priority populations.

We continue to work closely with NHS providers, local authorities and the voluntary and community sector to strengthen outreach in communities where uptake has historically been lower. This includes the development and sharing of accessible and translated materials, alongside the use of trusted frontline networks to improve reach and engagement.

Through this collaborative approach, we are aiming to ensure that vaccination remains accessible, equitable and responsive to the needs of all communities across our system.

1.10 Staff Survey Results

The 2025 NHS Staff Surveys and Pulse Quarterly Surveys, across both ICBs highlight a mixed picture during a period of significant organisational change. Staff continue to report strong purpose and supportive teams; however, declining morale, wellbeing pressures, and concerns around communication, staffing and uncertainty remain, particularly in the context of national reforms.

These insights are informing our response. The survey findings have shaped the organisational development programme to support staff through transition and to define the future cluster culture. This includes a focus on strengthening communication and engagement, alongside targeted improvements such as the introduction of inclusive recruitment training for colleagues involved in Management of Change activity.

2.0 Primary Care

2.1 ‘Building Confidence for a CQC Inspection’ workshop

A ‘Building Confidence for a CQC Inspection’ workshop was delivered on 29 April 2026 as part of our ongoing commitment to supporting primary care colleagues. This comprehensive and engaging programme was designed to strengthen understanding of Care Quality Commission requirements while supporting continuous improvement in the quality of care delivered across our services.

The workshop was very well attended by GP practices from across the area, demonstrating a strong level of engagement and a shared commitment to ensuring readiness for inspection. Feedback and participation reflected the value of creating dedicated space for learning, reflection and preparation.

The event was organised and delivered collaboratively by the Staffordshire Training Hub, working in partnership with the GP Support Team within the ICB, exemplifying the benefits of coordinated system working in supporting our primary care workforce.

2.2 Gill Boast receives her MBE

In May, Gill Boast, Practice Nurse Facilitator and Training Programme Lead, attended her MBE Investiture, marking a significant and well-deserved recognition of her contribution to the profession. Reflecting on the occasion, Gill shared that it was a memorable day and a privilege to

meet HRH Prince William, noting his genuine interest in her career and the work being undertaken across Staffordshire.

This recognition highlights the impact of Gill's dedication and leadership, and we are extremely proud of her achievements and the contribution she continues to make across Staffordshire and Stoke-on-Trent.

3.0 Urgent and Emergency Care (UEC)

May remained a challenging period, with several key performance metrics continuing to operate below plan. Notwithstanding these system pressures, we have seen incremental improvements across several areas, reflecting the sustained focus, professionalism and resilience of teams working across a complex operational environment.

In Shropshire, Telford and Wrekin, the Urgent and Emergency Care (UEC) Transformation Programme for 2026/27 and 2027/28 has now been established and is moving into delivery. The programme brings together a coordinated focus on community urgent care, acute flow and streaming, and discharge transformation, with winter and surge planning and the proposed Flow Centre acting as key cross-cutting enablers. Collectively, this work will support a more consistent system approach to reducing avoidable emergency department demand, improving ambulance handover and front-door flow, strengthening same-day and community-based alternatives, and improving discharge processes, including non-clinical treatment ready (NCTR) pathways and long length of stay. Importantly, the programme will also inform winter planning for 2026/27, ensuring that preparedness is fully aligned with wider system transformation rather than developed in isolation.

The revised UHNM in-hospital improvement programme has now been launched, structured around five workstreams aligned to the Getting It Right First Time (GIRFT) recommendations. Each workstream is underpinned by clear executive, corporate, care group and clinical leadership, with ongoing support from the GIRFT team to ensure delivery remains clinically led, evidence based and focused on measurable improvement.

Across the system, the ICC has been testing a range of senior decision-making models to support the development of a future system-wide operating approach. This work is currently under review, alongside the continuation of the UHNM/ICC Silver Line pathway, which remains in place to help reduce avoidable hospital conveyances for care home residents. In parallel, work is progressing to develop an ICS-wide Long Lie policy, aimed at supporting more people to remain safely within their usual place of residence and strengthening community-based alternatives to hospital admission.

On 6 May, partners from across the Staffordshire and Stoke-on-Trent ICS came together for a system-wide review of winter 2025/26. This marked the third event of its kind and saw strong representation from across system partners, reflecting a shared commitment to collective learning and continuous improvement.

The session focused on revisiting key learning from winter 2024/25, maintaining a strong emphasis on quality and patient experience, including the use of a patient story to illustrate system pathways. It also included a high-level review of performance and key metrics, alongside pre-collected system feedback to provide a more comprehensive understanding of pressures and opportunities. Breakout sessions enabled focused discussion to ensure learning is embedded into

planning for 2026/27, with a particular focus on evolving models of care and strengthening collaborative delivery.

The insights from this event will directly inform our planning for winter 2026/27. Further development and formal ratification of system partner plans will follow, ensuring we are well positioned to meet the demands of the forthcoming winter period.

4.0 Medicines Optimisation

4.1 Reducing Harm from Inappropriate Opioid Prescribing Poster Presentation, Clinical Pharmacy Congress London

This pharmacist-led initiative has made a significant contribution to improving patient safety by addressing inappropriate opioid prescribing. Through the introduction of structured medication reviews, strengthened collaboration with prescribers, and a consistent focus on evidence-based practice, the project has delivered measurable improvements in prescribing quality and increased awareness of the risks associated with opioid use across the system.

The impact of this work has been recognised nationally, with selection for poster presentation at the Clinical Pharmacy Congress. In addition, Renee Larsen was shortlisted for the Excellence in Primary Care Practice award, reflecting both the quality of the initiative and its positive impact on patient care.

4.2 Community Pharmacy - Independent Prescribing Pharmacist Anticoagulant service

Sustainable Primary Care funding has now been secured to maintain the community pharmacy-based independent prescribing anticoagulant service, ensuring its continuation beyond the initial pilot phase. The service was originally established through the NHS England Independent Prescribers Pathfinder programme to address a recognised commissioning gap and has, over the past two years, provided specialist anticoagulation support to patients.

Delivered within a community pharmacy setting, the service enables an independent pharmacist prescriber to undertake dosing, prescribing, and ongoing monitoring, alongside regular clinical review. This model has improved access to care, enhanced patient safety, and contributed to better clinical outcomes.

The confirmation of recurrent funding represents an important step in embedding this service within the local healthcare system, securing its long-term sustainability and ongoing value to the communities it serves.

4.3 NHS England AMR (Antimicrobial Resistance) Leadership Start-Up Funding

Funding of £50,000 has been secured across the SSOT/STW Cluster to strengthen ICB leadership in antimicrobial resistance (AMR), supporting delivery of national priorities in this critical area. The programme is currently in development and will enhance system leadership, coordination and oversight of AMR, with a particular focus on improving outcomes for children.

This investment is especially important given the current level of need within the system, with SSOT identified as the third highest ICB in England for AMR-related concern. Strengthening our leadership approach will be key to driving improvement, supporting more effective antimicrobial stewardship, and reducing associated risks to patient safety.

4.4 General Pharmaceutical Council (GPhC) Governing Council Appointment

Claire Dearden, Medicines Optimisation Governance and Service Improvement Lead within the ICB, has been appointed as a Pharmacy Technician Registrant Member of the General Pharmaceutical Council (GPhC) Governing Council, with her term commencing in April 2027. The appointment, made by the Privy Council, represents national recognition of her expertise and leadership across system-level pharmacy services.

The GPhC Governing Council plays a critical role in setting strategic direction and ensuring that regulatory arrangements continue to protect patients and the public. In this role, Claire will bring valuable ICB insight to national discussions, working collaboratively with colleagues to support the ongoing development of pharmacy practice and to help shape the future of regulation in line with evolving population health needs.

5.0 Mental Health

5.1 Physical Health Checks for people with Severe Mental Illness (PHSMI) data released

The Q4 2025/26 data for Physical Health Checks for people with Severe Mental Illness (PHSMI) was published on 21 May 2026 via NHS England Digital. Staffordshire and Stoke-on-Trent ICB achieved a rate of 69%, exceeding the national ambition of 60% by nine percentage points and demonstrating strong system performance in this priority area.

This also represents an 11-percentage point improvement from Q3 to Q4, reflecting the continued focus and commitment of partners to improving outcomes for people with severe mental illness.

The NHS Oversight Framework for 2026/27 is currently being finalised and approved through NHS England executive processes. It is anticipated that PHSMI will remain a key metric within the framework, reinforcing the importance of sustaining progress and maintaining delivery in this area.

6.0 Improving Population Health

6.1 B.E.A.T. initiative has been delivered in partnership with Pumping Marvellous

Through Staffordshire and Stoke-on-Trent ICB Health Inequalities funding, the B.E.A.T. (Breathlessness, Exhaustion, Ankle Swelling – Take a Test) initiative has been delivered in partnership with Pumping Marvellous. The most recent community events, held in Tamworth and Chesterton, were well attended, attracting approximately 800 people and demonstrating strong community engagement.

The campaign is focused on raising awareness of the key symptoms of heart failure and encouraging earlier identification and intervention. By promoting a clear and accessible message, the initiative supports individuals experiencing symptoms to seek timely assessment and appropriate testing.

These events have specifically targeted residents aged 40 and over who are not currently on a heart failure register but may be experiencing relevant symptoms. Through the use of point-of-care testing, elevated NT-pro BNP levels were identified in seven individuals, indicating possible heart failure, while a further eight individuals were identified as being in atrial fibrillation. This approach is supporting earlier detection, timely intervention, and improved patient outcomes.

Engagement has been particularly strong, with a continued focus on improving access to cardiovascular screening within underserved communities. The next event is scheduled to take place in Kidsgrove on 12 June, as the programme continues to adopt a proactive, population

health management approach. Our longer-term ambition is to ensure that the B.E.A.T. message is widely recognised and understood across our communities.

6.2 Locality Improvement Framework (LIF)

All 12 localities have now submitted proposals for Locality Improvement Framework investment and are progressing into delivery. The LIF is designed to support local areas in developing new, collaborative ways of working, bringing together partners across health, local authority and the voluntary, community and social enterprise (VCSE) sector. Each proposal aims to strengthen cross-sector partnership working and deliver measurable improvements in health outcomes, underpinned by a population health management approach.

Delivery is now well underway in several areas. In Tamworth, the “GSB” Wellness Project is progressing positively, with the first cohort of participants engaged and baseline data collection in place to support evaluation and impact assessment. Early activity has focused on establishing strong foundations for delivery and building relationships with both participants and partners.

Micro-grant funding has also been allocated, enabling a range of community-led initiatives to be mobilised across the locality in line with LIF priorities. In parallel, school holiday provision is developing well, with partners coordinating accessible activities for children and young people, supporting both engagement and wellbeing during the holiday period.

In Cannock, the “Focus on Food” 12-week programme successfully concluded at the end of May, engaging both adults and children in developing healthier relationships with food. The programme has supported participants to build practical skills and confidence in preparing nutritious meals, while also strengthening community connections.

A particularly positive outcome has been the sustained engagement of adult participants, who have established an ongoing community cooking club to continue peer support and shared learning. In addition, the group is collaboratively developing a children’s healthy recipe book for publication, extending the impact of the programme and promoting healthier lifestyles within the wider community.

7.0 Elective Care

Recent data confirms that the NHS achieved the Government’s target of ensuring 65% of patients receive elective treatment within 18 weeks by March, despite the considerable operational challenges experienced during the year, including the impact of industrial action.

Locally, we have seen significant progress over the past 12 months. In March 2024, just over half of patients were receiving treatment within 18 weeks. By March 2025, this had increased by almost 20 percentage points to 69.5%, exceeding the national target and reflecting the sustained efforts of teams across our health and care system.

This improvement has been driven by strong performance across all local providers. The Shrewsbury and Telford Hospital NHS Trust achieved 68.9%, exceeding both local and national expectations and recording the largest improvement of any acute trust in England over the past year. Shropshire Community Health NHS Trust achieved 81.3%, representing an improvement of almost 29 percentage points, while The Robert Jones and Agnes Hunt Orthopaedic Hospital achieved 62.2%, an increase of more than 16 percentage points and one of the most significant improvements nationally.

These achievements are testament to the dedication and commitment of colleagues across our organisations, who have continued to focus on reducing waiting times and improving access to care for patients. While there remains more to do, this progress demonstrates what can be achieved through strong partnership working, clinical leadership and a shared commitment to improving patient outcomes.

For patients across Staffordshire and Stoke-on-Trent, performance against the 18-week elective care standard continues to improve. In March 2024, 55.9% of patients received treatment within 18 weeks of referral; by March 2026, this had increased to 66.0%, achieving the national target and reflecting sustained progress in reducing waiting times.

This improvement has been accompanied by a significant reduction in the overall waiting list, with more than 20,000 fewer patients waiting for treatment compared to March 2024.

Performance improvements have been evident across our providers. At University Hospitals of North Midlands, the proportion of patients treated within 18 weeks increased from 50.6% in March 2024 to 64.7% in March 2026, demonstrating substantial progress over the two-year period. Midlands Partnership University NHS Foundation Trust has continued to perform strongly, achieving 92.8% in March 2026 and consistently exceeding the national standard.

These improvements are a testament to the commitment and hard work of colleagues across our provider organisations and wider system partners, who remain focused on improving access to care and delivering better outcomes for patients.

Simon Whitehouse,

Chief Executive Officer

June 2026

Classification: Official

To: Ian Green
Simon Whitehouse

cc. Dale Bywater

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

2 June 2026

Dear Ian & Simon,

Merger of ICB clusters on settled footprints

Moving from ICB clusters to merged ICBs will allow the achievement of further efficiencies and full focus on strategic commissioning. Therefore, it is proposed that on 1 April 2027, ICB clusters will be replaced by merged ICBs serving populations of at least 1.5 million. It is anticipated that ICB clusters, where the footprint is aligned to confirmed, or reasonably anticipated, strategic authority footprints, will be merged on those footprints.

In the 10 Year Health Plan the Government committed to aligning ICB footprints with strategic authorities (one or more) 'wherever feasibly possible'. Parliament has recently passed the English Devolution and Community Empowerment Act 2026 which will streamline the establishment of strategic authorities and the devolution of powers, subject to local consent. In addition, it is expected that this summer the final unitary authority footprints – replacing two tier county and district councils – will be decided ahead of implementation on 1 April 2028. These milestones, combined with the benefit that early certainty on footprints will give to staff and partners, means now is the right time to address this commitment.

We are consulting you on delivering this 10 Year Health Plan commitment, ahead of NHS England deciding in September the ICB boundaries to be implemented on 1 April 2027. You are expected to engage local partners before responding to your Regional Director by 14 July 2026. In particular, we would strongly encourage you to engage actively with local MPs, and also with the local authorities covering your areas, and where you have them, strategic authorities. Your local engagement will be important for understanding local priorities, including on the future establishment of strategic authorities and devolution. We encourage you to engage meaningfully at political and senior officer level to be able to understand and

reflect back to us the views of these key stakeholders, in particular their views on the impacts of ICB boundaries on their ability to support the delivery of local services.

Your response should:

- Confirm your current cluster footprint, on which it is proposed you will merge, aligns to confirmed or reasonably anticipated strategic authority footprints.
- If the above does not apply, submit suggested minimum boundary changes that would be necessary to merge on confirmed or reasonably anticipated strategic authority footprints, or
- Explain why it is not 'feasibly possible' to amend your cluster footprint to merge fully on confirmed or reasonably anticipated strategic authority footprints, including due to significant uncertainty on the footprints of any strategic authorities that may be established in future.

NHS England, DHSC and MHCLG officials stand ready to engage with you on these points where helpful or where there is a lack of local clarity.

In all cases your response should consider the impact on health inequalities and delivery of the Public Sector Equality Duty, as well as any other legal duties you consider relevant and necessary to take into account.

Where you are making the case that it is not 'feasibly possible' to align to a confirmed or reasonably anticipated strategic authority (one or more), you should include an explanation supported by evidence and address how added complexity for partnership working will be mitigated (suggest in total no more than 10 sides of A4).

As noted above, the footprints of unitary authorities replacing county and district authorities will not be confirmed until later this summer. Alignment with upper tier local authorities, responsible for social care and public health, is important for simplicity in co-commissioning and particularly in the context of developing the neighbourhood health service overseen by the health and wellbeing board. If your ICB proposes non-alignment not only with a strategic authority or authorities but also with an upper tier authority, then you must provide evidence for why that is in the best interests of those in receipt of both health and care services, and share feedback from your stakeholder engagement with local and strategic authorities that reflects how sensible governance arrangements would be established. Mitigations must be described having been developed with local authority partners.

Regional teams can support dialogue across ICBs and where appropriate regional boundaries.

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After you have submitted your responses, we may come back to you for clarification in the context of cross-government discussions and progress on the Government's devolution and local government reorganisation priorities.

For further details of this process, including on engagement, please see our guidance on implementing ICB mergers and boundary changes for April 2026 and 2027.

Yours sincerely,

Glen Burley
Deputy Chief Executive,
NHS England.

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Enclosure No: 06

Report to:	Integrated Care Board
Date:	25 June 2026
Title:	Emergency Preparedness, Resilience and Response (EPRR) Annual Reports and documents for approval
Presenting Officer:	Phil Smith, Cluster Chief Officer for System Development and Integration / Accountable Emergency Officer, Katie Weston, SSOT ICB EPRR Strategic Lead, and Felicity Govas, STW ICB Senior EPRR Lead
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Document Type:				**Action Required (select):**			
Report	☒	**Business Plan**	☐	**Information (I)**	☐	**Discussion (D)**	☐
Strategy	☐	**Policy**	☒	**Assurance (S)**	☒	**Approval (A)**	☐
Other	☐	*(please describe)*		**Ratification (R)**	☒		

Is the decision within SOFD powers & limits	**Yes**	☒	**No**	☐
Any potential / actual Conflict of Interest?	**Yes**	☐	**No**	☒
Any financial impacts: ICB or ICS?	**Yes**	☐	**No**	☒
Any impacts on ICB Undertakings?	**Yes**	☐	**No**	☒
Appendices:	None			

(1) Purpose of the Paper:

As required by standard 3 of the mandatory NHS Core Standards for Emergency Preparedness, Resilience and Response (EPRR) this paper will provide the Board with a comprehensive overview of the arrangements in place within Staffordshire and Stoke-on-Trent ICB (SSOT ICB) and Shropshire, Telford and Wrekin ICB (STW ICB) with regards to EPRR and Business Continuity. The enclosed part 1 and part 2 reports confirm the 2025 annual assurance position of substantial compliance for both ICBs, outline the action plan in place to maintain this compliance rating for 2026, seek support for those ICB arrangements requiring Board level approval, and confirm the Cluster's ongoing commitment to maintaining suitable and sufficient EPRR resource going forwards.

Additionally, the Board is advised that to reflect Management of Change outcomes for the Senior Leadership Team, the STW ICB EPRR and Business Continuity Policy, SSOT ICB EPRR Policy,

and SSOT ICB Business Continuity Policy, each confirmed as in date at the time of reporting, have undergone minor updates to maintain compliance, as outlined in the executive summary below. In line with Governance advice, and recognising these as non-material amendments, the updates will be reported to the next Audit Committee in Common meeting and are not required to be presented in full at this time.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	Date
SSOT ICB Annual EPRR Report: Audit Committee (A/S)	22 April 2026
STW ICB Annual EPRR Report: Strategic Commissioning and Productivity Committee (A/S)	24 February 2026

(3) Implications:	
Legal / Regulatory	ICBs are legally required to have suitable arrangements in place to place for incidents and events that could adversely impact on statutory or essential functions, or on the sustained delivery of commissioned health services, under the: Civil Contingencies Act 2004; NHS Act 2006 (as amended) - s252A (9); Health and Social Care Act 2012; Health and Care Act 2022; NHS England EPRR Framework 2022 and associated NHS Core Standards for EPRR; NHS Standard Contract – Service Condition 30 (Emergencies and Incidents).
CQC / Patient Safety	Nil
Financial (CFO-assured)	Nil
Sustainability	Nil
Workforce / Training	Nil
Equality & Diversity	Nil
Due Regard: Inequalities	Nil
Due Regard: wider effect	Nil

(4) Statutory Dependencies & Impact Assessments:

	Completed?			If N - N/A, Rationale	If Y, Outcome / Date Reported & Signed off
	Yes	No	N/A		
DPIA	☐	☒	☒	The report presents the annual EPRR position to the Board. A DPIA will be completed, as required,	

				for any associated policies or plans as part of the EPRR workstream.	
EIA	**Yes** ☐	**No** ☒	**N/A** ☒	The report presents the annual EPRR position to the Board. An EIA will be completed, as required, for any associated policies or plans as part of the EPRR workstream	
QIA	**Yes** ☐	**No** ☒	**N/A** ☒	The report presents the annual EPRR position to the Board. An EIA will be completed, as required, for any associated policies or plans as part of the EPRR workstream	
Has there been Public / Patient Involvement?			**Yes** ☐ / **No** ☒ / **N/A** ☒		Click or tap here to enter text.

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

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

This paper covers the following areas:

1. The outcome of the 2025 NHS Core Standards for EPRR assurance process, as conducted by NHS England, confirming SSOT ICB and STW ICB as Substantially Compliant. For STW ICB this represents an improvement on the Partially Compliant position recorded in 2024 and is illustrative of the incremental and continuing progress made over the last 12 months. SSOT ICB maintained their high standard of preparedness between 2024 and 2025, as reflected in their continued Substantial Compliance rating. Going forward, SSOT ICB and STW ICB are committed to maintaining sufficient dedicated resource to meet their statutory and contractual responsibilities

with regards to EPRR and Business Continuity. This is reflected in the future structures, as outlined in the Cluster Management of Change process.

2. The levels of compliance achieved by System partners in SSOT and STW in 2025.

-Across the system, MPFT and NSCHT maintained substantial compliance, and UHNM achieved partial compliance. The system was rated as substantially compliant overall, and within the CBRN (Chemical, Biological, Radiological, and Nuclear) response domain, by the Local Health Resilience Partnership Group in November 2025.
- In STW all partners improved or maintained their levels of compliance between 2024 and 2025. Robert Jones and Agnes Hunt improved from Non-Compliant to Partially Compliant, Shrewsbury and Telford Hospitals improved from Partially Compliant to Substantially Compliant, Shropshire Community Health Trust maintained their Substantially Compliant position.

3. The positive progress made by SSOT and STW ICBs against the following EPRR workstreams, demonstrating robust readiness to respond to incidents and emergencies:

- Response to Business Continuity, Critical and Major Incidents
- Continuous improvement
- Training and exercising
- Business Continuity
- EPRR work programme

4. Outstanding areas of compliance with the Core Standards across SSOT and STW ICBs.

5. Minor updates to the STW ICB EPRR and Business Continuity Policy, the SSOT EPRR Policy and the SSOT Business Continuity Policy.

In accordance with the Core Standards, ICBs are required to have a range of documents in place to support the response to, and governance surrounding incidents and emergencies. This year, the assurance of ICBs by NHS England will remain separate, as opposed to in Cluster groupings. For this reason, and due to competing priorities within the limited time ahead of the 2026 Core Standards process, the decision has been made, with Executive support, to maintain some separate ICB documentation in the short term. As a result, the aforementioned documents have undergone minimal changes to ensure compliance with the relevant Core Standards. These changes include:

- Update of role titles
- Amending governance structures in line with SLT Management of Change outcomes
- Reflecting alterations brought about by developing clustering arrangements
- Incorporating minor observations raised during the 2025 Assurance process

Going forward, and ahead of the 2027 assurance process, the intention is for all EPRR documentation to be harmonised across the Cluster.

(7) Recommendations to Board:

1. **SSOT ICB Annual EPRR Report (Part 1)**

The Board are asked to:

I. Note the EPRR resources outlined to support delivery of EPRR and incident response functions and note the cluster EPRR governance alignment with Audit Committee in Common going forwards.

II. Note the 2025 EPRR annual assurance compliance rating of substantial compliance.

III. Note and support the EPRR annual assurance 2026/27 priorities as listed in part 1 section 5.

2. **STW ICB EPRR Report (Part 2)**

It is recommended that the Board be assured that STW ICB is discharging its statutory and mandatory responsibilities and duties appropriately, based on:

- The performance of the ICB and its commissioned providers during the 2025 EPRR Core Standards process.
- The ongoing activity and progress made in relation to EPRR.

3. **STW ICB EPRR and Business Continuity Policy, SSOT ICB EPRR Policy, and SSOT ICB Business Continuity Policy**

☑ It is recommended that the Board note the minor updates made to the Policies as set out above, to support compliance with the 2026 NHS Core Standards for EPRR. As noted, the intention is for all EPRR Policies and associated documentation to be harmonised across the Cluster within the next year.

Part 1: SSOT ICB Annual EPRR Report

Emergency Preparedness, Resilience and Response (EPRR)
Annual Report to the ICB Public Board Meeting in Common – 2025-26

1. Background

1.1 The Civil Contingencies Act (CCA) 2004, NHS Act 2006, Health and Care Act 2022, and the NHS England EPRR Framework 2022 requires NHS organisations and providers of NHS-funded care to have plans and arrangements in place to respond to a wide range of incidents that could affect health or patient care, while maintaining services to patients.

2. Purpose

2.1 The purpose of this report is to provide the ICB Public Board, with assurance of the ICB arrangements in place to fulfil the ICB's EPRR obligations, and seek approval for those elements of the ICB EPRR portfolio requiring Board level approval, in particular:

- Outline the resources currently available to support delivery of EPRR functions and duties
- Confirm the ICB rating against the NHS Core Standards for EPRR annual self-assessment for 2025, including an update on upcoming ICB and ICS EPRR priorities.
- Provide a summary of incidents experienced by the organisation and system in the past year, and an overview of the lessons process for continuous improvement.
- Provide an overview of training and exercises undertaken by the organisation.
- Provide an overview of business continuity and organisational readiness performance.

3. EPRR Structure and Resource

3.1 The NHS EPRR Framework and Core Standards require the organisation to appoint an Accountable Emergency Officer (AEO) responsible for EPRR. This individual must be a Board level Director within their organisation, and have the appropriate authority, resources, and budget to direct the EPRR portfolio.

3.2 This role is delegated to the Cluster Chief Officer for System Development and Integration by the Chief Executive Officer, with the roles and responsibilities as set out within the ICB EPRR Policy. The AEO has responsibility for EPRR delivery within their portfolio.

3.3 In line with the new Cluster and Committee in Common arrangements with Shropshire, Telford and Wrekin (STW) ICB, EPRR governance for the Cluster will align with the Audit Committee in Common going forwards.

3.4 The EPRR function is an example of matrix working, with delivery of the EPRR agenda currently fulfilled across the EPRR and UEC Operations Team, ICB directorates, and across the Integrated Care System to enable collaborative working, and delivery of a system EPRR programme to ensure incident preparedness and readiness to respond.

3.5 This to time has provided a level resilience across both the EPRR and UEC portfolios, supporting the interdependence between system capacity and pressures, and opportunities for collaboration during planned or unexpected events and incidents.

3.6 The current ICB EPRR resource is as follows, with resource roles and responsibilities confirmed within the ICB EPRR Policy:

Position	Role	Band

Executive Director Lead / Accountable Emergency Officer (AEO)	Accountable Emergency Officer (AEO) and Executive Director with statutory responsibility for EPRR delivery.	VSM
Portfolio Director – Delivery and Improvement	Director level deputy for the Executive Director Lead as required.	9
Associate Director for UEC and EPRR	Associate Director Lead for UEC Operations and EPRR deputising for the EPRR Director Lead / Portfolio Director as required	8d
EPRR Strategic Lead	EPRR Lead responsible for delivery of EPRR functions against the work programme. Lead for the EPRR annual assurance process for the ICB and assessment of returns from SSOT NHS providers.	8b
EPRR Operational Manager	EPRR Operational Manager responsible for supporting the EPRR Strategic Lead in delivery of the EPRR work programme.	7
UEC Managers	Supporting the EPRR team in delivery of key EPRR projects, training, and incident response support.	3 x b6
On Call Staff	The organisation maintains a 24/7 response capability at a strategic, tactical, and clinical level. These roles are held by post holders at VSM/Band 9, Bands 8d/8c, and ICB clinicians respectively. These individuals can deliver effective incident response to any incident affecting the system through training and exercising appropriate to their role.	
Directorate/ Service Leads for Business Continuity	Each Directorate has identified leads from each team to support business continuity planning where their service area is identified as maintaining critical/essential services within the ICB. This role holder will continue to review essential functions and contingency arrangements for their team.	
Directorate/ Service Business Continuity Recovery Teams	Each Team (for Business continuity purposes) has identified a business continuity recovery team that will lead the response to and recovery from an unplanned event or incident impacting the service or directorate.	

3.7 An assessment of the required number of roles across a complex incident response structure has been undertaken by the EPRR team and has confirmed the ICB is able to respond to a sustained incident via the current On-Call Manager structure and incident response arrangements.

3.8 Recommendation 1 – Board are asked to note the EPRR resources outlined to support delivery of EPRR and incident response functions, and note the cluster EPRR governance alignment with Audit Committee in Common going forwards.

4. EPRR Annual Assurance Position

4.1 NHS organisations are required to complete an annual self-assessment for EPRR against a set of nationally mandated core standards, verified through a confirm and challenge process with NHS England, and report the results of this to the public ICB Board in Common.

4.2 The purpose of the NHS core standards for EPRR is to enable health agencies across the country to share a common approach to EPRR, allow coordination of EPRR activities according to the organisation’s size and scope, provide a consistent and cohesive framework for EPRR activities, and inform the organisation’s annual EPRR work programme.

4.3 **2025 Core Standards compliance** – as reported to SSOT ICB Audit Committee in November 2025, SSOT ICB achieved a substantially compliant position of 93.6%, a rise from 91.5% in 2024, and sustaining the substantially compliant position from 2023-2025 in line with the strategy for EPRR transformation led by the EPRR team.

4.4 A breakdown of compliance against each core standard domain is outlined below, with those listed as partially compliant having action plans in place to address these ahead of the 2026 August assessment:

Core Standard Domains	Total standards	Fully compliant	Partially compliant	Non-compliant
Governance	6	6	0	0
Duty to Risk Assess	2	0	2	0
Duty to Maintain Plans	8	8	0	0
Command and Control	2	2	0	0
Training and Exercising	4	4	0	0
Response	5	5	0	0
Warning and Informing	4	4	0	0
Cooperation	6	6	0	0
Business Continuity	10	9	1	0
Total	**47**	**44**	**3**	**0**
Overall self-assessment:	**Substantial Compliance**			

4.5 Of the eleven ICBs in the Midlands region, eight were substantially compliant, including SSOT ICB, with one ICB achieving partial compliance, and two ICBs achieving full compliance. Regionally there has been year on year growth in the compliance of organisations in the region.

4.6 Across the system, MPFT and NSCHT achieved substantial compliance, and UHNM achieved partial compliance. The system was rated as substantially compliant overall, and within the CBRN (Chemical, Biological, Radiological, and Nuclear) response domain, by the Local Health Resilience Partnership Group in November 2025.

4.7 Good actions plans are underway to continue to build upon compliance success across the system, with monthly assurance discussions in place between the ICB EPRR Strategic Lead and Provider EPRR Leads to support this.

4.8 **Recommendation 2 – Board are asked to note the 2025 EPRR annual assurance compliance rating for SSOT ICB of substantial compliance.**

5. EPRR Assurance 2026/27 Priorities

5.1 The 2025 EPRR annual report to Board sets out the strategy for 2025-2028 with a focus on building upon the identified assurance priorities, and enhancing ICB and system resilience through the following areas:

- Sustained substantial compliance against the EPRR annual assurance process
- Continued development of on-call teams and incident commanders
- Enable and empower business continuity lead self-sufficiency in preparing and maintaining service level arrangements against incidents and disruptive events

- Continue to develop robust EPRR risk management processes
- Work to enhance supply chain resilience through the assessment of business continuity plans during the tendering process of our commissioned services

5.2 Good progress is being made in this space, including excellent engagement in training and exercising for on-call teams, established business continuity plans in place across the board, and development of a regional supplier resilience framework led by the EPRR team.

5.3 Noting the move to cluster ICB arrangements, the EPRR team will seek to achieve continued substantial compliance in the 2026 EPRR annual assurance process, however national and local transition requirements are currently unknown and may impact this. A work programme review is underway to support maintained compliance as transition arrangements progress. The ICB self-assessment will be submitted on 28 August 2026.

5.4 Across the system, good engagement in the system EPRR agenda has been seen throughout, supporting collaboration and partnership working. Collaboration across core planning themes continues, with areas of focus including mass casualty, evacuation and shelter, and countermeasures response. Notably, there has been excellent partnership in planning and engagement with the Local Resilience Forum (LRF) multi-agency biological CBRN exercise to test medical countermeasures arrangements, and the collaboration between the system EPRR and LRF risk assessment groups has been recognised as good practice by LRF and Ministry for Housing, Communities, and Local Government colleagues.

5.5 The outcomes of the annual assurance process relating to areas of improvement aligned closely to the general trend across the region, with areas for improvement including assurance of service providers within business continuity, and evacuation and shelter arrangements. The system EPRR agenda will additionally focus on Martyn's Law (formally the Terrorism (Protection of Premises) Act 2025) requirements, recognising the requirement for sites to put in place mandatory and proportionate measures to protect against terrorism by April 2027.

5.6 As reported to the Local Health Resilience Partnership (LHRP), these areas will form areas for improvement for the system for the joint work programme, in addition to workstream focus areas including new and emerging pandemics, mass countermeasures, mass casualty, evacuation and shelter, excess fatalities, and cyber response arrangements.

5.7 A system EPRR away day took place in February 2026 to support work programming for joint priorities and promote the sharing of expertise, learning, and collaboration to continue to develop a system approach to EPRR.

5.8 NHSE have confirmed the new set of core standards for annual assurance are not expected for use in 2026. When released, this will be incorporated into the ICB EPRR work programme planning.

5.9 Recommendation 3 – Board are asked to note and support the EPRR annual assurance priorities for 2026/27 as listed.

6. 2025-26 System Incident Log

6.1 15 incidents were declared by the ICB or Providers in 2025/26 and are listed below for information. This is lower comparatively to 2024/25 which saw 22 incidents declared within the system. A list of multi-agency incidents, and events of note not declared as incidents within the system, are listed in section 7.

6.2 The EPRR team maintains a register of post-incident / exercise lessons and debrief reports to support the process of continuous learning outlined within the ICB EPRR Policy.

Trust	Site	Dates	Incident Type	Detail
UHDB	Queen's Hospital / Sir Robert Peel / Samuel Johnson	25 April 2025	Business Continuity	Meditech outage
UHNM	Royal Stoke Hospital	16 May 2025	Critical Incident	Maternity unit lockdown
MPFT	Redwoods Wenlock Building	06 June 2025	Critical Incident	Reception evacuation
UHDB	Queen's Hospital Burton	06 June 2025	Security Incident	Site lockdown
UHDB	Queen's Hospital Burton	03 July 2025	HAZMAT Incident	Offsite – Patient Decontamination
NSCHT	Keele Practice	08 July 2025	Business Continuity	IT and telephony outage
UHNM	Royal Stoke Hospital	29-31 July 2025	Critical Incident / Business Continuity	Loss of emergency bleep system
MPFT	St Georges Hospital	09 October 2025	Critical Incident	Welfare concern
UHDB	Queen's Hospital Burton	20-21 October 2025	Business Continuity	Diabetes clinic loss of water
UHDB	Queen's Hospital Jubilee Building	30-31 October 2025	Business Continuity	Lift failure
UHDB	Sir Robert Peel Hospital	14 October- 11 December 2025	Business Continuity	Theatre ventilation failure
UHNM	Royal Stoke / County Hospital	08- 21 December 2025	Critical Incident / Business Continuity	UEC capacity and pressure
UHNM	Royal Stoke / County Hospital	18-21 December 2025	Business Continuity	System C (Careflow / iPortal) service outage
UHNM	Royal Stoke / County Hospital	06-07 January 2026	Business Continuity	System C (Careflow / iPortal) service outage
UHNM	Royal Stoke / County Hospital	13- 16 January 2026	Business Continuity / Critical Incident	UEC capacity and pressure

7. Undeclared Incidents / Events of Note

7.1 In addition to those outlined previously, the ICB has successfully responded to the following consecutive and concurrent incidents during 2024-25, demonstrating an ability in the organisation to respond and support the ICS while delivering the EPRR work programme:

Incident	Date	Type	Detail

Walleys Quarry	2021 - present	Multi-agency - waste site	NHS representation and response support to strategic and recovery groups.
NHS Industrial Action	November 2022 to present	Industrial action	Development of ICB and ICS arrangements for ongoing/ad hoc industrial action by NHS unions.
Operation Lazurite	October 2023 to July 2025	MOD and NHS joint Operation	NHS representation and support to Afghan Relocations and Assistance Policy (ARAP) scheme
Hyperwaste Site	April 2025 to present	Multi-agency – waste site	NHS representation and response support to strategic and tactical response groups.
Asylum Hotel Protests	August 2025 to present (ad hoc)	Public protest / unrest	NHS representation and support to tactical assessment meetings as required.
Measles Outbreak	November 2025	Infectious disease outbreak	NHS representation and support to UKHSA incident management team response.
Storm Claudia	13-14 November 2025	Adverse weather	NHS representation and support to multi-agency flood advisory meetings.
Storm Goretti	07 January 2026	Adverse weather	NHS representation and support to multi-agency tactical response group.
Stryker Cyber Attack	11-12 March 2026	Cyber attack	Cyber attack on major commercial supplier of medical devices and consumables with nationwide impacts. Attendance at regional calls to share information and understand risk.
Meningococcal B Outbreak	March 2026	Infectious disease outbreak	System preparedness discussions to ensure readiness in the event of an outbreak of Meningitis B outside of Kent area.

8. EPRR Training, Development, Testing and Exercising

8.1 The ICB is required to have resilient and dedicated mechanisms and structures in place to enable 24/7 receipt and action of incident notifications. A strategic and tactical On-Call Manager function is in place to ensure appropriate escalation, command and control during an incident, supported by a training and exercise programme to ensure individuals are suitably trained and competent in their roles.

8.2 This training is delivered in accordance with the NHS England EPRR competencies (minimum occupational standards). A training needs analysis and role specific training pathways are in place for all On-Call Managers to support their development, with training records/portfolios held by the EPRR team.

8.3 Monthly development sessions are held for all Strategic and Tactical On-Call Managers with training and exercises delivered based on key risks and planning arrangements to support incident response competency. 6 of 12 sessions are mandatory across the year.

8.4 While there is good engagement in sessions and attendance from a group of Tactical On-Call Managers in particular, improvement in attendance is needed in this space in 2026/27. However, all On-Call Managers have completed mandatory introductory EPRR training to fulfil their on-call role.

8.5 Key highlights of training in 2025/26 include:

- 95% of Strategic On-Call Managers have completed or booked on to NHS England's mandatory training for strategic level incident response – Principles in Health Command (strategic). Where three-year refresher courses are due, there is good uptake in bookings.

- 36% of Tactical On-Call Managers have completed or booked onto the newly released tactical version of this course, showing good uptake and engagement to time.

- This course has also been completed by the EPRR Team and System Coordination Centre Commanders to support the provision of tactical and strategic advice to On-Call Managers during incidents.

- The AEO and EPRR Senior Team have attended Multi-Agency Gold Incident Command training delivered by the College of Policing.

- Uptake of the monthly on-call development sessions for Strategic and Tactical On-Call Managers has been consistently good, particularly with excellent engagement by the Tactical group, who actively participate in discussions on a range of topics relating to incident response and risk specific arrangements, such as mass casualty response plans. Improvement is needed in 2026/27 to achieve the target KPI for attendance across both on-call tiers, which is a focus of current EPRR work programme delivery and transition work.

- Attendance at system and multi-agency exercises has increased across the On-Call team and Communications Team, supporting development of individuals in responding to a multi-agency or system wide major incident.

9. Exercises Completed during 2025-2026

9.1 The ICB are required to have a testing and exercising programme in place to safely test incident response arrangements, in a manner that is relevant to local risks, meets the needs of the organisation type and stakeholders, and ensures warning and informing arrangements are effective.

9.2 These exercises help to develop the necessary skills and knowledge of On-Call Managers in managing incidents at a tactical and strategic level in preparation for a real event.

9.3 A full list of exercises delivered or attended by the ICB in 2025/26 is listed below:

Exercise	Type	Participants
Exercise Tangra – 08 April 2025	NHS England / UKHSA regional pandemic exercise.	EPRR, SCC, Public Health, Primary Care
System Countermeasures	System exercise and workshop – distribution of medical countermeasures	EPRR, Public Health, Medicines Optimisation, System partners

Exercise/Workshop – 30 April 2025		
Exercise Solaris – 09 May 2025	Multi-agency pandemic exercise – Tier 1 national exercise	Public Health, EPRR, Tactical On-Call Manager
Exercise Toucan – 12 May 2025	NHS England communications cascade exercise.	SCC / EPRR, UHNM, MPFT, NSCHT
Exercise Raven / Crow – 2x tactical and 2x strategic exercises during 2025/26	Multi-agency exercises – large scale biological attack and distribution of medical countermeasures	On-Call Managers, EPRR, Communications team, System Coordination Centre Commander, system partners.
Exercise Arrow – 29 July 2025	Business continuity scenario involving widespread staff sickness.	On-Call Managers.
Exercise Morse Code – 14 August 2025	Six-monthly system communications exercise	EPRR, SCC, System partners.
Exercise Aegis – 10 September 2025	System winter plan exercise.	SCC, UEC, Primary Care, Planned Care, Intelligence and Analytics, Quality, Communications, EPRR, system operational leads.
Exercise Mercury – 11 September 2025	Multi-agency resilient communications exercise.	EPRR Operational Manager, System EPRR teams.
Exercise Astral – 13 September 2025	WMAS major incident escalation exercise – Plane crash	SCC, On-Call Managers, UHNM, MPFT, NSCHT
Winter Learning Event – 17 September 2025	NHS England regional winter stress test event.	Delivery Portfolio representatives (UEC and EPRR), system operational leads.
Exercise Pegasus 1 – 23 September 2025	Multi-agency pandemic and high consequence infectious disease outbreak exercise.	EPRR, Public Health, Primary Care, and Communications.
Exercise Tall Reception – 30 September 2025	Multi-agency reception centre exercise.	EPRR team
Exercise Pegasus 2 – 14 October 2025	Multi-agency pandemic and high consequence infectious disease outbreak exercise	EPRR, Public Health, Primary Care, and Communications.
Exercise Sweet Tooth – 15 October 2025	Control of Major Accident Hazards tactical exercise – James M Brown chemical site, Stoke-on-Trent.	EPRR Lead
Exercise Pegasus 3 – 04 November 2025	Multi-agency pandemic and high consequence infectious disease outbreak exercise	EPRR, Public Health, Primary Care, and Communications.
Exercise Fallow – date tba June 2026	Six-monthly system communications exercise	EPRR, SCC Team, System partners.

9.4 Upcoming exercises include a suite of multi-agency incident exercises 'Exercise Raven' and 'Exercise Crow' throughout 2026/27 focusing on a severe weather heatwave incident and its impacts upon NHS and multi-agency partners, and NHS England's regional evacuation and shelter exercise.

10. Business Continuity Monitoring and Evaluation

10.1 The ICB has in place a business continuity policy, strategy and management system (BCMS), which commits to monitoring and evaluating the effectiveness and performance of business continuity arrangements and drive continuous improvement.

10.2 The key performance indicators set within the BCMS are:

- KPI 1 - The ICB has in place a strategic and operational framework to ensure business continuity arrangements are established, maintained, and aligned to a cycle of continuous improvement.

- KPI 2 - The ICB has in place a process for assessing business impacts at a strategic and service level.

- KPI 3 - The ICB has in place robust business continuity plans to enable continued delivery of critical activities at a pre-defined level during a disruptive incident.

- KPI 4 - The ICB has arrangements in place to coordinate business continuity incidents at the strategic (Directorate and Corporate) level to support a whole organisational approach.

- KPI 5 - The ICB has in place a process to validate business continuity arrangements to ensure they are fit for purpose and are reviewed as part of the EPRR continuous improvement process.

- KPI 6 - The ICB has in place a process to embed business continuity arrangements to ensure staff are trained and confident in activation and escalation of arrangements.

10.3 Organisational resilience is strong in the business continuity planning space. Business continuity plans at a service and directorate level are established across the organisation, with exercises to be scheduled for quarters 1 and 2 of 2026/27. The corporate BCP is in sign-off stage, recognising all plans will be reviewed in full once Cluster structures are in place.

10.4 Progress metrics against the KPIs are as follows:

KPI 1

- Business continuity policy reviewed and approved by ICB Board (three-yearly)
- Quarterly review of EPRR lessons register undertaken
- Annual audit undertaken

KPI 2

- Strategic Business Impact Analysis (BIAs) of service criticality completed and updated annually
- Standardised service level BIAs in place with risk mitigations in place. Plans are reviewed annually:
- BCP interdependencies are mapped within Directorate BCPs

KPI 3

- Standardised Business Continuity Plan template in place across all services, with 100% of plans signed off and quality checked by the EPRR team

KPI 4

- Documented process in place for business continuity, critical and major incident escalations
- 100% of directorate level BCPs in place and quality checked by EPRR team
- Corporate BCP in sign-off stage

KPI 5

- Annual training and exercise programme in place
- Strategic BIA tested annually via EPRR led business continuity exercise

KPI 6

- Business continuity management training delivered to On-Call Managers
- Annual EPRR and Business Continuity update delivered to all staff briefing via Team Brief in 2025

11. Conclusion and Recommendations

11.1 EPRR is a statutory and essential function of ICBs, and ensures the organisation can prepare for, respond to, and recover from any incident, regardless of the size, scale and duration. The ICB provides a vital role in supporting and coordinating the preparedness of our NHS providers within the system.

11.2 Fundamental to delivery of the EPRR portfolio is commitment to resourcing, system collaboration across the EPRR agenda, and visible support from Executives, Committees, and Board. As SSOT ICB cluster with Shropshire, Telford and Wrekin ICB, the ICBs need to commit to the retention of sufficient EPRR capacity within future resource to continue to meet the category 1 responder duties placed upon the organisations through EPRR legislation.

11.2 Board are therefore asked to note the arrangements in place as described within this report and consider and approve the recommendations as outlined:

- Recommendation 1: Board are asked to note the EPRR resources outlined to support delivery of EPRR and incident response functions, and note the cluster EPRR governance alignment with Audit Committee in Common going forwards.

- Recommendation 2: Board are asked to note the 2025 EPRR annual assurance compliance rating of substantial compliance.

- Recommendation 3: Board are asked to note and support the EPRR annual assurance 2026/27 priorities as listed in section 5.

Part 2: STW ICB Annual EPRR Report

1. NHS Core Standards for Emergency Preparedness, Resilience and Response

1.1. Introduction

1.1.1 Emergency Preparedness, Resilience and Response (EPRR) is a core function in the NHS. In accordance with the Civil Contingencies Act 2004, the NHS Act 2006, the Health and Social Care Act 2012 and the Health and Care Act 2022, providers of NHS-funded care must demonstrate that they have appropriate measures in place to respond to incidents and disruptive challenges, whilst continuing to deliver resilient services, and maintain safe patient care. Examples of such circumstances may include, extreme weather conditions, outbreaks of infectious disease, major transport incidents, or mass casualty events.

1.1.2 Each year, NHS partners are obliged to complete the nationally mandated NHS Core Standards for EPRR, which set out the minimum requirements in relation to resilience. The Core Standards enable health agencies to share a common approach to emergency preparedness, and provide a consistent and cohesive framework for EPRR activities across the country.

1.1.3 In addition to undertaking their own self-assessment, ICBs are required to conduct the Core Standards review process for those local healthcare providers for which they are the lead commissioner.

1.1.4 In accordance with the Core Standards, this paper will provide an update to the Board, outlining the key aspects of EPRR activity that have taken place over the course of the last year.

1.2. Background

1.2.1. In 2025, the Core Standards assessment covered the following domains. Across these domains, each provider was required to adhere to a number of standards, dependent on the type of organisation.

1. Governance
2. Duty to risk assess
3. Duty to maintain plans
4. Command and control
5. Training and exercising
6. Response
7. Warning and informing
8. Cooperation
9. Business continuity
10. Hazardous Materials (HazMat) / Chemical Biological Radiological Nuclear (CBRN)
11. CBRN Support to Acute Trusts (applicable to Ambulance Service Providers only)

1.2.2. As in previous years, NHS partners were required to submit a self-assessment against each standard. The RAG rating options for the standards were as follows:

Compliance level	Definition
Fully compliant	Fully compliant with the core standard
Partially compliant	The organisation's EPRR work programme demonstrates evidence of progress and an action plan is in place to achieve full compliance within the next 12 months
Non-compliant	In line with the organisation's EPRR work programme compliance will not be reached within the next 12 months

1.2.3. In previous years, organisations have been required to submit documentary evidence against each standard to support their self-assessment. However, in acknowledgement of the current competing pressures within the Health sector, a change to the Midlands Assurance process was introduced by NHS England in 2025, allowing for unchanged 2024 compliance positions against individual standards to be carried forward. Supporting evidence was still required against standards for which improvement had been recorded, and those that had been identified as having not met the relevant criteria for compliance during the consultation process.

1.2.4. Further to the main Core Standards, in previous years a different resilience related topic has been selected for examination. However, in 2025 a National decision was taken to forego this deep dive investigation.

1.2.5. A return to the full Assurance process is anticipated in 2026, whereby organisations will be required to provide a complete suite of evidence to support the position reported in their self-assessment. However, it is not anticipated that there will be any changes to the Core Standards self-assessment criteria in the year ahead.

1.3. STW ICB assurance position

1.3.1. In 2025, STW ICB submitted an overall assessment of substantial compliance, an improvement on the 2024 position. 43 out of the 47 applicable standards were rated as fully compliant (91%) with 4 standards being rated partially compliant. Full details of the standards that were rated as partially compliant can be found in Appendix A.

1.3.2. The ICB's submitted position was supported by NHS England Midlands Region, with no challenges made.

Provider	Organisation Type	Compliance level 2024	Compliance level 2025	Applicable Standards
Shropshire, Telford and Wrekin ICB	ICB	Partially Compliant	Substantially Compliant	47

		(79% of standards fully compliant)	(91% of standards fully compliant)	

1.3.3. To note, the NHS England assurance rating thresholds are set by design at the higher end of compliance and are challenging to achieve. For example, an ICB requires full compliance with 42 or more of the 47 standards to attain an overall rating of substantial compliance. Provider thresholds vary depending upon the type of organisation.

1.4. Provider assurance position

1.4.1 All ICBs are required by NHS England to undertake the assurance of providers for which they are the lead commissioner.

1.4.2 Following a review of the documentary evidence supporting each provider's self-assessment, confirm and challenge meetings were held alongside NHS England, where clarification was sought on issues arising, in order to agree the final compliance level.

1.4.3 The outcomes of the 2025 provider assessments are set out in the table below.

Provider	Organisation Type	Compliance level 2024	Compliance level 2025	Applicable Standards
Shrewsbury and Telford Hospital NHS Trust	Acute	Partially Compliant (82% of standards fully compliant)	Substantially Compliant (92% of standards fully compliant)	62
Shropshire Community Health NHS Trust	Community	Substantially Compliant (91% of standards fully compliant)	Substantially Compliant (90% of standards fully compliant)	58
Robert Jones and Agnes Hunt Orthopaedic Hospital	Specialist	Non-Compliant (65% of standards fully compliant)	Partially Compliant (83% of standards fully compliant)	59

1.4.4 Shropshire Doctors was assured under the Core Standards for EPRR in 2024 by STW ICB. Since then, their contract has come to an end and the new provider (HealthHero) took over on the 1st October 2025. As this contract commenced while the assurance process was underway, HealthHero was not included in this year's Core Standards process in the STW

area. However, in line with their existing contract, they were assured by Bath and North East Somerset, Swindon and Wiltshire ICB and received a compliance rating of fully compliant.

1.4.5 The results of the annual assurance process were presented at the Local Health Resilience Partnership (LHRP) Executive meeting on the 19th November 2025, prior to being formally submitted to NHS England.

1.4.6 All providers should be recognised for the significant work undertaken throughout the year to improve or maintain their compliance ratings, and STW ICB would like to thank them for their support and cooperation during the assurance process.

1.4.7 Naturally there is further work to be done and the ICB EPRR team will continue to work with partners to improve emergency preparedness within the health system and multiagency sector.

2. Incident response

2.1. Declared incidents

2.1.1 Between 31st January 2025 and the 31st January 2026 STW ICB declared no Business Continuity, Critical or Major Incident.

2.1.2 During this timeframe, the following incidents were declared by STW health system partners.

Organisation	Incident type (Business Continuity, Critical or Major)	Incident detail	Date(s) of incident
Shrewsbury and Telford Hospitals	Business Continuity Incident	Trust-wide bleep outage	11th May 2025
Shrewsbury and Telford Hospitals	Business Continuity Incident	Bleep outage at Princess Royal Hospital	3rd-4th June 2025
Shrewsbury and Telford Hospitals	Critical Incident	Flooding at Princess Royal Hospital	23rd-24th June 2025
Shrewsbury and Telford Hospitals	Business Continuity Incident	Burst waste pipe in Cardiac Catheter Laboratory at Princess Royal Hospital	5th-12th January 2026

2.2. Continuous improvement

2.2.1. In accordance with the ICB's policies and procedures, and in line with its commitment to continuous improvement, debriefs are held following all declared incidents. The learning from these is distilled into actions and allocated to individuals for completion. The completion of actions is monitored via the EPRR team, with Executive oversight provided on a quarterly basis. Lessons identified are shared with partners via the LHRP, the Health Emergency Preparedness Officers Group (HEPOG) and NHS England Midlands Region. Opportunities for isomorphic learning are identified and incorporated into ICB plans and processes, as appropriate.

3. Training and exercising

3.1. The STW ICB EPRR training programme is informed by the National Occupational Standards for command roles, and the NHS Minimum Occupational Standards for EPRR. In order to ensure that staff meet the required level of competency for their roles, training needs analyses have been developed for different staff groups who may be required to participate in the response to an incident, for example, Strategic, and Tactical Commanders, and those supplying support functions such as Loggists.

3.2. An overview of the current organisational levels of EPRR training compliance can be seen below.

Incident management training for Strategic and Tactical Commanders (mandatory) *New training, introduced in January 2026	
Staff group	Percentage of eligible staff trained as of February 2026
Strategic Commanders	85%
Tactical Commanders	100%

All staff EPRR awareness training	
Staff group	Number of staff trained as of February 2026
All staff	140

3.3. In addition, the following staff are currently compliant with the requirement to partake in the Principles of Health Command training delivered by NHS England. This training is mandatory for all those who may be required to undertake a strategic or tactical leadership role during an incident and must be completed every 3 years.

Principles of Health Command training (mandatory)			
Staff group	**April 2025** Percentage of eligible staff trained	**February 2026** Percentage of eligible staff trained	**Increase**
Strategic Commanders	31.25%	100%	68.75% ↑
Tactical Commanders	25%	100%	75% ↑

3.4. Furthermore, as outlined below, the following staff have completed the mandatory STW ICB media training required for the ICB's strategic leaders. This training should be completed every 2 years.

Media training (mandatory)			
Staff group	**April 2025**	**February 2026**	
	Percentage of eligible staff trained	Percentage of eligible staff trained	**Increase**
Strategic Commanders	25%	81.25%	56.25%

3.5. In addition to the preparation of Incident Commanders, the ICB has also undertaken training for those tasked with fulfilling the role of Loggist.

Loggists training	
Staff group	Number of staff trained as of February 2026
Nominated administrative staff	8 (increased from 1 in August 2025)

3.6. In January 2026, a series of Business Continuity training sessions were introduced to support Department Leads in the completion of the ICB's newly developed Service Level Business Continuity documentation (see section 4 for further details). This workstream has temporarily been paused while the new Cluster staffing structures are embedded, however, going forward, it will continue as part of the EPRR harmonisation piece across the two ICBs. The training uptake as of February 2026 was as follows.

Business Continuity training *New training, introduced in January 2026	
Staff group	Percentage of eligible staff attended
Directorate/Service Business Continuity Leads	33%

3.7. In accordance with the NHS EPRR Framework 2022, and the NHS Core Standards for EPRR, the ICB has a duty to maintain a robust exercising programme to ensure that core plans and procedures are validated and tested.

3.8. The ICB must undertake the following:

- **Communications exercises:** Minimum frequency, every six months
- **Tabletop exercises:** Minimum frequency, every 12 months
- **Live play exercises:** Minimum frequency, every three years
- **Command post exercises:** Minimum frequency, every three years

3.9. Between 31st January 2025 and 31st January 2026, the ICB participated in the following exercises.

Date	Exercise	Type of exercise	Participants

24th February 2025	Exercise Tollard	**Tabletop exercise:** Identifying and supporting vulnerable people during an emergency	West Mercia Local Resilience Forum Partners
28th March 2025	Exercise Solaris	**Tabletop exercise:** Local pandemic response	West Mercia Local Resilience Forum partners
8th April 2025	Exercise Tangra	**Tabletop exercise:** Regional health system pandemic response	Health partners from across the Midlands region
12th May 2025	Exercise Toucan	**Communications exercise:** National-to-provider level exercise to support the NHS EPRR Framework and Core Standards requirements.	NHS England Midlands regional team, STW ICB Strategic Commander, provider single points of contact
10th June 2025	STW Fire Evacuation	**Live exercise:** Full evacuation of the NHS office space within Wellington Civic Offices	STW ICB staff
13th September 2025	STW Communications Cascade	**Communications exercise:** Cascade of a Major Incident notification to STW health partners and convening of an ICS incident management system call	STW ICB Tactical Commander Shrewsbury and Telford Hospitals Shropshire Community Health Trust Midlands Partnership University Foundation Trust
22nd and 23rd September 2025	Exercise Pegasus - Phase 1 (Emergence)	**Tabletop exercise:** National Tier 1 Pandemic exercise	West Mercia Local Resilience Forum Partners
22nd September 2025	Exercise Pegasus - Phase 1 (Emergence)	**Tabletop exercise:** Test of health system processes in response to the information received during Exercise Pegasus.	STW ICB Strategic Commander Shrewsbury and Telford Hospitals Shropshire Community Health Trust Robert Jones and Agnes Hunt Orthopaedic Hospital

10th October 2025	Exercise Activate	**Communications exercise:** Test of West Mercia Local Resilience Forum's incident activation processes. Health notification process from ICB to system partners tested within this exercise.	West Mercia Local Resilience Forum Partners
13th and 14th October 2025	Exercise Pegasus - Phase 2 (Containment)	**Tabletop exercise:** National Tier 1 Pandemic exercise	West Mercia Local Resilience Forum Partners
24th October 2025	Exercise Tempestes	**Tabletop exercise:** Local adverse weather response	STW health partners Shropshire Council Shropshire Fire and Rescue Met Office
3rd and 4th November 2025	Exercise Pegasus - Phase 3 (Mitigation)	**Tabletop exercise:** National Tier 1 Pandemic exercise	West Mercia Local Resilience Forum Partners

3.10. As per the process described in section 2.2, improvement actions arising from exercises are also monitored by the EPRR team, with Executive oversight.

4. Business Continuity

4.1. STW ICB has a Business Continuity Management System (BCMS) in place to ensure compliance with its statutory duties. As set out in the organisation's EPRR and Business Continuity Policy, this Management System is measured and evaluated against established Key Performance Indicators. One of the key outputs of the BCMS is the development, audit, and review of Service Level Business Impact Analyses (BIAs) and Business Continuity Plans (BCPs), which in turn inform the organisation's overall assessment of its critical functions. Each of STW ICB's services has a nominated Business Continuity Lead, who is responsible for ensuring that local arrangements are regularly updated.

4.2. In order to align with the globally recognised ISO 22301 business continuity standard and the NHS England Business Continuity Toolkit, STW ICB has recently undertaken a full review of its business continuity arrangements and developed a new combined BIA and BCP service level template. This template was rolled out across the organisation in January 2026.

4.3. In addition to the updated service level documentation, a new Organisational Business Continuity Management Plan has been developed in alignment with the latest guidance and best practice. This document has been reviewed by NHS England and is deemed compliant with the NHS Core Standards for EPRR. The purpose of this plan is to enable STW ICB to respond to business disruptions that affect multiple Services/Directorates within the organisation. In the event of an incident, this plan will provide a basis for an organisation-wide

response, and, as far as reasonably practicable, shorten the period of disruption, limit the impact of the incident, and enable the continued provision, or timely restoration of services.

4.4. The Business Continuity lifecycle is an ongoing, cyclical process, and STW ICB is committed to continually improving its arrangements to create a robust and resilient organisation. An internal audit of the Business Continuity Management System will be conducted in 2026 to ensure that the ICB is complying with its established Key Performance Indicators.

5. EPRR work programme

5.1. The ICB has an ongoing EPRR work programme, which is informed by:

- Current guidance and good practice
- Lessons identified from incidents and exercises (both internal and external)
- Identified risks
- Outcomes of assurance and audit processes
- The NHS Core Standards for EPRR

5.2. Each year, following the annual assessment of compliance with the EPRR Core Standards, an action plan is developed to improve any areas of weakness. These actions are incorporated into the overarching EPRR work programme.

5.3. Progress against the EPRR work programme is monitored by the Senior EPRR Lead and overseen by the Accountable Emergency Officer for EPRR (Chief Officer: System Development and Integration). Periodic updates are provided to the Audit Committee for assurance.

5.4. Collectively, STW ICB and SSOT ICB are committed to maintaining sufficient dedicated resource to meet their statutory responsibilities with regards to EPRR and Business Continuity, as the ongoing clustering arrangements progress. The current planning assumption is that ICBs will retain Category 1 responder responsibilities under the CCA 2004 for the foreseeable future and this will be taken into account as organisational structures are developed and resources allocated.

6. Recommendations

6.1. It is recommended that the Board be assured that STW ICB is discharging its statutory and mandatory responsibilities and duties appropriately, based on:

- The performance of the ICB and its commissioned providers during the 2025 EPRR Core Standards process.
- The ongoing activity and progress made in relation to EPRR.

Appendix A: STW ICB partially compliant standards 2025

Core Standard	Domain	Standard	Standard Detail

12	Duty to Maintain Plans	Infectious Disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Disease.
13	Duty to Maintain Plans	New and Emerging Pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic.
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the Board.
53	Business Continuity	Assurance of Commissioned Providers / Suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.

Enclosure No: 07

Report to:	Integrated Care Board
Date:	25th June 2026
Title:	Freedom to Speak Up (FTSU) – ICB Cluster Annual Report 2025/26
Presenting Officer:	Mish Irvine, Chief of Staff
Author(s):	Paul Winter, Associate Director: Corporate Governance; Shabana Mahmood (NHS SSOT) & Brett Toro-Pearce (NHS STW) FTSU Guardians

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

Is the decision within SOFD powers & limits	**Yes**	☒	**No**	☐
Any potential / actual Conflict of Interest?	**Yes**	☐	**No**	☒
If Y, the mitigation recommendations:				
Any financial impacts: ICB or ICS?	**Yes**	☐	**No**	☒
If Y, are those signed off by and date:				
Any impacts on ICB Undertakings?	**Yes**	☐	**No**	☒
If Y, are those signed off by and date:				
Appendices:	None			

(1) Purpose of the Paper:

The Freedom to Speak Up (FTSU) Annual Report for the Cluster of ICBs presents the last financial year's annual caseload statistics, principal themes and trends and what was done for these. It also includes some "horizon scanning" policy matters for noting that will reshape the local policy approach to this key area of NHS business.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	**Date**
First Review today (by Board)	
Periodic in-year updates have gone to PCI Committee	

(3) Implications:	
Legal / Regulatory	*Regulatory Frameworks require ICB adoption of national FTSU policy as a minimum standard*
CQC / Patient Safety	*Clinical risks raised will be discussed anonymously with CNO*
Financial (CFO-assured)	*Financial risks raised will be discussed anonymously with CFO*
Sustainability	*n/a*
Workforce / Training	*FTSU Guardians are required to undergo regular training & mentoring*
Equality & Diversity	*No implications, however, this report aims to provide assurance and update on any EDI concerns raised under the FTSU process.*
Due Regard: Inequalities	*ICBs must have regard to reducing inequalities in its FTSU activities*
Due Regard: wider effect	*ICBs must have regard to the wider FTSU impact of their decisions*

(4) Statutory Dependencies & Impact Assessments:					
	Completed?			If N - N/A, Rationale	If Y, Outcome / Date Reported & Signed off
DPIA	Yes ☐	No ☐	N/A ☒	*Covered by Staff Privacy Notice*	
EIA	Yes ☐	No ☐	N/A ☒	*Done for FTSU policy*	
QIA	Yes ☐	No ☐	N/A ☒	*Per QIA Policy, FTSU is out with quality of services assessment*	
Has there been Public / Patient Involvement?		Yes ☐	No ☒	N/A ☐	Click or tap here to enter text.

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

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

This report provides the Board with formal assurance regarding the effectiveness of the Cluster ICBs' Freedom to Speak Up (FTSU) arrangements from 1st April 2025 to 31st March 2026.

It demonstrates compliance with national guidelines set by the National Guardian's Office (NGO) and the Care Quality Commission (CQC). The core purpose remains ensuring that all staff feel safe, supported, and empowered to raise concerns regarding patient safety, staff well-being, and organisational governance.

Key Achievements and Progress
The cases raised with our FTSU Guardians during the reporting period are covered in detail in the main body of the report.

FTSU Guardians Expansion
We successfully recruited and trained a number of new FTSU Guardians in-year for NHS SSOT, owing to the impacts of organisational change. The same is currently happening for NHS STW Guardians, with the Chief Of Staff team working with the NGO to register those who expressed an interest in becoming a new Guardian, significantly expanding our reach and capacity.

Themes, Trends, and Learning
Organisations need to ensure their Guardians are trained and all colleagues know how to contact them, so they feel safe to speak up, knowing organisations will listen and act. The most prevalent themes identified in the cases raised are covered in detail in the main body of the report.

Organisational Learning
NHS England have held a series of engagement sessions for senior healthcare leaders with FTSU responsibilities. Locally, triangulation with annual Staff Survey has taken place to ensure that themes, trend convert into actions. The annual Staff Survey results have previously been brought to the Boards' attention. Because 'learning from listening' is core to the Cluster and assurances need to be given that issues of compliance are addressed in a timely manner.

Strategic Priorities for Next Year
To build on our current momentum, the FTSU service will be reworked in line with recently published NHSE Guidance (due to the forthcoming closure of the NGO and mainstreaming of their activities into NHSE). The report provides our strategic focus areas for next year in light of this and related ICB policy harmonisation & reviews for Cluster working.

(7) Recommendations to Board:

- ☑ To **ASSURE** both BOARDS of the Cluster ICBs' proactive and effective FTSU approaches;
- ☑ To **ASK** both BOARDS to note the planned FTSU activities for the forthcoming year.

2.1 Introduction & Background

This report provides the Board with formal assurance regarding the effectiveness of the Cluster ICBs' Freedom to Speak Up (FTSU) arrangements from 1st April 2025 to 31st March 2026. It provides the ICB Boards in Common with an update and overview of our FTSU activity throughout the year, the work undertaken by our FTSU Guardians, themes of the types of contacts made and resolutions reached, and an overview of the actions the ICBs have implemented to support a positive, open and accessible speak-up culture.

However before the analysis is provided, it is important to note that revised responsibilities of Freedom to Speak Up (FTSU) have recently been published, ahead of the National Guardian's Office (NGO) closing in June.

NHS England (NHSE) has recently confirmed that from 1st July 2026, following a recommendation in July 2025 by the Dash Review of patient safety across health & care, NHSE will deliver some activities previously undertaken by the National Guardian's Office (NGO). Meaning that NHS Trusts, Primary Care Organisations, ICBs and independent providers will take on greater responsibility and accountability for embedding effective FTSU arrangements.

- *NHSE will*:-
  - ☑ Support existing FTSU Guardian networks and individual guardians, including managing general enquiries through a national contact centre and escalating specialist queries to the NHSE FTSU team;
  - ☑ Provide and maintain the platform for free online FTSU Guardian Foundation Training;
  - ☑ Collect FTSU data nationally and use both qualitative / quantitative insights to strengthen system learning (insight will be shared routinely with Guardian networks);
  - ☑ Review national FTSU policy & guidance across all sectors, starting with Primary Care Organisations.
- *NHS Healthcare Providers + Commissioners will*:-
  - ☑ Have sole responsibility for ensuring that information about how to contact their FTSU Guardians is kept accurate, made publicly available and is accessible;
  - ☑ Routinely submit their FTSU data through NHSE's national data collection system (for 2026/27, this will be NHS Trusts & ICBs only);
  - ☑ Ensure that any Guardian they appoint completes the mandatory foundation training before starting their role, and support their continuing professional development;
  - ☑ Ensure appropriate psychological support is available for their Guardians once the nationally sourced independent Employee Assistance Programme ends on 31/12/2026.

2.2 Our Cluster ICBs 2025/26 Annual Report

(a) NHS Staffordshire & Stoke-on-Trent ICB

There has been a total of **15** contacts made to the SSOT ICB Guardians, spread over the past 18 months within which this reporting period falls. There are currently no open cases on the caseload at the end of the year.

Key Themes were as follows:-

- Bullying & Harassment (x10 cases);
- Patient Safety (x1 case);
- Concerns regarding Redundancies (x1 case);
- Concerns regarding the new Organisation Structure (x1 case);
- General Practice - Partnership issues [1] (x2 cases).

All matters raised were recorded confidentially by the two Guardians and considered appropriately. As per the effective processes to encourage staff to speak up confidentially and for NHS organisations to respond in timely manner, without any detriment to those that raise concerns.

There were no cases of delay in concluding investigations for further (anonymous) review by either the PCI or the Audit Committee. All matters were expedited efficiently and were in the majority of cases, handled through effective signposting of clients through to ICB colleagues for action or with other agencies (only where required).

(b) NHS Shropshire Telford & Wrekin ICB

There has been a total of **6** contacts made to the STW ICB Guardians; with no concerns resulting in a formal case being opened. There are no open cases on the caseload at the end of the year; and no matters outstanding, with all cases resolved or closed at the person's request.

Of the concerns, only one could have progressed to a formal response; however, the person raising the concerns did not wish to proceed.

There have been too few cases raised to reliably report Themes / Trends or outcomes. And to do so would risk identifying the individuals; which goes against the principles of the FTSU process. The main reasons for informal contacts were:-

- HR process and identifying an appropriate route to raise concerns;
- Dissatisfaction with a Management decision;
- Perceived difference between Leadership actions and organisational values.

Guardians responded to all contacts within one working day and have always been able to provide timely follow-up and ongoing support.

(c) FTSU Matters pertaining to both ICBs

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[1] *NHS SSOT ICB also covers FTSU for GP Practices staff, should they wish to (a GP Federation FTSU Guardian is also employed in the North Staffs locality to provide availability in this way too).*

Aside from only very limited circumstances (e.g. where there is a significant safeguarding risk or potential regulatory or criminal conduct) all FTSU Guardians are required to respect confidentiality and only raise concerns with any third party if the person consents to them doing so.

Colleagues can speak up openly and confidentially. Where an FTSU Guardian is aware of the caller's identity, these are never shared with a third party unless anonymously. In 2025/26, no anonymous contacts were received by either ICB, with the majority of colleagues speaking up freely to their Guardian, consenting to their identity being known only by them.

Both ICBs' FTSU policies are established fully in line with official guidance provided by the NGO; and clearly set out the necessary processes to comply with implementation of NHSE-NGO guidance. These are available to staff on both Intranets; along with identification of the key roles & responsibilities for FTSU at Exec/Non-Exec levels. The current NHS STW ICB policy was implemented on 30/09/2025.

Governance arrangements continued to provide quarterly oversight reports to the relevant lead Committee. All FTSU Guardians are on the National Guardian Register.

There has also been effective partnership working between the FTSU Guardians and senior ICB employees, with anonymous escalation of issues or concerns shared whenever needed, in order to elicit corporate actions to be taken on the matters raised.

100% positive feedback has been received from those who have engaged with the FTSU process and been supported by all FTSU Guardians. There have been no reports of any detriment (defined as "any disadvantageous and/or demeaning treatment for speaking up").

Since appointment, our FTSU Guardians have actively engaged with colleagues. This includes:-

- ☑ Presenting at all-staff briefings, to raise awareness of the FTSU process;
- ☑ Attending team meetings to engage, raise further awareness, discuss wider concerns;
- ☑ Engaging with system FTSU colleagues to co-ordinate initiatives / triangulate themes;
- ☑ Engaging with a variety of ICS and Equality, Diversity and Inclusion groups to seek to understand and remove barriers to speaking up;
- ☑ Identifying themselves as FTSU Guardians in email signatures, Teams backgrounds;
- ☑ Attending regional & national networking events, supporting best practices;
- ☑ Updating ICB intranets & webpages with information, contact details & routes to access.

Our Guardians also recommended that all staff undertake FTSU training. The NGO (and via E-learning for Health) offers 3 levels of awareness training: Speak Up, Listen Up, Follow Up:-

- *Speak Up: core training for all staff and covers what speaking up is, why it matters, how to speak up and what to expect;*
- *Listen Up: for Managers and focuses on listening to concerns, understanding the barriers to speaking up and how they should respond when someone speaks up;*
- *Follow Up: for Senior Leaders, focussing on how to promote a consistent/effective FTSU culture, to enable colleagues to speak up and be confident they will be listened to.*

In 2025/26 this training was rolled out to all staff as mandatory training via the ESR system; with all colleagues required to undertake the Speak Up + Listen Up modules, with Executive & Board level colleagues required to undertake the Follow Up module.

2.3 FTSU Horizon Scanning – looking forward to 2026/27

Aside from the latest national FTSU developments signalled in section 2.1, the Guardians and Chief of Staff wish to bring the following to the attention of the Boards in Common:-

(a) FTSU Staffing

- ☑ 2026/27 will bring a period of further, significant change to ICBs and it is imperative that the FTSU Guardians remain accessible during this period to support staff to raise their concerns. It is recognised that periods of change may in and of themselves also increase FTSU activity, if this occurs the current volume of protected time may need to be reconsidered if activity increases.
- ☑ The dual impact of NHS Reform and several Guardians leaving the ICBs, means additional recruitment is underway for replacement and additional Guardians at both ICBs, to increase resilience with regards to cross-cover and ensuring accessibility, especially with the mandatory roll-out to all GP Practices in the wider footprint.
- ☑ Currently a “Cluster Pool” model of FTSU Guardians is envisaged, to secure an enhanced number of FTSU Guardians and provide coverage / support pan-ICB Cluster and pan-GP Practices (alone potentially up to 200 separate employers, before any consideration of the other Primary Care Contractor Groups is considered; as might be the case).
- ☑ Closer working with NHS Staffordshire and Stoke-on-Trent colleagues has commenced, with intention to align processes, reporting methods and ways of working.

(b) Changes to National Reporting Arrangements

- ☑ Following NGO’s closure on 30th June 2026, quarterly reporting of case numbers will be submitted directly to NHSE. Responsibility for this reporting function will no longer sit with FTSU Guardians. It must now be undertaken at organisational level. A new Single Point of Contact will need to be identified to liaise with Guardians to optimise reporting.
- ☑ In addition to continuing the engagement and work implemented in 2025/26 the Guardians intend to increase their presence across teams with further awareness sessions planned and will deliver annual awareness training to all staff; allowing time for Clustering and ICB Management of Change arrangements to be concluded.

(c) Harmonisation of Cluster FTSU Policy

- ☑ Plans for detailed policy reviews were already being considered pre-NHSE changes. Clustering and the impacts of NGO cessation / new NHSE roles conferred on ICBs ref. GP Practice cover means a Cluster FTSU policy review is essential.
- ☑ The following early amendments are proposed:-

- Inclusion of a standard case management template used by Guardians to record case information, ensuring individuals raising concerns understand what information will be collected, and supporting consistency among Guardians;
- Inclusion of Records Retention guidance on the management of FTSU records – specifically when a Guardian leaves their post, or is temporarily unavailable to the "Bank", as well as clearer information re. general requirements for cases;
- Clarification on how a Cluster will help people raise concerns: e.g. with an FTSU Guardian from their employing organisation ICB until the ICBs formally merge;
- Amendments to online forms for Staff to access a central Cluster point of contact (including a single FTSU Inbox, and development of a standard form for collecting feedback following closure of concerns);
- Strengthening Learning from Events so that proactive work / efforts focus on developing solutions for key case themes, with strategic direction requested from the Executive & Board;
- Establishment of processes for collating data on the number, themes, trends of concerns for governance reporting purposes to NHSE;
- Update of the policy to incorporate 'Detriment Guidance', in line with January 2025 NGO's guidance, including use of a detriment risk assessment;
- Clarification that responsibility for Guardian wellbeing support will sit with individual organisations until the point of ICB merger;
- Confirmation that whilst training for new Guardians will be provided by NHSE, ongoing training for existing Guardians will be the responsibility of individual organisations.

Enclosure No: 08

Report to:	Integrated Care Boards
Date:	25th June 2026
Title:	Fit and Proper Person Test Assurance
Presenting Officer:	Ian Green – Chair
Author(s):	Angie Porter- Governance Manager

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

Is the decision within SOFD powers & limits	**Yes**	☐	**No**	☒
Any potential / actual Conflict of Interest?	**Yes**	☐	**No**	☒
If Y, the mitigation recommendations:	*E.g. Staff have Financial + Non-Financial Professional Interests which can be managed by recording those in minutes and allowing presence in discussions with recusals from formal decisions*			
Any financial impacts: ICB or ICS?	**Yes**	☐	**No**	☒
If Y, are those signed off by and date:	*E.g. Chief Finance Office, dd-mmm-yyyy*			
Any impacts on ICB Undertakings?	**Yes**	☐	**No**	☒
If Y, are those signed off by and date:	*E.g. Chief Finance Office, dd-mmm-yyyy*			
Appendices:	Appendix 1 & 2 – NHS Shropshire, Telford and Wrekin and NHS Staffordshire, Stoke on Trent - Fit and Proper Person Test Submissions June 2026			

(1) Purpose of the Paper:

The purpose of this report is for the Board to note that the ICB has completed its annual Fit & Proper Person Test (FPPT) assessment during 2026/27 and that the annual submission will be submitted by 30th June 2026 in line with national NHS England guidance.

This report presents for assurance the 2026/27 Fit and Proper Persons Test (FPPT) submission to NHS England.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	Date
E.g. First Review - Board	25/06/2026

(3) Implications:	
Legal / Regulatory	*Completed in line with NHSE Fit and Proper Person Test Framework*
CQC / Patient Safety	*Ensuring staff members are "Fit and Proper" impacts on patient safety. The Fit and Proper Person Test takes into account CQC requirements.*
Financial (CFO-assured)	*No financial implications have been identified.*
Sustainability	*N/A*
Workforce / Training	*Compliance with mandatory training is included as part of the Fit and Proper Person Test Checklist*
Equality & Diversity	*N/A*
Due Regard: Inequalities	*Ensuring staff members are "Fit and Proper" impacts on inequalities.*
Due Regard: wider effect	*Ensuring staff members are "Fit and Proper" provides public reassurance around organisational integrity.*

(4) Statutory Dependencies & Impact Assessments:					
	Completed?			**If N - N/A, Rationale**	**If Y, Outcome / Date Reported & Signed off**
DPIA	**Yes** ☐	**No** ☐	**N/A** ☒	Click or tap here to enter text.	
EIA	**Yes** ☐	**No** ☐	**N/A** ☒	Click or tap here to enter text.	
QIA	**Yes** ☐	**No** ☐	**N/A** ☒	*Per QIA Policy, this doesn't impact quality of services*	
Has there been Public / Patient Involvement?	**Yes** ☐	**No** ☐	**N/A** ☒		Click or tap here to enter text.

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

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

NHS England has developed the fit and proper person test (FPPT) Framework in response to recommendations made by Tom Kark KC in his 2019 review of the FPPT (the Kark Review). This takes into account the requirements of the Care Quality Commission (CQC) in relation to directors being fit and proper for their roles.

The Fit and Proper Persons Framework applies to the Board Members of all NHS organisations. A full assessment needs to be completed for all new appointments; temporary appointments (including secondments) or acting up into Board roles; Board Members moving from one NHS organisation to another; or individuals joining the ICB as a Board Member from non-NHS organisations; or if a Board Member moves from one Board position to another.

NHS Shropshire, Telford and Wrekin has developed a Fit and Proper Persons Test Framework Policy, which is based upon the national framework and was approved at the Remuneration Committee meeting held on 30 July 2024.

(7) Recommendations to Board:

The Board is asked to be assured that the annual Fit and Proper Persons Test (FPPT) assessment has been completed and that the annual submission will be submitted to NHS England by 30 June 2025 (Appendix 1 &2).

It should be noted that the process has been completed in respect of current board members, however references are still to be produced for NHS Shropshire, Telford and Wrekin board members who have now left the organisation. This is in process and the plan is that these will be completed prior to the annual submission deadline.

Appendix 5: NHS FPPT submission reporting template

This is a submission form. If anything changes during the year, submit a new form and notify an RD immediately. Do not alter the form.

NAME OF ORGANISATION	TYPE OF ORGANISATION *Select organisation*		NAME OF CHAIR	FIT AND PROPER PERSON TEST PERIOD / DATE OF AD HOC TEST:
NHS Staffordshire, Stoke on Trent Integrated Care Board		Trust	Ian Green	1st July 2025 – 30th June 2026
		Foundation Trust		
	X	ICB		

Part 1: FPPT outcome for board members including starters and leavers in period

Role**	Total Number Count	Confirmed as fit and proper?			Leavers only	
		Yes	No	How many Boad Members in the 'Yes' column have mitigations in place relating to identified breaches? *	Number of leavers	Number of Board Member References completed and retained
Chair/NED board members	6	X		0	3	3
Executive board members	8	X		0	8	8
Partner members (ICBs)	6	X		0	0	0
Total	20	X		0	11	11

**** See 3.8 'Breaches to core elements of the FPPT (Regulation 5)' in the Framework.***

***** Do not enter names of board members.***

Have you used the Leadership Competency Framework as part of your FPPT assessments for individual board members?	Yes	Yes

Part 2: FPPT reviews / inspections

Use this section to record any reviews or inspections of the FPPT process, including CQC, internal audit, board effectiveness reviews, etc.

Reviewer / inspector	Date	Outcome	Outline of key actions required	Date actions completed
N/A	N/A	No Inspections have taken place	N/A	N/A

Add additional lines as needed

Part 3: Declarations

<table>
<tr><th colspan="5">DECLARATION FOR NHS SHROPSHIRE, TELFORD AND WREKIN INTEGRATED CARE BOARD 2025</th></tr>
<tr><td colspan="5">For the SID/deputy chair to complete:</td></tr>
<tr><td rowspan="2">FPPT for the chair (as board member)</td><td>Completed by (role)</td><td>Name</td><td>Date</td><td>Fit and proper?
Yes/No</td></tr>
<tr><td>Senior Independent Director (SID)</td><td>Mike Lawton</td><td>28/05/2026</td><td>Yes</td></tr>
<tr><td colspan="5">For the chair to complete:</td></tr>
<tr><td rowspan="2">Have all board members been tested and concluded as being fit and proper?</td><td>Yes/No</td><td colspan="3">If ‘no’, provide detail:</td></tr>
<tr><td>Yes</td><td colspan="3">N/A</td></tr>
<tr><td rowspan="2">Are any issues arising from the FPPT being managed for any board member who is considered fit and proper?</td><td>Yes/No</td><td colspan="3">If ‘yes’, provide detail:</td></tr>
<tr><td>No</td><td colspan="3">N/A</td></tr>
<tr><td colspan="5">As Chair of [organisation], I declare that the FPPT submission is complete, and the conclusion drawn is based on testing as detailed in the FPPT framework.</td></tr>
<tr><td>Chair signature:</td><td colspan="4"></td></tr>
<tr><td>Date signed:</td><td colspan="4"></td></tr>
<tr><td colspan="5">For the regional director to complete:</td></tr>
<tr><td>Name:</td><td colspan="4"></td></tr>
<tr><td>Signature:</td><td colspan="4"></td></tr>
<tr><td>Date:</td><td colspan="4"></td></tr>
</table>

Appendix 5: NHS FPPT submission reporting template

This is a submission form. If anything changes during the year, submit a new form and notify an RD immediately. Do not alter the form.

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NHS Shropshire, Telford and Wrekin Integrated Care Board		Trust	Ian Green	1st July 2025 – 30th June 2026
		Foundation Trust		
	X	ICB		

Part 1: FPPT outcome for board members including starters and leavers in period

Role**	Total Number Count	Confirmed as fit and proper?			Leavers only	
		Yes	No	How many Boad Members in the 'Yes' column have mitigations in place relating to identified breaches? *	Number of leavers	Number of Board Member References completed and retained
Chair/NED board members	6	X		0	3	
Executive board members	8	X		0	2	
Partner members (ICBs)	6	X		0	4	
Total	20	X		0	9	

**** See 3.8 'Breaches to core elements of the FPPT (Regulation 5)' in the Framework.***

***** Do not enter names of board members.***

Have you used the Leadership Competency Framework as part of your FPPT assessments for individual board members?	Yes	Yes

Part 2: FPPT reviews / inspections

Use this section to record any reviews or inspections of the FPPT process, including CQC, internal audit, board effectiveness reviews, etc.

Reviewer / inspector	Date	Outcome	Outline of key actions required	Date actions completed
N/A	N/A	No inspections have taken place	N/A	N/A

Add additional lines as needed

Part 3: Declarations

<table>
<tr><th colspan="5">DECLARATION FOR NHS SHROPSHIRE, TELFORD AND WREKIN INTEGRATED CARE BOARD 2025</th></tr>
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<tr><td>Name:</td><td colspan="4"></td></tr>
<tr><td>Signature:</td><td colspan="4"></td></tr>
<tr><td>Date:</td><td colspan="4"></td></tr>
</table>

Enclosure No: 09

Report to:	Integrated Care Board
Date:	25 June 2026
Title:	Working with people and Communities Strategy
Presenting Officer:	Mish Irvine, Chief of Staff
Author(s):	Adele Edmondson, Head of Communications and Involvement

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

Is the decision within SOFD powers & limits	**Yes**	☒	**No**	☐
Any potential / actual Conflict of Interest?	**Yes**	☐	**No**	☒
Any financial impacts: ICB or ICS?	**Yes**	☐	**No**	☒
Any impacts on ICB Undertakings?	**Yes**	☐	**No**	☒
Appendices:	Appendix A – Working with People and Communities Strategy			

(1) Purpose of the Paper:

To seek Board endorsement of the ICBs' 'Working with People and Communities Strategy' and plan for further engagement to shape the delivery plan.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	**Date**
Integrated Care Board in Common	25 June 2026

(3) Implications:	
Legal / Regulatory	*The strategy supports compliance with the ICB Statutory Duties + NHSE Statutory Guidance.*
CQC / Patient Safety	*The strategy recognises the role of communications and involvement in capturing patient experience to support improvements in patient safety.*
Financial (CFO-assured)	*The Strategic Commissioning Framework sets out a requirement for involvement and co-production to be adequately resourced.*
Sustainability	*The strategy will support the ICBs sustainability objectives through communications and involvement activities.*
Workforce / Training	*The strategy recognises the role of workforce and the importance of effective communications and involvement with them.*
Equality & Diversity	*The strategy supports delivery of the Joint Patient and Population Equality, Diversion and Inequalities (EDI) Framework and the ICBs equality patient/population equality aims and objectives.*
Due Regard: Inequalities	*The strategy supports compliance with the Public Sector Equality Duty and having due regard to reducing inequalities in access and outcomes. It describes how inclusive communications and involvement supports the aim to reduce inequalities, including health and wider determinants of health where applicable and based on insight and population health data.*
Due Regard: wider effect	*The strategy supports the ICBs aim to improve health and wider determinants to increase employment, access to education and improve wider socio economic benefits through inclusive communications and involvement.*

(4) Statutory Dependencies & Impact Assessments:

	Completed?			If N - N/A, Rationale	If Y, Outcome / Date Reported & Signed off
	Yes	No	N/A		
DPIA	☐	☐	☒		
EIA	☐	☐	☒		
QIA	☐	☐	☒		

Has there been Public / Patient Involvement?	Yes	No	N/A	
	☒	☐	☐	*VCSE, Healthwatch and Lived Experience partners have contributed to the development of the strategy. We will work with people and communities to develop the action plan that underpins the strategy.*

(5) Integration with SBAF (for NHS SSOT) / Strategic Risks (SR, for NHS STW)					
SBAF1	Responsive Patient Care - Elective	☐	**SBAF5**	High Quality, Safe Outcomes	☐

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

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

Our Working with People and Communities Strategy outlines how we will commission and plan local health services in partnership with patients, communities and stakeholders. The strategy is aligned to NHS England guidance and supports ongoing, meaningful and inclusive communications and involvement with staff, partners, patients and wider communities as well as compliance with the ICBs statutory duties. It underpins the ICBs Joint Operating Model and is integral to us achieving our goal and delivering the ambitions outlined in the Government's 10 Year Health Plan.

The strategy sets out how inclusive communications and involvement will:

- support the four stages of the strategic commissioning cycle
- ensure compliance with NHS England guidance and statutory duties
- provide assurance to the Board
- establish the public voice at Place and in neighbourhoods
- support and involve our staff
- design and deliver co-production and co-design methodologies
- ensure the voice of Lived Experience in strategic commissioning
- support delivery of equality, diversity and inclusion
- be delivered in partnership with VCSE and Healthwatch partners
- contribute to the outcomes of the ICBs joint Operating model.

In developing the strategy, we have reviewed existing involvement mechanisms and forums across both ICBs and identified areas to grow and develop further, we have engaged Healthwatch and the Voluntary, Community and Social Enterprise sector, and we have listened to those who support and work with people with lived experience.

To develop the strategy further, we are:

- engaging our strategic networks and on-line digital forums
- engaging partners, patients and communities to shape the delivery plan
- holding a workshop with VCSE partners to develop a Memorandum of Understanding
- working with Healthwatch to support a smooth transition of responsibilities
- establishing a joint Equality and Involvement Committee to shape and monitor our approach.

(7) Recommendations to Board:
☑ To **ASK** both BOARDS to approve the ICBs' 'Working with People and Communities Strategy' and endorse the plan for further engagement to shape the delivery plan

Working with People and Communities Strategy

2.1 Introduction

This paper presents the Working with People and Communities Strategy for the Shropshire, Telford & Wrekin (STW) and Staffordshire & Stoke-on-Trent (SSOT) ICB cluster. It outlines how we will commission and plan local health services in partnership with patients, communities and stakeholders. It ensures that public voices and lived experience drive healthcare decisions, reduce inequalities and our compliance with statutory duties. The Board is asked to receive the paper and note progress to date, recognising that further engagement will take place to shape and tailor our approach and delivery at a strategic, place and neighbourhood level.

2.2 Background

In developing the strategy, we have reviewed the Strategic Commissioning Framework and mapped where involvement with staff, partners, patients and wider communities would support delivery of the four stages in the strategic commissioning cycle:

- understanding the local context
- developing long-term population health strategy
- delivering through payer functions and resource allocation
- evaluating impact.

The strategy is aligned to the ICBs Joint Operating Model and has been shaped by national policy, including the NHS 10-Year plan and NHS England guidance on how to meet our legal duty to involve people in decisions about the services we commission.

We have built on foundations already in place across the cluster, including established relationships with partners, agreed principles for effective involvement and existing channels, both digital and non-digital. We have also identified areas we need to grow or strengthen to support delivery of strategic commissioning and to develop a unified commissioning-led approach to involvement.

Recognising the value of collaboration and partnership working, in developing the strategy we have engaged with Healthwatch and our voluntary, community and social enterprise (VCSE) partners. We have reviewed the King's Fund report 'The future of patient voice: learning from the Healthwatch model' and are continuing to engage with Healthwatch to support a smooth transition that retains the 'independent voice'. We have also engaged and listened to those who support and work with people with lived experience and identified opportunities to work with partners on developing a supportive infrastructure for co-production and lived experience.

To develop the strategy further and to shape our delivery plan, we are continuing to engage with staff, partners, patients and communities. This includes engagement with our strategic patient and public networks and a workshop with VCSE partners to develop a Memorandum of Understanding. The strategy will also continue to evolve alongside the ICBs Joint Operating Model and as neighbourhood health becomes more established across the cluster.

2.3 Summary of the Working with People and Communities Strategy

Working as a cluster across Shropshire, Telford and Wrekin and Staffordshire and Stoke-on-Trent, our ambition is to improve outcomes, tackle inequalities, enhance value for money and support broader social and economic development. Effective and meaningful involvement is integral to us achieving these goals and to support delivery of the ambitions set out in the Government's 10 Year Health Plan.

Inclusive communications and involvement will help us to reach local people, including those least likely to be heard and those furthest away from services. It will help us to understand people's needs, experiences and barriers and to involve people in identifying priorities and developing solutions.

The Strategic Commissioning Framework describes strategic commissioning as a 'continuous, evidence-based process' and the key to securing improvements in access, care and quality and delivering greater value for money. Sustained and meaningful involvement with people and communities will support the four stages of strategic commissioning by:

- increasing our understanding of population needs, now and in the future, and identifying inequalities in access, experience and outcomes
- ensuring co-production of our long-term population health strategy and commissioning intentions to achieve shared priorities
- informing allocation of resources by monitoring the quality, performance and productivity of services
- ensuring patient and carer insight and experience shapes continuous improvements.

Under NHS England guidelines, ICBs are legally required to involve people and communities in the planning and development of services. The strategy outlines how we will comply with these legal duties, as well as national guidance and policy, and the governance processes to provide assurance to the Board, regulators and our public.

The strategy recommends the development of a joint strategic Equality and Involvement Committee, made up of partners and the public, to monitor, challenge and shape the ICBs approach to communications and involvement. It will be aligned to and support the ICBs quality and equality impact assessment processes and provide assurance to the Board through the Strategic Commissioning and Transformation Committee. The strategy also sets out how we will continually monitor and evaluate involvement activity and its impact to establish its effectiveness in achieving its intended goals as well as shaping the development and delivery of better targeted communications and involvement in the future.

To help us achieve our goals and support delivery of the three shifts in the 10 Year Health Plan, we will seek opportunities to engage at the most effective geographical level. This could be at a system or cluster level for delivery of national public health messages, but we also recognise that one of the best ways to respond to health inequalities is by utilising local knowledge and engaging with seldom-heard communities at a very local level. The strategy outlines how we will work collaboratively with

our partners, including our networks at place and in neighbourhoods, to talk to people about the issues that matter to them and to find out what we can do collectively to support them.

A successful involvement strategy relies heavily on established networks acting as the bridge between the NHS and the public. In Shropshire, Telford and Wrekin and Staffordshire and Stoke-on-Trent we are committed to working with our wide range of partners including local authorities, voluntary, community and social enterprise (VCSE) partners, local champions and community connectors, citizen panels and patient forums. We also recognise the important role that our workforce can play both as advocates of the ICB but also as patients of our services and a conduit between us and our communities through families and friends.

The strategy acknowledges the proposal that the statutory functions of local Healthwatch should transfer to ICBs on health care and local authorities for adult social care. We are committed to working with our Healthwatch partners to support a smooth transition, subject to any change in legislation, and to recognise the recommendations made by the King's Fund to build on the core conditions that enabled Healthwatch to have a positive impact, including a review of the proposal outlining what the 'independent voice' could look like for the cluster.

As strategic commissioners, ICBs are required to have a systematic approach to co-production that goes beyond formal consultation and means working with patients, carers and communities as partners. The strategy recognises that co-production can take multiple forms but sets out our approach to co-production and co-design and the 'Ladder of engagement' framework that we will use when planning the types of engagement required.

Inclusive communication and involvement are integral to the ICBs meeting the Public Sector Equality Duty and supporting delivery of the Joint Patient and Population Equality, Diversity and Inequalities Framework. Through the strategy we will use tailored approaches to reduce barriers to participation and to actively reach out to groups and communities experiencing the poorest outcomes. We will work with trusted partners and local connectors, including those working with Core20Plus5 groups, to focus on reducing inequalities across the life course.

In developing the strategy, we recognise there are strong foundations to build on but equally acknowledge there is more we need to do to strengthen inclusive communications and involvement across the cluster. Our delivery plan sets out how we will seek to do this over the next 12 months, working in partnership with staff, partners, patients and wider communities, to ensure the public voice is embedded in strategic commissioning and that services are shaped by what matters most to local people.

2.4 Recommendation(s)

The Integrated Care Board is asked to receive and approve the Working with People and Communities Strategy, acknowledge the strategy will evolve over time and endorse the plan for further engagement to shape the delivery plan

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

Working with people and communities

Putting the public voice at the heart of strategic commissioning

Foreword

Integrated Care Boards are increasingly focused on their role as strategic commissioners - leading population-based planning, making best use of resources, and working with partners to improve access, quality and outcomes while reducing inequalities. This approach reflects the ambitions of the NHS 10 Year Health Plan, particularly its focus on prevention, care closer to home and smarter use of digital and data.

Working as a cluster across Shropshire, Telford and Wrekin and Staffordshire and Stoke-on-Trent, our five-year commissioning plans set out clear ambitions to support people to live healthier, more independent lives, strengthen neighbourhood and community-based care, and reshape services to better meet the needs of both rural and urban populations. Achieving this depends on effective, inclusive communication and meaningful involvement with the people we serve.

Across our systems, we support diverse communities with different experiences of health and care, and significant variation in outcomes, life expectancy and access. Working in genuine partnership with people and communities is therefore central to how we improve outcomes and address inequalities. This strategy sets out how we will strengthen our approach to involvement - making it more consistent, inclusive and impactful - so that services are shaped by what matters most to local people.

Ian Green OBE
Chair

Simon Whitehouse
Chief Executive Officer

Our goals

As a cluster of ICBs, our goals are:

To lead and support delivery of the four aims of the Integrated Care Systems (ICS) across Shropshire, Telford and Wrekin and Staffordshire, and Stoke-on-Trent by:

- improving outcomes in population health and care
- tackling inequalities in outcomes, experience, and access
- enhancing productivity and value for money
- helping the NHS to support broader social and economic development.

To support the three strategic shifts for the NHS set out in the Government's Fit for the Future: 10 Year Health Plan for England:

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

What this means for involvement

Prevention: co-design with communities to shape prevention priorities and solutions

Community: neighbourhood voice informs service models and access

Digital: digital transformation is designed inclusively to avoid widening inequalities

Our health and care landscape

Shropshire, Telford and Wrekin

Around 500,000 Population

Shrewsbury and Telford Hospital Trust – Shropshire Community Health NHS Trust – Robert Jones and Agnes Orthopaedic Hospital Foundation Trust – Midlands Partnership University NHS Foundation Trust and West Midlands Ambulance Services University Foundation Trust

50 General Practices working through 8 Primary Care Networks
81 Community pharmacies
63 Dental Practices
62 Community Opticians

Shropshire Council and Telford & Wrekin Council

Independent and VCSE sector – including VCSA and Telford and Wrekin Alliance (COG) and community groups

Staffordshire and Stoke-on-Trent

1.1 Million Population

University Hospital of North Staffordshire – University Hospital of Derby and Burton – Midlands Partnership University NHS Foundation Trust – North Staffordshire Combined Healthcare Trust and West Midlands Ambulance Service NHS Foundation Trust

141 General Practices working through 25 Primary Care Networks
237 Community Pharmacies,
230 Dental Practices
140 Community Opticians

Stoke-on-Trent City Council and Staffordshire County Council

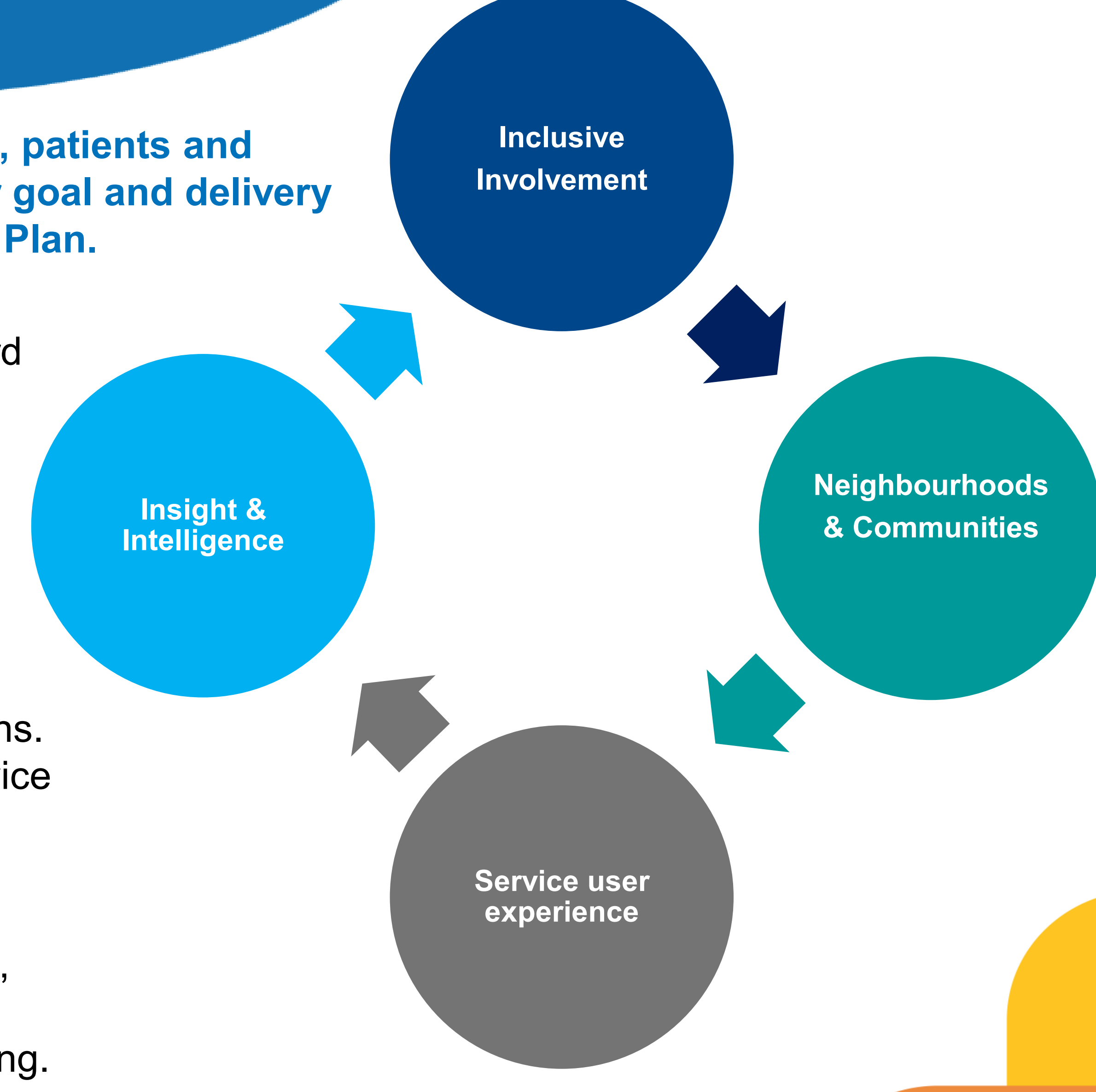
Independent and VCSE sector – including VCSE Healthy Communities Alliance and community groups

Working with people and communities

Effective and meaningful involvement with our staff, partners, patients and carers, and wider communities is integral to us achieving our goal and delivery of the ambitions outlined in the Government's 10 Year Health Plan.

Inclusive communications and involvement will help us to:

- **reach** local people, including those least likely to be heard and those furthest away from services
- **understand** people's needs, experiences and barriers, including wider factors affecting health and wellbeing
- **plan** involvement early and be clear on what people can influence
- **co-produce** priorities, services and pathways with communities and VCSE partners
- use data and lived experience together to **shape** decisions.
- ensure co-design **informs** commissioning, including service specifications and change
- involve people in defining and **monitoring** success, including outcomes, access and inequalities
- show how views shape decisions through clear "you said, we did" **feedback**
- **empower** people to support their own health and wellbeing.



This approach ensures involvement directly informs commissioning decisions, outcomes and service change.

Role of involvement in Strategic Commissioning

Strategic Commissioner Outcomes

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

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

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

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

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

Strategic Commissioning Framework

The Strategic Commissioning Framework describes strategic commissioning as a 'continuous, evidence-based process' and the key to securing improvements in access, care and quality and delivering greater value for money.

- Sustained and meaningful involvement with people and communities supports each of the four stages of strategic commissioning:
  - **understanding the context** – triangulating data and lived experience
  - **developing long term population health strategy** – co-produce priorities and commissioning intentions
  - **delivering through payer functions** and resource allocation (contracting and procurement) – co-design specifications/service redesign and communicating changes
  - **evaluating impact** – co-design evaluation and feedback loops.

- Stakeholder engagement with staff and partners, including the Voluntary, Community and Social Enterprise (VCSE) sector will play a vital role in shaping the long-term population health strategy and delivering better outcomes for residents.

- Involvement will be a required part of commissioning decisions, supported through Integrated Impact Assessment and governance processes.

Understanding the local context

Understanding the local context means having a clear and detailed picture of the needs of our population, now and in the future, and the quality and effectiveness of our services on which to base our strategy and decisions.

- Engagement and insight from inclusive communications and involvement will ensure community perspectives are embedded and that the patient voice shapes our understanding.
- We will routinely combine Public Health Management (PHM)/Joint Strategic Needs Assessment (JSNA) and service data with lived experience and staff insight to form a single needs narrative.
- Inclusive communications and involvement with staff, partners, patients, carers, and wider communities will:
  - **increase** our understanding of population needs at a local level including variations
  - gather **insight** on who is using health and care services and why
  - increase our understanding of how different groups **access** services and **experience** health and care support
  - **identify** underserved or marginalised communities and increase our understanding of any barriers
  - identify **gaps** in access, experience and outcomes
  - **assess** quality, performance and productivity of services from a staff and user perspective
  - add a patient, public and clinical **voice** to the ICBs' insight function
  - increase **awareness** and delivery of value-based healthcare
  - **influence** prioritisation, commissioning intentions and resource allocation at both place and cluster level.

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

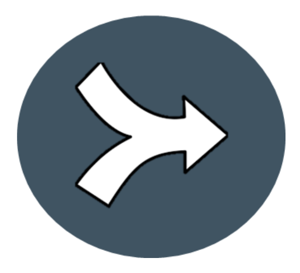
Developing a long-term population health strategy

Evidence from the insight function will help to shape the ICBs' long-term population health strategy and strategic priorities across prevention, pathways, workforce, quality, digital, estates, and service change.

- Inclusive communications and involvement will ensure co-production of a strategy that is credible, evidence-based, clinically endorsed and financially sustainable.
- Working collaboratively with staff, partners, patients, carers, and wider communities will:
  - provide insight to help **shape** the ICBs' Strategy (5-year Commissioning Plan) and Joint Forward Plan
  - help to **prioritise** current and potential commissioning intentions
  - **facilitate** clinical and professional leadership
  - ensure research and innovation and digital transformation is **inclusive**
  - support delivery of the Population Health Improvement Plan through **behaviour change** and **awareness** campaigns
  - enable **co-production** or **co-design** of care models and pathways
  - ensure **compliance** with statutory duty to involve people and communities in the planning, development and delivery of NHS services.

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

Delivering the strategy through payer functions and resource allocation



Resource allocation will be based on population need, inequality impact, and value for money, enabling consistent and aligned implementation across the system.

- Inclusive communications and involvement will inform delivery of strategic outcomes and ensure allocation of resources is informed by local data and intelligence. It will:
  - assess **quality**, **performance** and **productivity** of services from a staff and user perspective
  - provide insight to **monitor** whether services meet access and quality standards and to shape and explain any necessary changes to meet these standards
  - provide insight to shape local **service design**, procurement decisions and implementation by place, neighbourhoods and provider collaborations, through co-design with communities and partners
  - **influence** prioritisation and resource allocation at both place and cluster level
  - ensure **compliance** with statutory duty to involve people and communities in the planning, development and delivery of NHS services, including clear **feedback** on how views influenced decisions (engagement log/"you said, we did").

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

Evaluating the impact

Robust multi-disciplinary evaluation will drive decisions to scale, commission or decommission services according to their impact on the health of the population.

- Inclusive communications and involvement will ensure patient and carer insight and experience shapes continuous improvement by monitoring delivery of outcomes, quality, safety, staff insight and operational learning, lived experience and community insight, and health inequalities.
- It will be informed by the ICB's Quality and Equality Impact Assessment process and support mitigation of impacts identified.
- Listening to staff, partners, patients, carers, and wider communities will:
  - **identify** gaps in access, experience, and outcomes, particularly for Core20PLUS and other marginalised groups
  - support evaluation of **outcomes** from commissioned services, care models and proactive interventions
  - capture feedback and experience from **diverse** communities, staff and partners, including by making use of existing partners' forums and groups
  - ensure user **feedback** mechanisms are **embedded** in how commissioning decisions are made, including clear feedback on what changed as a result ("you said, we did")
  - support the use of evaluation and co-design **deliberative and inclusive dialogue** with people and communities and triangulate outcomes, safety, experience and staff insight in routine review
  - deliver **evaluation reports** / insight summaries / action logs that inform future commissioning decisions.

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

Meeting our statutory duties

Integrated Care Boards (ICBs) must comply with legal duties that ensure the voice of people and communities is at the heart of decision-making. These duties apply throughout the strategic commissioning cycle and include:

- **involving** patients, the public, and carers in commissioning, planning and proposing changes to NHS services
- **enabling** patients and carers to participate in planning, managing and making decisions about their care and treatment, through the services they commission
- supporting effective participation of people and communities in the commissioning process so that services **reflect the needs** of local people
- effective public involvement as part of any substantial **service change** process, including compliance with NHS England's tests for service change
- notifying the Secretary of State of any **notifiable reconfigurations** of NHS services
- prohibitions against **unlawful discrimination** in the provision of services on the grounds of 'protected characteristics'
- due regard to the need to reduce **health inequalities** between patients in access to health services and the outcomes achieved
- effective **partnership working** with people and communities to improve services and meet the public involvement legal duties
- engagement plans and logs; accessible communications record; equalities/Integrated Impact Assessment (IIA); committee minutes showing **influence**.

Legislation/Guidance

- **NHS Act 2006/2012**
- **Health and Care Act 2022**
- **NHS Constitution**
- **Public Sector Equality Duty**
- **NHSE PADS* Guidance 2018**
- **Gunning Principles 2001**
- **Working with People and Communities Guidance 2022**
- **NHSE guidance on Ministerial Intervention**

Legislation and Guidance

National Health Service Act 2006 (Section 242)

Mandates NHS commissioners (ICBs) and trusts to involve service users in the development and consideration of proposals for service change, which would impact on the range of services available or their delivery

Health and Care Act 2012 and 2022

Places specific duties on ICBs and NHS England to involve patients and their carers in planning, managing and making decisions about their care and treatment, through the services they commission and in commissioning decisions and processes so that services reflect the needs of local people

Statutory guidance on ministerial intervention in reconfiguration of NHS services (2024)

Requires ICBs to notify the Secretary of State of any proposed service changes that would trigger a formal consultation

Planning, assuring and delivering service change for patients (PADS)

Sets out how new proposals for change are tested through independent review and assurance by NHS England, considering the framework of Procurement, Patient Choice and Competition Regulations. Includes key considerations for commissioners and requirement to demonstrate:

- strong public and patient engagement
- consistency with current and prospective need for patient choice
- a clear clinical evidence base
- support for proposals from clinical commissioners
- + an additional test for beds

NHS Constitution

Enshrines the duty to involve legally and morally, pledging that the NHS will actively encourage feedback and involve patients in decisions about their care and treatment

Working in partnership with people and communities

Inclusive communications and involvement will support compliance with NHS England's 2022 statutory guidance 'Working in partnership with people and communities.

The guidance, which is adopted as policy, supports ICBs to meet their legal duties for public involvement and the 'triple aim' of better health and wellbeing, improved quality of services and sustainable use of resources.

Key components of the guidance include:

- **10 principles for success**: Effective partnerships should be built on 10 core principles, including involving people early, fostering trust and feeding back how input has shaped decisions
- **active involvement**: Moving beyond consultation to proactive, on-going engagement with communities and the VCSE (Voluntary, Community and Social Enterprise) sector
- **addressing inequality**: Focusing on actively reaching out to groups experiencing the poorest outcomes, using tailored approaches to reduce barriers to participation
- **range of approaches:** Using a blended approach on co-design, co-production, and direct engagement to create authentic relationships
- **resource allocation**: Ensuring funding and resources are in place to support collaborative working with partners.

Governance and assurance

Inclusive communications and involvement needs to be at the heart of strategic commissioning decision making and a golden thread in our corporate governance structures, systems, processes and procedures, including:

Involvement Champion at Board level

A Non-Executive Director responsible for championing the public voice and promoting our work on inclusive communications and involvement.

Board Assurance

Assurance on involvement and compliance with statutory duties to the Integrated Care Boards in Common through the Strategic Commissioning and Transformation Committee. A joint strategic Equality and Involvement Committee, with partners and the public, will monitor, challenge and shape the ICBs approach to communications and involvement.

Health Overview and Scrutiny Committees

Regular engagement and involvement of our local health scrutiny committees to enable a constructive and transparent process of scrutiny. There is a strong commitment to work in partnership with our local authority colleagues at a system and local level.

Health and Wellbeing Boards

Regular engagement and involvement of our local Health and Wellbeing Boards. They have a key role to play in producing the Joint Strategic Needs Assessment (JSNA).

Outcome: Compliance with legislation, statutory duties and NHS England guidance with clear evidence of equality and accessibility and where involvement has helped to inform commissioning decisions and evaluation.

Staff, partners and communities

In line with national guidance, we will:

- Ensure the voices of people and communities are central to our decision making.
- Involve people and communities throughout the commissioning cycle and feed back about how it has influenced activities and decisions - (“you said, we did”).
- Provide clear and accessible public information.
- Tackle system priorities and service reconfiguration in partnership with people and communities.
- Involve stakeholders in our strategic planning to shape and monitor the ICBs approach to communications and involvement.

Measuring activity and impact

Evaluation of activity is essential to establish its effectiveness in achieving its intended goals, and whether there are any unintended consequences. The outcomes of evaluation will feed a cycle of continuous improvement, which will allow the development of better targeted communications and engagement work in the future.

- Evaluation of engagement and involvement activity will include:
  - **reporting** on involvement activity such as survey and focus group results
  - report of **findings**, including those for formal consultations
  - mid-point and end-point **reviews** to monitor activity, accessibility and reach and identify any actions/adaptations required
  - **surveying** public, stakeholders, partners on involvement activity and impact
  - **feedback** from patient and public groups, broken down into demographic groups as required
  - review of activity against **quality/equality impact** assessments
  - **analysis** of intended **outcomes** (e.g. uptake of screenings, use of services) and evidence of how involvement has influenced decisions, service change and outcomes
  - monitoring **social media** via analytics to measure reach and engagement with activity undertaken
  - monitoring **website** engagement
  - sharing **learning** and insight with and between partners.
- **Metrics** will be regularly monitored and reviewed and used to inform reports back to the Integrated Care Board on progress and performance.
- **Evaluation** will support the ICBs commitment to feedback to communities and clearly show the impact their involvement has made.

Role of involvement at Place and Neighbourhood level

How we work at a population level

Place

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

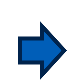
This approach aims to shifts resources and decision making closer to the people that they affect.

Neighbourhood

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

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

Neighbourhood health objectives

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

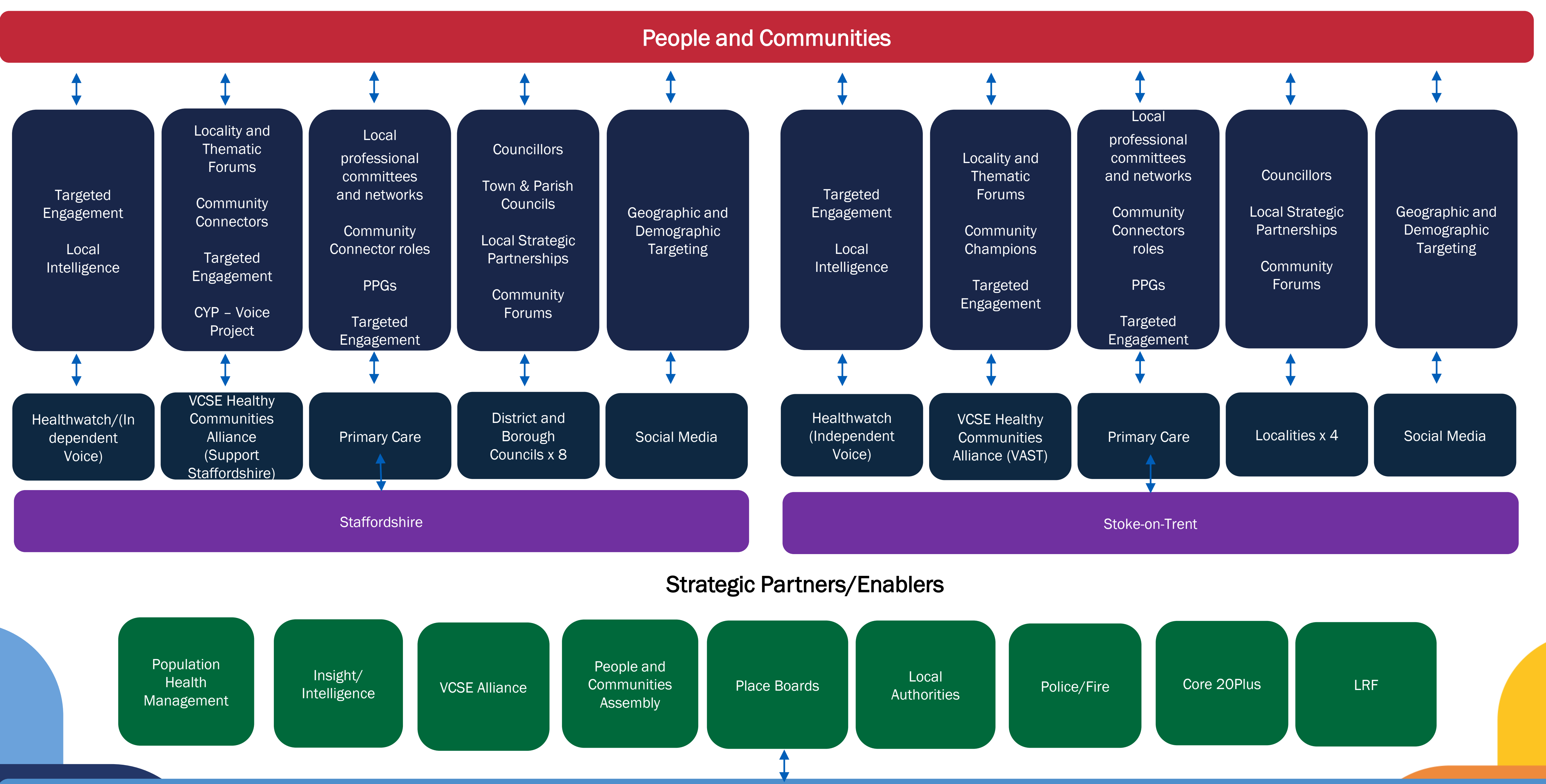
Establishing the public voice at place and in neighbourhoods

To deliver the objectives of Neighbourhood Health and design services that fit around people's lives, address inequalities and better support individuals, families and communities, we need to listen to local people. We need to go out into communities and talk to people about the issues that matter to them and find out what we can do to support them.

Our networks at place and in neighbourhoods will have a key role to play in helping to:

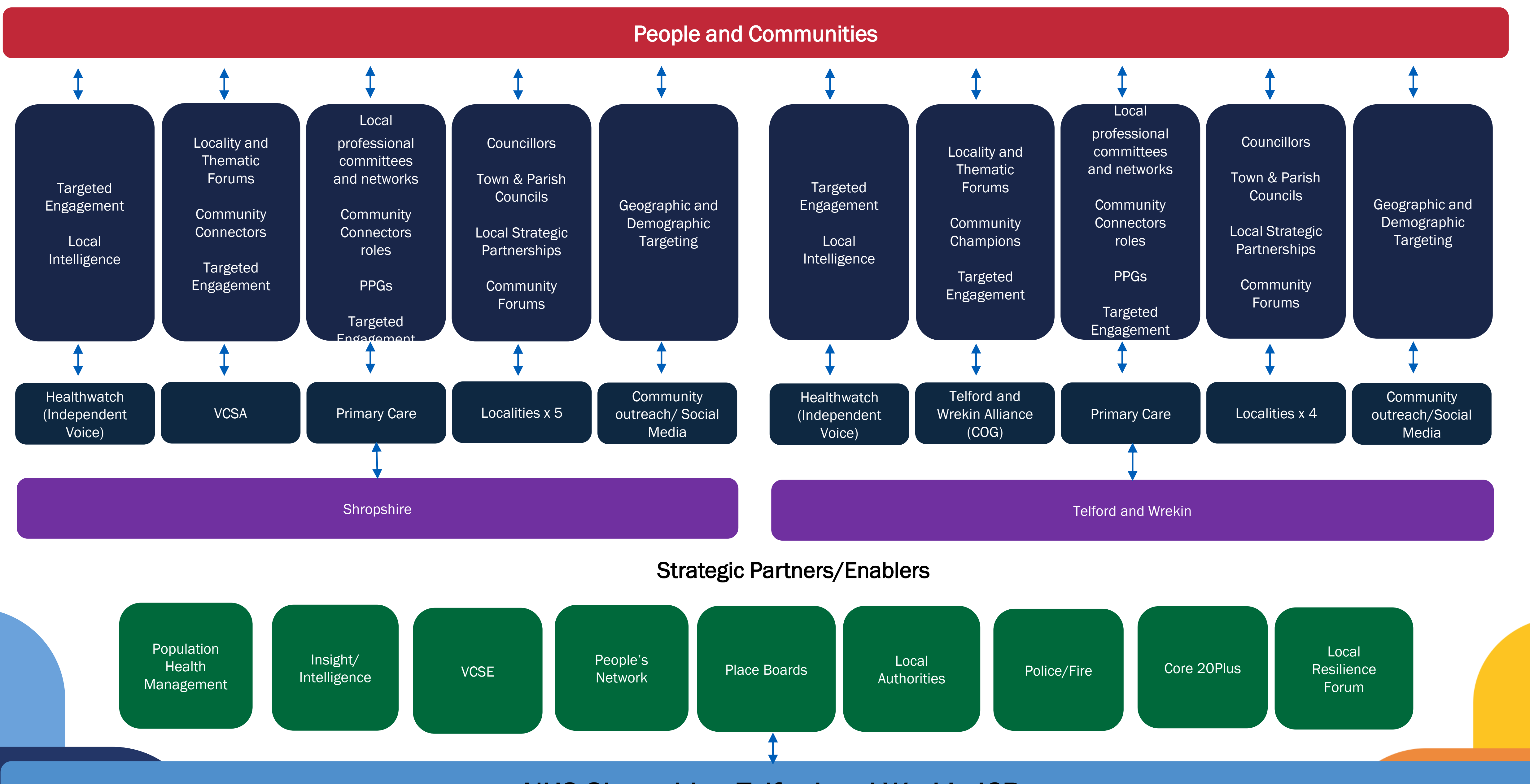
- **understand** the **needs** and **challenges** of local populations, including those least likely to be heard
- build on existing **relationships** and community assets
- support **conversations** with communities about their priorities as well as those of the local NHS
- **be clear** about what people can shape (e.g access, service design, communication, outcomes) and feed back what changed ("you said, we did").
- remove barriers to participation by providing **inclusive options** and support (e.g accessible formats, interpretation/translation, reasonable adjustments, expenses)
- increase **trust** and improve participation, by meeting people where they are and **tailoring approaches** for marginalised or vulnerable groups
- ensure staff, the public and local communities are involved in discussions and receive **feedback** on how they have made a difference
- **embed** our principles of engagement at the heart of planning, priority setting and decision-making
- use feedback from people and communities to develop programmes of work that **address inequalities**.

Outcome: Two-way engagement which will support delivery of the neighbourhood health objectives and empower neighbourhoods and individuals to take charge of their own physical and mental health



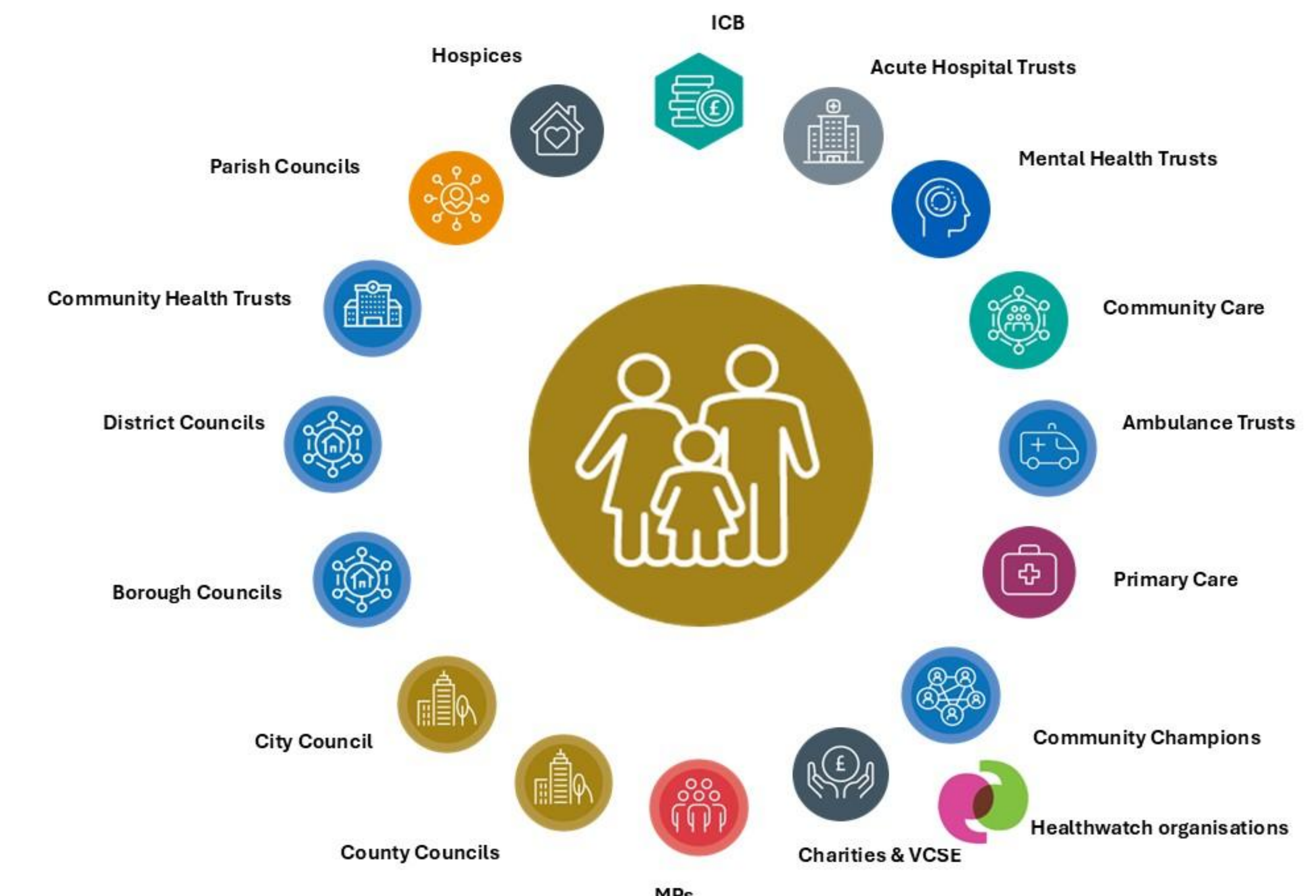
Community Engagement model – Staffordshire and Stoke-on-Trent
People and Communities
Targeted Engagement
Local Intelligence
Locality and Thematic Forums
Community Connectors
Targeted Engagement
CYP – Voice Project
Local professional committees and networks
Community Connector roles
PPGs
Targeted Engagement
Councillors
Town & Parish Councils
Local Strategic Partnerships
Community Forums
Geographic and Demographic Targeting
Targeted Engagement
Local Intelligence
Locality and Thematic Forums
Community Champions
Targeted Engagement
Local professional committees and networks
Community Connectors roles
PPGs
Targeted Engagement
Councillors
Local Strategic Partnerships
Community Forums
Geographic and Demographic Targeting
Healthwatch/(Independent Voice)
VCSE Healthy Communities Alliance (Support Staffordshire)
Primary Care
District and Borough Councils x 8
Social Media
Healthwatch (Independent Voice)
VCSE Healthy Communities Alliance (VAST)
Primary Care
Localities x 4
Social Media
Staffordshire
Stoke-on-Trent
Strategic Partners/Enablers
Population Health Management
Insight/ Intelligence
VCSE Alliance
People and Communities Assembly
Place Boards
Local Authorities
Police/Fire
Core 20Plus
LRF
NHS Staffordshire and Stoke-on-Trent ICB

Community Engagement model – Shropshire and Telford & Wrekin



Our communities, our people

Our communities and partners



Our staff

Our staff are already at the forefront of integrated working and we are building a culture of 'one workforce' across Shropshire, Telford and Wrekin and Staffordshire and Stoke-on-Trent.

- We want our staff to feel **valued**, supported, **empowered** and equipped to provide excellent quality, compassionate and safe care, wherever they live or work.
- We will strive to affect positive change across the whole workforce; **enabling** and **encouraging** collaboration and alignment with our values.
- We will engage and involve the workforce in designing how we achieve '**one workforce**' – including opportunities for them to work with their peers to redesign ways of working, rotational roles and cross sector working.

Working with our partners, we will:

- empower staff to **influence** the work of the ICBs by creating an inclusive culture and providing clarity of vision and objectives
- create new and **enhanced** internal communication channels – including opportunities for feedback and ideas
- engage staff as **advocates** of the ICBs, ensuring there is a fuller understanding of our overall aim and objectives
- **involve** staff earlier when developing and delivering transformation that addresses the underlying financial deficit and supports clinical/workforce sustainability
- involve staff in the transition to the role of the ICBs as **Strategic Commissioners**.
- triangulate staff **insight** with patient experience and outcomes to inform monitoring and evaluation.

Monitoring patient experience

Feedback from people about their experience of local services is a fundamental part of the quality and quality improvement process. We use a range of mechanisms to capture patient experience including:

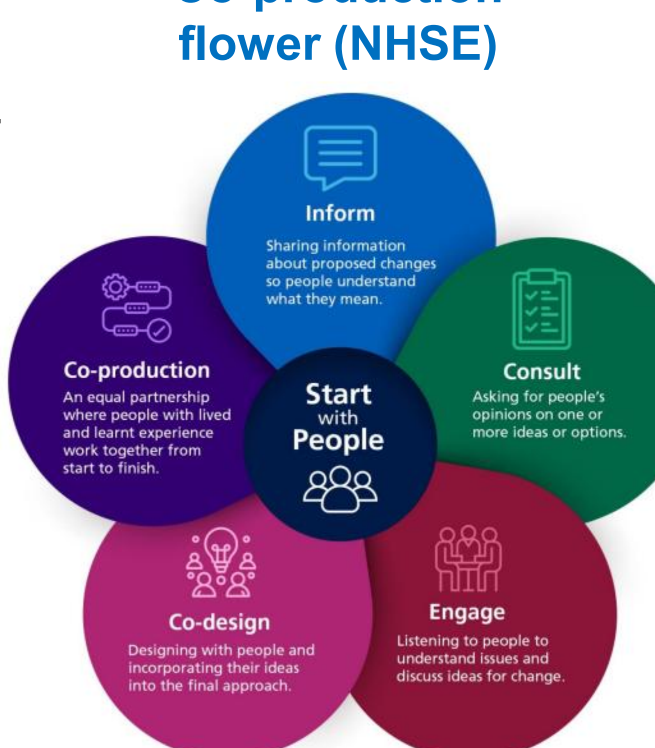
- **patient experience** reports, including contacts to the Patient Advice and Liaison Service (PALS), complaints and MP letters, provide an overview of key themes and trends of patient feedback and any actions taken in response to concerns
- annual **complaints** analysis includes complaints that directly relate to commissioned services and those handled on behalf of external providers
- capturing **soft intelligence** enables patients, the public and healthcare professionals to provide feedback on local services. All soft intelligence is clinically reviewed and taken to a monitoring group for assurance, review of themes and trends or a multidisciplinary review
- **Learning Disabilities Mortality Review** (LeDeR) – a programme that undertakes a review of all deaths involving individuals with learning disabilities aged four years and over. The aim is to improve the quality of health and social care service delivery for people with learning disabilities, reduce premature mortality and health inequalities and influence practice at individual, operational and strategic levels.

Our approach to co-design and co-production

For services to truly meet the needs of communities, people must be involved from the start of planning through to implementation and review.

- ICBs are required to have a systematic approach **to co-production** – meaningfully involving patients, service users, unpaid carers and communities in developing solutions. This goes beyond formal consultation and means working with **people as partners**.
- Co-production can take **multiple forms**, and we recognise there is no single way to effectively involve people and communities so we will:
  - **be clear** on the difference between co-production and co-design
  - use a **range of approaches** and methods to reach, hear from, engage and involve our communities in co-design and co-production
  - work across a **spectrum of involvement** (see involvement flower), depending on the purpose and impact from informing and listening through to collaboration, co-design, empowerment and co-production
  - use the **right method** for the task – from surveys and digital engagement to community outreach, deliberative engagement and co-production etc
  - reach people in **different ways** – combining system insight with community-led approaches to engage diverse and underserved groups
  - **embed** co-production throughout – involving people from planning through to delivery and evaluation when appropriate.

Co-production flower (NHSE)



Ladder of engagement

The 'Ladder of engagement' is a framework for understanding different forms and degrees of patient and public participation. The ICBs will use the framework when planning the types of engagement required for different pieces of work.

Devolving	Placing decision-making in the hands of the community and individuals. For example, Personal Health Budgets or a community development approach.
Collaborating	Working in partnership with communities and patients in each aspect of the decision, including the development of alternatives, and the identification of the preferred solution.
Involving	Working directly with communities and patients to ensure that concerns and aspirations are consistently understood and considered. For example, partnership boards, reference groups, and service users participating in policy groups
Consulting	Obtaining community and individual feedback on analysis, alternatives and / or decisions. For example, surveys, door knocking, citizens' panels and focus groups.
Informing	Providing communities and individuals with balanced and objective information to assist them in understanding problems, alternatives, opportunities, solutions. For example, websites, newsletters and press releases.

The Power of Lived Experience

Health and care services are at their best when they are designed with people with lived experience, including those affected by health inequalities.

We recognise and **value** the contribution that patients, carers and families can make in shaping healthcare services and policies but also the need to ensure appropriate training and support to maintain their wellbeing.

To support **meaningful** engagement with people with lived experience we will:

- work with partners to develop a supportive **infrastructure** for co-production and lived experience
- develop terms for lived experience, including **support**, **training** and **reimbursement**
- be **guided** by Lived Experience Partners such as National Voices, the Patient and Public Voice Partner Network and Peer Support Workers
- use **inclusive** methodologies to listen to people, especially those who experience health inequalities
- develop clear **mechanisms** to ensure lived experience can influence commissioning decisions and **feedback loops** so people can clearly see their impact and build trust
- be clear about what we are **asking** from people, how they will be **supported** and what they can **influence**.

You can't build a house without the right foundations

Reducing inequalities

Public Sector Equality Duty

The Public Sector Equality Duty (PSED) of the Equality Act 2010 requires ICBs to have due regard to the need to:

- **Eliminate discrimination, harassment and victimisation**
- **Advance equality of opportunity**
- **Foster good relations.**

As a cluster of ICBs, we are committed to:

- improving equity of access to health and care services and health and wellbeing outcomes for all
- building and maintaining a diverse, culturally competent and inclusive workforce
- creating and maintaining an environment where dignity, understanding and mutual respect is experienced by all, free from prejudice and discrimination.

How this will shape our approach to involvement.

We will:

- design engagement to be accessible and inclusive by default, removing barriers to participation
- actively reach underserved and seldom-heard groups, working with trusted VCSE and community partners
- monitor who we are hearing from (and who we are not) and take action to address gaps
- clearly show how insight has influenced decisions and feed back to communities ("you said, we did").

Equality, diversity and inclusion

Inclusive communications and involvement will support the ICBs to meet their Public Sector Equality Duty (PSED) responsibilities and ensure equality, diversity and inclusion. It will:

- enable us to actively **reach** out to groups experiencing the poorest outcomes
- use **tailored** approaches to reduce barriers to participation and identify who we need to target
- support **delivery** of the Joint Patient and Population Equality, Diversity and Inequalities (EDI) Framework
- support delivery of the ICBs equality patient/population equality **aims** and **objectives**.

Objective 1 –Reduce avoidable inequalities in access, experience, and outcomes across priority services by protected characteristic, deprivation, and place.

Aims:

- **Identify and prioritise the most significant inequalities**
- **Target action where disparities are greatest**
- **Ensure commissioning contributes to inequality reduction**

Action 1: Minimum patient equality data standard and disaggregate data

Action 2: Place-based inequality profiles reflecting rurality and deprivation

Action 3: Targeted improvement actions where inequalities persist

Action 4: Joint equality/health impact assessment **framework** across commissioning functions, policies, service change, review, and design.

Objective 2 – Strengthening system leadership, accountability and transparency for patient and population equality

Aims:

- **Embed clear leadership and accountability.**
- **Improve equality reporting and transparency.**
- **Strengthening engagement and lived experience insight**

Action 1: Named executive leadership and clear roles and responsibilities

Action 2: Accessible equality reporting on access, experience and outcomes

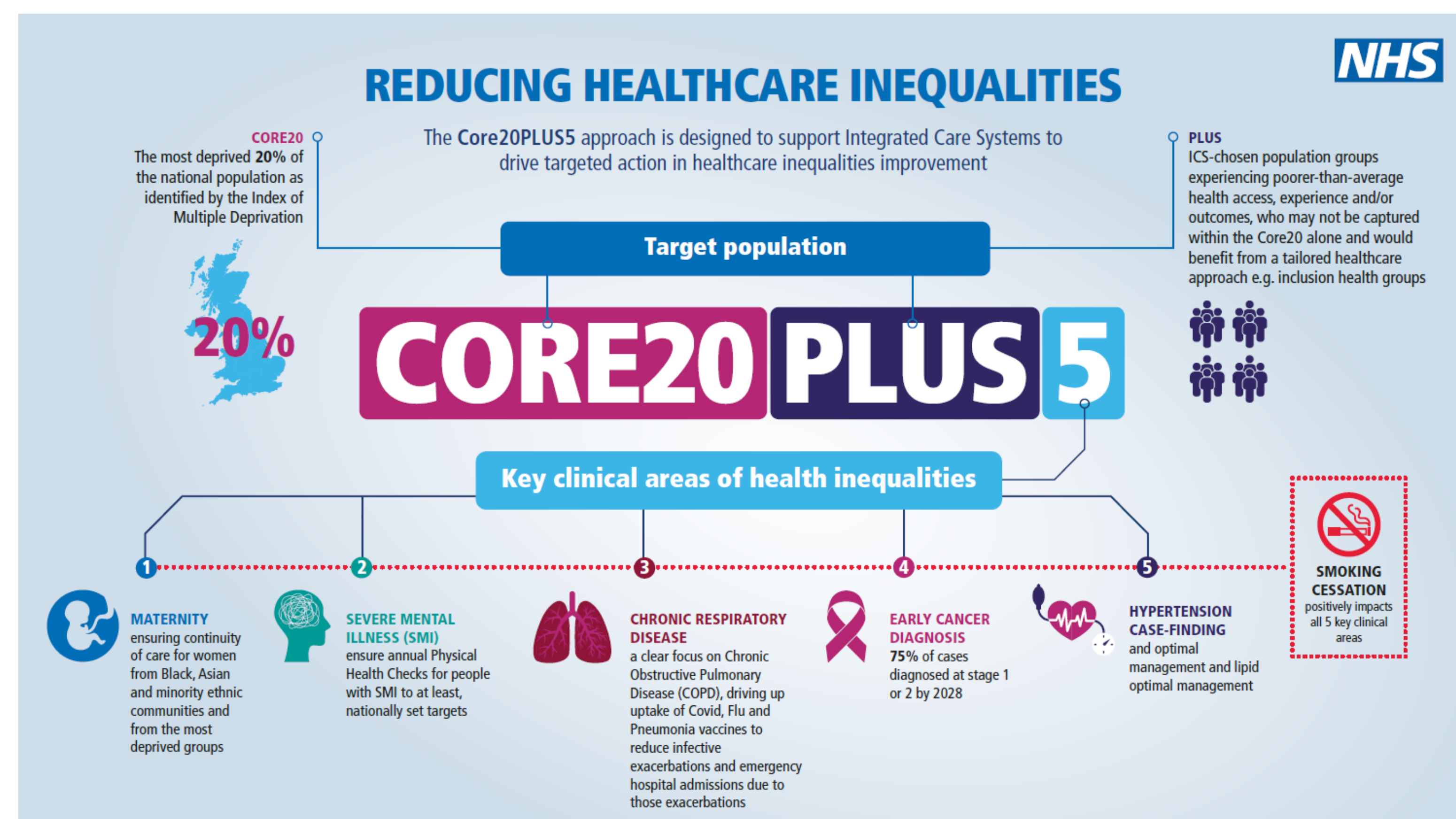
Action 3: Align PSED reporting with population health intelligence

Action 4: Work with VCSE and community partners to inform/co-produce service design and assurance.

Working with people to reduce Health Inequalities

Inclusive communications and involvement will support the ICB to reduce health inequalities. We will:

- **prioritise** Core20PLUS5 groups (Core20 + local inclusion groups) for involvement and action, aligning to our Clinical Strategies on reducing inequalities across the life course
- combine Population Health Management data with lived experience to **identify barriers** and **shape commissioning** responses in priority clinical pathways
- work through trusted partners (VCSE/community leaders) and local champions/connectors and **show impact** through clear feedback "you said, we did".



Core20PLUS5 priorities: In Shropshire, Telford & Wrekin and Staffordshire and Stoke-on-Trent we use Core20PLUS5 to focus involvement and action on people in the most deprived 20% of areas, plus locally identified underserved groups (including learning disability and rural exclusion, and other inclusion health groups), with targeted improvement across the five Core20PLUS5 clinical priorities and smoking cessation as a key enabler.

Healthwatch and VCSE

Healthwatch

Healthwatch was established by the Health and Social Care Act 2012 as the health and social care champion for the local population. Its role and responsibilities include:

- understanding the **needs**, **experiences** and **concerns** of people who use health and social care services and to speak out on their behalf
- undertaking **'Enter and View'** visits to local services to see and hear how they are provided and collect feedback on people's experiences
- using the information and insight they collect to **influence** and **inform** service change.
- Across the cluster, we have four local Healthwatch organisations covering:
  - Shropshire
  - Telford and Wrekin
  - Staffordshire
  - Stoke-on-Trent.

The future of Healthwatch

- In July 2025, Dr Penny Dash's Review of patient safety across the health and care landscape proposed the abolition of Healthwatch England and local Healthwatch.
- It also proposed that the statutory functions of local Healthwatch should transfer to Integrated Care Boards on health care and local authorities for adult social care.
- The King's Fund was commissioned to review the progress made by local Healthwatch and identify the positive steps that can be learnt from the Healthwatch model.
- They reviewed existing evidence, conducted interviews and carried out two workshops with local and national stakeholders.
- The Future of patient voice: learning from the Healthwatch model report was published in March 2026 and includes two key sections:
  - What did we learn from our research?
  - Implications for the future

Implications for the future

The King's Fund report recommends key learning that should be taken forward to build on the core conditions that enabled Healthwatch to have a positive impact:

- a voice **independent** of government and services
- capacity to gather **unsolicited, varied and rich** community insight, including from seldom heard groups
- to enhance – not weaken – the system's capacity to **hear, understand and respond** to people's experiences
- to reflect the importance of **partners listening** together and acting on what they learn
- a **geographical scale** that supports both local insight and system or national-level influence
- to **review** other patient and service user **feedback mechanisms** to ensure patient and public voice is central to how services are both commissioned and provided
- a hub and spoke model to address concerns about merging ICBs and their ability to engage communities **meaningfully at scale** with a reduced workforce
- **clarity** on how any new model aligns with local government and neighbourhood structures
- a renewed focus on ensuring that patient and service **user voice** is central to how the health and care system operates
- **leadership** and organisational cultures that genuinely prioritise the experiences and perspectives of those who use services.

Outcome: To ensure a smooth transition that builds on the core conditions that enabled Healthwatch to have a positive impact

Voluntary, community and social enterprise sector

The Voluntary, Community and Social Enterprise (VCSE) sector plays an essential role in health and social care. The ICB operating model describes the VCSE sector as an "equal, sustainable system partner with the necessary associated infrastructure, not just a delivery arm" and is a vital cornerstone in progressive health and care systems, including:

ICB **governance** - acting as a critical friend and helping to shape the ICBs approach to involvement and assurance

Supporting the capability and functions of the ICBs to deliver **integrated** care, including neighbourhood development

System, strategic, workforce and **operational plans**

Shaping, improving and delivering services and developing and delivering plans to **tackle wider determinants of health**

Population Health Management – capturing and shaping data, system intelligence and insight into the needs of people and communities

VCSE partnership working

The ICBs are committed to working in collaboration with the VCSE sector to shape our approach and delivery of inclusive communications and involvement.

The model will deliver recognised means of engagement, involvement and empowerment for health and care partners to work collaboratively with the VCSE sector, at both a system level and within communities.

VCSE will be involved in: priority setting workshops, targeted outreach, co-design sessions, and evaluation.

We will use partnership agreements / MOU and maintain regular engagement.

Developing our strategy

Building on foundations

In developing our strategy, we have built on foundations already in place across the cluster, including:

collaboration with partners: A cluster-wide strategic communications and involvement group, including providers, local authorities, Healthwatch and the voluntary, community and social enterprise (VCSE) sector. This is supported by local operational groups for each ICB area. Local Resilience Forum communication groups help to coordinate a joint response to system priorities.

working with community and VCSE: Established relationships with a wide range of VCSE organisations, community groups and patient representative bodies such as Healthwatch. These trusted networks give us reach into seldom-heard communities and include established forums such as locality and thematic groups and parent-carer forums.

agreed principles for involvement: We have strong principles around seeking out voices, involving people early, ensuring communications are accessible, and feeding back what has changed through engagement. These principles underpin our strategy.

involvement embedded in decision-making: Existing governance structures, including the Equalities and Involvement Committee, People and Communities Assembly and Health Overview and Scrutiny Committees, scrutinise involvement activity and provide assurance to the Board, stakeholders and our populations. These are strengthened by links into system partners, routine reporting of engagement findings, and the requirement for involvement to be considered throughout the commissioning process.

on-line engagement: Our People's Panel and People's Network provide an online network of residents with varied health interests, enabling targeted engagement at pace.

insight channels: A range of insight informs service design and improvement, including soft intelligence, community and targeted outreach, surveys, PALS compliments and complaints, feedback routes and resident stories. Additional sources include:

- Involvement Networks, which support forward planning and help to avoid engagement fatigue, maximise resource and reduce duplication across partners.
- Operational communications and engagement system meetings, providing a monthly space for informal sharing of intelligence.
- An insight library/observatory, which collate insight and feedback from engagement and are a useful starting point for reviewing what we already know.
- A stakeholder database and master engagement log to maintain community relationships and maintain visibility of protected characteristics and health inequality themes.
- The Integrated Impact Assessment (IIA) process, which provides a foundation for shaping proportionate engagement.

Areas to grow

We have also identified areas to grow or strengthen to support delivery of strategic commissioning. Working collaboratively with staff, partners, the public, and our communities, we will:

develop a unified commissioning-led involvement approach: We will create a shared framework to support delivery of inclusive communications and involvement across the cluster. This will include clear commissioning standards for when and how involvement is required and ensure consistency across the cluster. It will support development and delivery of Neighbourhood Health.

strengthen joint insight and analytics capability: We will further develop our system-wide insight libraries and integrate approaches to collecting, sharing and analysing intelligence from communities. We will increase and improve our use of insight and intelligence to complement clinical data and analytics as part of the evidence for decision making.

ensure robust governance and assurance: We will align and strengthen our governance processes to ensure the public voice is embedded throughout the strategic commissioning cycle and demonstrate how feedback has shaped decisions.

support learning and shared accountability: We will provide advice, training and guidance on the ICBs duties and responsibilities to involve people and communities within commissioning.

build on established relationships and community assets: We will continue to work with partners and stakeholders across the cluster to:

- shape our approach to inclusive communications and involvement
- identify best practice and shared learning
- align and strengthen existing channels at a cluster, ICB and neighbourhood level
- build trust with communities and secure support of community leaders
- better understand our population including the issues that matter to them and how we can work better together
- identify any gaps in our reach into communities and groups, or barriers to communications and involvement, and develop inclusive, tailored approaches to address them
- explore digital solutions to monitor and respond to people's experiences of health and care services.

Delivery Plan 2026/2027

To support delivery of the strategy and the goals of the ICBs, we have engaged with the VCSE sector and Healthwatch but will continue to collaborate with partners and stakeholders. In 2026/2027 we will:

- engage with staff, partners, patients and wider communities on the strategy and delivery plan, including outreach engagement with seldom heard groups, to continually develop our approach to involvement
- develop a work programme of involvement aligned to the ICBs commissioning priorities
- engage with Healthwatch to build on the conditions that enabled Healthwatch to have a positive impact, including a review of the proposal outlining what the 'independent voice' could look like for the system
- review the SSOT Memorandum of Understanding (MOU) with the voluntary, community and social enterprise (VCSE) sector and establish a joint MOU across the cluster. We will do this in partnership through a collaborative workshop
- work with partners to develop a supportive infrastructure for co-production and lived experience
- establish a joint strategic Equality and Involvement Committee across the cluster to shape and monitor our approach the inclusive communications and involvement
- develop a cluster-wide framework and tools to ensure consistent and robust impact assessments across commissioning
- develop an Inclusive Involvement Policy, roles and training to ensure sufficient capacity and compliance with statutory duties around service change
- create demographic involvement profiles aligned to the neighbourhood model and a single insight library of local intelligence to complement clinical data
- establish a joint digital forum across the cluster, bringing together the SSOT People's Panel and the STW People's Network.

What success looks like

Effective and inclusive communications and involvement will support delivery of our goal as strategic commissioners and the desired outcomes outlined in the ICBs joint operating model:

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

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

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

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

Outcome: Compliance with legislation, statutory duties and NHS England guidance with clear evidence of equality and accessibility and where involvement has helped to inform commissioning decisions and evaluation.

Enclosure No: 10

Report to:	Integrated Care Board
Date:	25th June 2026
Title:	Equality, Diversity and Inclusion Update
Presenting Officer:	Mish Irvine, Chief of Staff
Author(s):	Granville Thelwell SSoT ICB, Vanessa Whatley STW ICB

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

Is the decision within SOFD powers & limits	**Yes**	☒	**No**	☐
Any potential / actual Conflict of Interest?	**Yes**	☐	**No**	☒
Any financial impacts: ICB or ICS?	**Yes**	☐	**No**	☒
Any impacts on ICB Undertakings?	**Yes**	☐	**No**	☒

Appendices:	Appendix A – STW PSED Patient-Population Equality Report; Appendix B – SSOT PSED Patient-Population Equality Report.

(1) Purpose of the Paper:

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

1. **Eliminate unlawful discrimination, harassment and victimisation**
2. **Advance equality of opportunity** between people who share a protected characteristic and those who do not
3. **Foster good relations** between people who share a protected characteristic and those who do not

By examining patterns in patient and population, access, experiences and outcomes where possible across protected characteristics, this reporting provides essential insight into where inequalities persist and where targeted action is required. Considering the information in these

reports ensures transparency, strengthens accountability, and supports evidence-based decision-making so that we can create a fair, inclusive, and high-performing organisation that reflects and serves our communities.

This paper focuses on **Patient and Population Reporting** in both ICBs, providing the Board with the information required for assurance and seeking permission to publish these reports on our webpages.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	Date
First Review today	25 June 2026

(3) Implications:	
Legal / Regulatory	*Ensuring alignment to our Public Duty in relation to Equality Diversity and Inclusion.*
CQC / Patient Safety	*Assurance that our patients are not receiving inequitable care.*
Financial (CFO-assured)	*n/a*
Sustainability	*n/a*
Workforce / Training	*Ensuring alignment to our Public Duty in relation to Equality Diversity and Inclusion and supporting the continued development towards inclusive accessible services supported by co-produced by stakeholders, service users and the populations we serve.*
Equality & Diversity	*Meeting our Public Duty in relation to Equality and Diversity.*
Due Regard: Inequalities	*Ability to identify areas for continuous improvements and to drive data driven priorities and objective setting in relation to Equality and Diversity.*
Due Regard: wider effect	*Evidencing due regard in relation to Equality Impact on wider activity.*

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

				Not required			
Has there been Public / Patient Involvement?				**Yes** ☐	**No** ☐	**N/A** ☒	*Not required*

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

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

This report provides a high level summary of equality, diversity and inclusion activity for each ICB in relation to patient and population access to services, their experiences and outcomes. Enclosed with this report are two reports which together form our PSED Patient and Population reports.

Information for these reports has been provided from a wide range of teams, and sources which includes STW's Tracey Jones and the Health Inequalities team.

This report provides assurance to the Joint Staffordshire & Stoke-on-Trent (SSoT) and Shropshire, Telford & Wrekin (STW) Integrated Care Boards that both organisations have discharged their statutory responsibilities under the **Public Sector Equality Duty (PSED)** during **2025–26**, and sets out the proposed approach to alignment through a **Joint Patient and Population EDI Framework for 2026–2028**.

During the reporting period, both ICBs have embedded equality and health inequalities considerations within **core commissioning, service transformation, procurement and governance arrangements**, supported by strengthened population health intelligence, systematic use of **Equality and Health Inequality Impact Assessments**, and targeted engagement with communities experiencing the greatest inequalities. This activity has been undertaken alongside system and cluster development and aligns with expectations set out in the **NHS ICB Blueprint**, **Health and Care Act 2022** and the **NHS Constitution**.

The main body of this report provides assurance against the **three aims of the PSED**, including:

- how discriminatory barriers have been identified and mitigated through service redesign, impact assessment and procurement activity;

- how equality of opportunity has been advanced through data-led targeting of inequalities in access, experience and outcomes; and
- how good relations have been fostered through strengthened engagement, co-production and use of lived experience to inform decision-making.

The report also highlights opportunities arising from the cluster arrangement to **reduce duplication, strengthen consistency and increase collective impact** through a shared set of objectives, governance arrangements and methodologies. The proposed **Joint Patient and Population EDI Framework (2026–2028)** provides a proportionate, place-based approach to sustaining compliance, strengthening Board assurance and continuing to reduce avoidable inequalities across both systems.

It is anticipated that future reporting cycles will move towards **joint cluster workforce reporting**. This will allow for a more unified view of equality, diversity and inclusion across the cluster footprint, support consistent workforce planning, and promote shared learning and improvement across both ICBs.

(7) Recommendations to Board:

☑ To **provide ASSURANCE** for the Board in relation to compliance with the statutory Public Sector Equality Duty in relation to Patients and Population

☑ Approve the proposed joint PSED equality objective – Patients and Population

☑ To **ASK** the Board to approve the publication of the full reports on each ICB's respective platforms.

2.1 Purpose

2.1.1 This paper provides the Joint ICB Boards with assurance that Staffordshire & Stoke-on-Trent (SSoT) ICB and Shropshire, Telford and Wrekin (STW) ICB have discharged their statutory duties under the Public Sector Equality Duty (PSED) during 2025–2026.

2.1.2 To summarise how patient and population equality activity undertaken by both ICBs aligns to the three aims of the PSED and supports improved access, experience and outcomes, with specific examples of delivery.

2.2 Main Body of the Report

2.3.1 This paper includes in the Appendices 2 x PSED Patient & Population Reports one for each ICB which detail a range of activities, programmes and initiatives focusing on patient and population access, experiences, outcomes disaggregated (where data is available) by protected and or social inclusion groups. There are some variations due to the way in which each ICB has historically gathered information and reported on this important area.

2.3.2 During 2025–2026, both ICBs embedded equality, diversity and inclusion within mainstream commissioning, service transformation and system governance.

2.3 Discharge of the Public Sector Equality Duty – Summary of evidence from 2025-25

2.3.1 PSED Aim 1 – Eliminating discrimination, harassment and victimisation

- Both ICBs embedded EHIAs/IIAs as a routine requirement across commissioning, procurement, organisational change and service redesign, ensuring risks of discrimination were identified and mitigated.
- In SSoT ICB, EHIAs supported the redesign of All Age Continuing Care pathways, leading to a 55% reduction in unnecessary restrictive 1:1 care hours for people with dementia, learning disability and mental health needs, directly addressing discriminatory over-restriction.
- In STW ICB, IIAs informed the redesign of maternity, CAMHS and learning disability and autism pathways, ensuring reasonable adjustments, accessible communication and inclusive service models were embedded from the outset.
- Both ICBs embedded statutory equality requirements within procurement activity, including wheelchair services, mental health services and primary care procurements, requiring providers to evidence inclusive practice and Equality Act compliance.

2.3.2 PSED Aim 2 – Advancing equality of opportunity

- Both ICBs strengthened their use of disaggregated population health and inequalities data to understand variation in access, experience and outcomes by protected characteristic, deprivation and Core20PLUS5 groups.
- In SSoT ICB, data-informed interventions improved primary care access, increased vaccination uptake in under-served populations, and supported targeted Locality Improvement Framework schemes addressing frailty, long-term conditions and deprivation.
- In STW ICB, population health dashboards and service access analysis supported targeted action to reduce inequalities in vaccination uptake, long-term condition management and access to mental health support among deprived children and young people.
- Across both systems, perinatal equity analysis drove targeted action to reduce disparities in pre-term birth, screening uptake and maternity outcomes for women from deprived and minority ethnic backgrounds.
- Blended digital and non-digital access models across primary care and community services reduced barriers for older people, disabled residents and those experiencing digital exclusion.

2.3.3 PSED Aim 3 – Fostering good relations between groups

- Both ICBs expanded engagement with voluntary, community and social enterprise (VCSE) organisations to strengthen relationships with communities who are less well heard.
- In SSoT ICB, locality-based engagement through the Locality Improvement Framework enabled co-production with communities experiencing poorer outcomes, directly shaping service priorities and interventions.
- In STW ICB, strengthened Maternity and Neonatal Voices Partnership arrangements improved representation and engagement with minority ethnic groups, LGBTQIA+ families, young parents and traveller communities.

- Across both ICBs, lived experience and patient voice were systematically used to inform service design, quality improvement and governance, supporting trust, transparency and improved relations between communities and the health system.

2.4 Conclusion

2.4.1 The report provides the context, legacy reporting position and equality diversity and inclusion reporting to demonstrate the ICBs have delivered their statutory Public Sector Equality Duty in relation to patients and population matters for 2025-26. Work to finalise the ICB's Public Sector Equality Duty.

2.4.2 Equality, diversity and inclusion is a key part of the success of the clustered ICBs as a strategic commissioner, whether in terms of strategic commissioning for the reduction of inequalities and health inequalities across both ICBs populations.

2.5 Joint Patient and Population EDI Framework 2026–2028

2.5.1 The two proposed joint objectives provide a streamlined, proportionate approach to meeting the Public Sector Equality Duty across both ICBs. They recognise differing population needs, including rural access challenges and areas of higher deprivation, while establishing a shared framework for reducing inequalities in access, experience, and outcomes.

2.5.2 Focusing on a small number of objectives strengthens accountability, supports place-based delivery, and ensures equality considerations are embedded in decision-making, commissioning, and service improvement.

2.5.3 STW – SSoT ICB PSED Objective 1

STW – SSoT ICB PSED Objective 1 – Patient and Population Equality **Reduce avoidable inequalities in access, experience, and outcomes across priority services by protected characteristic, deprivation, and place.**
Aims: • **Identify and prioritise the most significant inequalities** • **Target action where disparities are greatest** • **Ensure commissioning contributes to inequality reduction**
Action 1: Implement a minimum patient equality data standard and routinely disaggregate data
Action 2: Develop place-based inequality profiles reflecting rurality and deprivation
Action 3: Require targeted improvement actions where inequalities persist
Action 4: Develop and embed joint equality/health impact assessment **framework** across commissioning functions, policies, service change, review, and design.

2.5.4 STW – SSoT ICB PSED Objective 2

STW – SSoT ICB PSED Objective 2 – Patient and Population Equality **Strengthening system leadership, accountability and transparency for patient and population equality**
Aims: • **Embed clear leadership and accountability.** • **Improve equality reporting and transparency.** • **Strengthening engagement and lived experience insight**
Action 1: Maintain named executive leadership and clarify roles and responsibilities.
Action 2: Publish accessible equality reporting on access, experience**,** and outcomes by relevant protected or social inclusion groups.
Action 3: Benchmark performance and align PSED reporting with population health intelligence
Action 4: Work with VCSE and community partners to inform/co-produce service design and assurance

2.6 Recommendation(s)

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

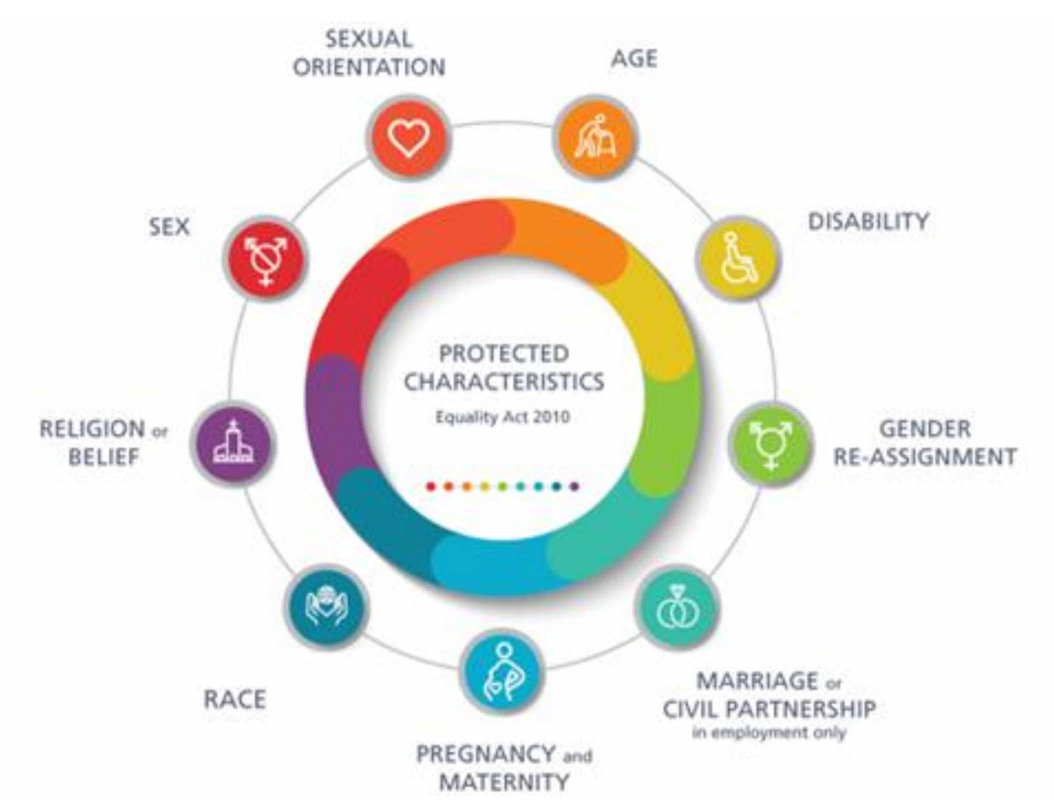
- whether the information contained provides ASSURANCE of compliance with the statutory Public Sector Equality Duty in relation to patients and populations.

- approve the joint PSED Objective Patients - Population 2026 - 2028

- whether permission is granted to PUBLISH the reports on each ICB's respective platform.

Shropshire Telford and Wrekin Integrated Care Board Integrated Care Board

PSED Patient – Population Equality Report 2025–2026



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1. Introduction

The Shropshire, Telford and Wrekin (STW) Integrated Care Board (ICB) is committed to meeting its statutory responsibilities under the Public Sector Equality Duty (PSED). This annual Patient Equality Report summarises activity and progress during 2025–2026, a period which has combined ongoing delivery with significant system development arising from the clustering of STW with Staffordshire & Stoke-on-Trent (SSoT)F ICBs, in line with the NHS ICB Blueprint and the NHS long-term direction.

Alongside progress in service delivery, strategic commissioning and targeted action to reduce health inequalities, the reporting period has included important work to map, align and strengthen governance, commissioning and data arrangements across the clustered system. This has ensured that equality, health inequalities and inclusion considerations are embedded within emerging joint structures and approaches, consistent with the Core20PLUS5 framework and local priorities.

The ICB recognises that health inequalities across the STW population are driven by factors including, one of the oldest populations in England, long-term conditions, disability, ethnicity, digital exclusion and barriers to access compounded by geographical differences spanning large rural areas alongside smaller urban centres.

Marked inequalities exist between affluent rural and suburban areas and pockets of deprivation, contributing to variation in life expectancy, healthy life years and health outcomes across STW. This report outlines how these inequalities have been addressed through both operational delivery and system planning activity, with a focus on improving patient access, experience and outcomes.

The evidence presented draws on ICB and ICS programmes, population health intelligence and engagement activity, and demonstrates how STW ICB, has had due regard to eliminating discrimination, advancing equality of opportunity and fostering good relations, in accordance with the Equality Act 2010, the NHS Long Term Plan and local health inequalities priorities.

2. Population Profiles Shropshire, Telford, and Wrekin

Shropshire and Telford and Wrekin have a combined population of over 528,000, spanning both rural and urban communities with differing health and care needs. The population is predominantly White (over 95% in Shropshire), with smaller but important minority ethnic communities, particularly in Telford and Wrekin. Most residents report good or very good health (around 80%), though 18.5% are disabled under the Equality Act, indicating ongoing inequalities. These differences highlight the need for inclusive, equitable services that respond to diverse population needs.

Population

Shropshire

Total population

2024

332,455

people

Telford and Wrekin

Total population

2024

195,952

people

Age profile

2024

Shropshire — (Telford and Wrekin)

0 years 85+

% of all people, 5 year age bands

Ethnic group

2021

Shropshire | (Telford and Wrekin)

Asian, Asian British or Asian Welsh **1.3%** (5.4%)

Black, Black British, Black Welsh, Caribbean or African **0.3%** (2.9%)

Mixed or Multiple ethnic groups **1.2%** (2.6%)

White **96.7%** (88.2%)

Other ethnic group **0.4%** (0.9%)

% of all people

Religion

2021

Shropshire | (Telford and Wrekin)

No religion **37.0%** (40.9%)

Christian **55.5%** (47.6%)

Buddhist **0.3%** (0.3%)

Hindu **0.2%** (0.7%)

Jewish **0.1%** (0.0%)

Muslim **0.5%** (2.7%)

Sikh **0.2%** (1.5%)

Other religion **0.5%** (0.5%)

Not answered **5.9%** (5.6%)

% of all people

General health

2021

Shropshire | (Telford and Wrekin)

Very good health **46.6%** (46.0%)

Good health **34.7%** (34.1%)

Fair health **13.6%** (13.8%)

Bad health **4.0%** (4.7%)

Very bad health **1.1%** (1.4%)

% of all people

Disability

2021

Shropshire | (Telford and Wrekin)

Disabled under the Equality Act **18.5%** (19.7%)

Not disabled under the Equality Act **81.5%** (80.3%)

% of all people

Sex

2024

Shropshire | (Telford and Wrekin)

Female **50.8%** (51.0%)

Male **49.2%** (49.0%)

% of all people

Sexual Orientation – Shropshire, Telford and Wrekin

Predominantly heterosexual (90%+), with 2–3% identifying as LGBT+ (including 1% bisexual), with slightly higher diversity in Telford and Wrekin.

Source: Office for National Statistics – Census

3. Health Inequalities

Health Inequalities are unfair and avoidable differences in health across the population, and between different groups within society. These include how long people are likely to live, the health conditions they may experience and the care that is available to them and they arise because of the environmental and social conditions in which we are born, grow, live, work and age.

These conditions influence how we think, feel and act and can impact both our physical and mental health and wellbeing. Within this wider context, *healthcare inequalities* are about the access people have to health services and their experiences and outcomes from those services.

Under the Health and Care Act 2022, Shropshire, Telford and Wrekin Integrated Care Board (ICB) have a duty to reduce inequalities in access to health services and the outcomes achieved from them. This duty is reinforced by the NHS Constitution for England, which commits the NHS to providing comprehensive, equitable care based on clinical need and to reducing health inequalities across the populations it serves.

As part of our statutory duty, we are required to reduce the inequalities experienced by our local communities in line with the National Healthcare Inequalities Improvement Programme and NHS England's Core20PLUS Framework.

Core20PLUS5

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

'Core20' refers to proportion of local residents who are among the most deprived 20% of the national population, as identified by the national Index of Multiple Deprivation (IMD). There are seven different factors that the IMD considers. This includes:

- Income
- Employment
- Education
- Health
- Crime
- Barriers to housing and services
- Living environment

Of the 510,000 people living across our geography, approximately 60,000 live in areas considered to be the 20% most deprived areas across England. 15,000 in Shropshire and 45,000 in Telford & Wrekin, which is a quarter of Telford & Wrekin's whole population.

'PLUS' refers to specific groups of the population. This is an additional way of identifying other groups in society who experience health inequalities. Some PLUS groups are identified nationally, such as individuals with a learning disability or people experiencing homelessness. Others are based on local outcomes we see specific to our Shropshire, Telford & Wrekin population, such as farming communities, service personnel and veterans and children in care.

4. Progress this Year

4.1 Data and Intelligence

One of our biggest developments in 2025/26 is the strengthening of our data granularity. Our Data Teams have worked to develop local intelligence and create visual dashboards on healthcare inequality. This means we are now able to understand what access to services looks like for different groups of our population and what inequality in service access and experience exists.

Using this data, we completed our first comprehensive report on service access indicators in January 2026. This was with the aim of understanding our progress in reducing existing healthcare inequality and narrowing the gaps between different groups of people. This work also helps us to provide a robust response to NHS England's Statement on Information on Health Inequalities (duty under section 13SA of the NHS Act 2006), which required ICBs to collect, analyse and publish information on health inequalities alongside our annual reports.
Highlights from the report demonstrate that over the last 12 months we have:

- Equitably increased the proportion of children and young people from deprived areas and minoritised ethnic backgrounds receiving diabetic technology to support with managing their condition.
- Removed inequalities in the management of high cholesterol between different population groups. High cholesterol is now managed equitably across all population groups, irrespective of where they live or their background.
- Reduced the differences in vaccination uptake between our most deprived and least deprived populations by offering targeted outreach in community settings closer to people's homes.
- Seen higher proportions of people with learning disabilities or severe mental illness being appropriately treated for hypertension (high blood pressure) through the delivery of targeted annual health checks.
- Increasing numbers of children and younger people from deprived areas are successfully accessing mental health support services.

- Reduced the differences in higher pre-term births experienced by women from black and Asian ethnic backgrounds and lower numbers of women from deprived backgrounds are being recorded as smoking at time of delivery.

4.2 Understanding Our Population: Perinatal Equity Analysis

Our Perinatal Equity Analysis marks a significant step forward in understanding inequalities across our system.

This work provides a comprehensive picture of the reproductive-age population, offering:

- Detailed insights into health needs before pregnancy
- A clearer understanding of who is accessing maternity services and how
- Intelligence to inform future service design, workforce planning, and prevention strategies

For the first time, we have combined population health data with maternity service user profiles to better understand variation in access, experience and outcomes. These insights are already shaping our priorities and enabling a more targeted, equitable approach to care.

4.3 Turning Insight into Action

Building on this analysis, we have co-produced an Equity and Equality Plan for 2026/27 with system partners. Our focus is on reducing inequalities and improving outcomes and experiences for all families, with targeted action in the following areas:

Reducing perinatal mortality - We are increasing awareness and uptake of safe sleep, early baby care and accident prevention, while targeting a reduction in both overall and unequal rates of preterm birth.

Improving access to services - We are working towards delivering more care closer to home, particularly in underserved communities, and reducing barriers to accessing maternity services.

Supporting perinatal mental health - We are improving our understanding of local need and demand to ensure services respond effectively, including targeted support for fathers and partners.

Improving maternal health - We are strengthening preconception health and addressing key risk factors such as smoking, alcohol use and unhealthy weight.

Tackling inequalities in care - We are embedding personalised, culturally sensitive care for all women and birthing people, improving understanding of variation in caesarean section rates, and expanding continuity of care for those with the greatest need, underpinned by kindness, compassion and respect.

Using better data - We are improving the quality, completeness and sharing of maternity data to strengthen oversight, equity monitoring and decision-making.

Putting families at the centre - We are expanding and diversifying service user involvement to ensure that the voices of all families shape service design, quality and improvement.

4.4 Delivering Change: Key EDI Highlights

Strengthening Preconception and Prevention
Our Preconception Education Pilot Project is equipping public health nurses with the knowledge and confidence to deliver high-quality education to young people.

The programme covers:
- Nutrition, exercise and lifestyle
- Reproductive health (female and male)
- Fertility and infertility
- Hormonal health and conditions such as PCOS
- The impact of weight, environment and behaviours on outcomes

This initiative supports earlier intervention and informed decision-making, helping to reduce inequalities before pregnancy even begins.

Next steps include:
- Rolling out education across colleges and community settings
- Delivering sessions to young people
- Evaluating impact and reach

Supporting Families in the First 1001 Days
Through our partnership with the NSPCC, all families now receive *"Our First 1001 Days Together"* guide at booking or shortly after birth.

This initiative:
- Provides clear, evidence-based guidance from pregnancy to age two
- Offers consistent messaging across all services
- Includes digital access via QR code to local support and referral pathways
- Is embedded across maternity and health visiting

This ensures every family, regardless of background, has access to trusted information at a critical time.

Reducing Inequalities in Antenatal Screening
We have secured national funding to improve uptake of sickle cell and thalassaemia screening, focusing on:

- Earlier access to booking appointments (before 10 weeks)
- Targeted support for communities at higher risk
- Reducing inequalities in screening uptake and outcomes

Embedding Inclusive and Culturally Competent Care
We are investing in workforce development to ensure care is inclusive and culturally responsive. this.

- A Cultural Intelligence Education Package is now embedded in midwifery training and mandatory education – delivered by the Trust's EDI Midwife.
- This work led to national recognition, with the midwife leading this work receiving the BAME Midwife of the Year award at the Health and Social Care National Awards in September 2025
- A full rollout to all maternity staff is underway

This supports staff to deliver care that is respectful, personalised and responsive to diverse cultural needs.

Expanding Access to Antenatal Education
We are broadening our antenatal offer to reach families who are often underserved:

- Targeted programmes for young parents, those with SEND, and families with social care involvement
- Community-based delivery through Family Hubs
- Commissioned Baby First Aid and Accident Prevention sessions to improve infant safety and respond to learning from child death reviews

These approaches reduce barriers to access and ensure education is available in familiar, trusted environments.

Supporting Fathers and Partners
The LMNS jointly funded a pilot with the perinatal mental health team (MPFT) to introduce DadPad through a six-year licence, providing fathers with practical, accessible support to build mental health literacy and confidence, and embedding father-inclusive care across the perinatal pathway.

Through the DadPad pilot, we are:

- Improving mental health literacy among fathers
- Providing accessible, practical support
- Embedding father-inclusive care across the perinatal pathway

This reflects our commitment to supporting the whole family.

Listening and Co-Producing with Communities
Strengthening the Maternity and Neonatal Voices Partnership (MNVP)
Our MNVP, working in close collaboration with the Trust's EDI Midwife**,** is central to our EDI approach, ensuring lived experience drives improvement. We are:

- Expanding volunteer recruitment to better reflect our communities
- Increasing engagement with underrepresented groups
- Embedding service user voice in decision-making at all levels

Reaching Underrepresented Communities

In 2025/26, we significantly expanded MNVP engagement with communities whose voices are often underrepresented.
This includes:

- Co-developing an African and Caribbean Stay and Play group, providing a culturally safe space for families
- Supporting a neonatal stay and play group for families with neonatal experience
- Engaging with LGBTQIA+ families, young parents, and those with lived experience of social care
- Planning targeted outreach to traveller communities

These initiatives create trusted spaces for listening, learning and co-production.

One parent shared: "It feels good to finally have a space where our voices are heard and where we can talk openly about our experiences."

5. Commissioning and Procurement

NHS commissioning within Shropshire, Telford and Wrekin is a continuous and evidence-led cycle, focused on planning, securing and monitoring health and care services that best meet the diverse and evolving needs of the local population. Procurement is a core component of this cycle and ensures that services and goods are purchased in a transparent, proportionate, and value-for-money way, while maintaining high standards of quality, safety, due process, and equity.

NHS Shropshire, Telford and Wrekin (NHS STW) recognise commissioning and procurement as powerful levers for addressing inequality and advancing patient equality. Equality, diversity, and inclusion (EDI) principles are embedded throughout commissioning activity to support compliance with the Equality Act 2010 and the Public Sector Equality Duty (PSED). This includes having due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations across all protected characteristics.

Equality and health inequalities considerations are integral to service design & development, review and transformation activity. Commissioning decisions are informed by population and public health and inequalities data & intelligence, engagement feedback including targeted proactive engagement with lesser heard voices and communities, and disaggregated data where available, to understand how access, experience and outcomes may differ between population groups, communities, and protected characteristics. This approach supports the development of services that are responsive to local need and aimed at reducing unwarranted variation and health inequalities.

Integrated Impact Assessments (IIA's) are routinely used to assess the potential impact of new or revised services, pathways and commissioning approaches, and increasingly used at the start of a review and redesign piece of work to inform bespoke development needs that will mitigate known inequalities. These assessments help identify risks of exclusion, disadvantage or variation in access and experience, and ensure that mitigating actions, reasonable adjustments, and inclusive service models are built in at the earliest stage.

EDI is also a key consideration within procurement activity. Proportionate and service-specific EDI questions are always included in procurement and tendering processes, and used as part of evaluating provider bids, enabling the NHS STW to assess how potential providers of a service:

- Understand and meet the needs of diverse population groups
- Address equality, accessibility, and inclusion within service delivery
- Ensure reasonable adjustments are available and clearly communicated
- Collect, monitor, and use equality data to improve patient outcomes
- Involve service users and communities, including those with lived experience, including in the informing of ongoing continuous service improvements.

Evaluation of tenders considers equality alongside quality, safety, and value, ensuring commissioned services align with the ICB's statutory equality responsibilities and strategic priorities.

NHS STW commissions services from a wide range of providers that meet NHS standards, including NHS Trusts, primary care, voluntary and community sector organisations, social enterprises and independent providers. This mixed provider landscape supports choice, innovation, and tailored service delivery, particularly for underserved or vulnerable groups.

Through commissioning and contract management processes, the ICB works with providers to promote continuous improvement in equality performance. This includes setting clear expectations on inclusive practice, monitoring delivery against equality-related requirements, and supporting learning and improvement where inequalities in access or outcomes are identified.

Commissioning and procurement are aligned with wider STW Integrated Care System (ICS) objectives to reduce health inequalities and improve population health. This includes

supporting targeted services and models of care for groups experiencing poorer outcomes, barriers to access or wider social disadvantage.

By embedding patient equality considerations into commissioning and procurement activity, the ICB aims to ensure that services are not only safe, clinically effective and cost-efficient, but also equitable, accessible and responsive to the needs of all communities across Shropshire, Telford and Wrekin.

Some examples of commissioned services where this approach is evident include:

Primary Care and Access-Focused Services

- Enhanced Primary Care Services and breadth of what is available locally in communities and neighbourhoods, designed to improve access for populations experiencing barriers, including people living in areas of deprivation, people with complex needs and those experiencing digital exclusion and remove the need for transport or travel to major hospitals.
- Special Allocation or Inclusive Registration Services to support patients who may struggle to access or remain registered with mainstream GP services.

Community and Out-of-Hospital Care

- Community-based clinical services (e.g. diagnostics, long-term condition management, rehabilitation) commissioned to reduce geographic inequalities, minimise travel barriers and support equitable access across rural and urban communities.
- Home visiting and outreach services for people who are frail, housebound, or living with disability.

Mental Health and Wellbeing Services

- Community mental health services commissioned with an emphasis on inclusive access, reasonable adjustments and culturally responsive care.
- Targeted early intervention and support services for groups at higher risk of poor mental health outcomes or disengagement from services.
- Fully redesigned and recommissioned CAMHS service that will deliver a strategic shift towards de-medicalised care and a focus on early help and prevention.

Learning Disability and Autism Services

- Learning Disability and Autism support services, including community-based provision, reasonable adjustment approaches and pathway design informed by Equality and Health Inequalities Impact Assessments.
- Preventative and proactive care models aimed at reducing avoidable admissions and improving patient experience and outcomes.
- Current all-age autism and ADHD services and pathways review that will be used to inform targeted redesign and recommissioning proposals.

Maternity, Children and Young People's Services

- Maternity and neonatal services commissioned with a focus on reducing inequalities in access and outcomes, particularly for women and families experiencing deprivation or additional vulnerability.
- Children and young people's health services designed to support early intervention, equitable access and smooth transitions between services.

Inclusion Health and Targeted Population Services

- Services supporting inclusion health groups, such as people experiencing homelessness, social exclusion or complex social need, delivered through partnership with voluntary and community sector organisations.
- Targeted prevention and support services aligned to local population health intelligence and identified inequalities.

Screening, Prevention and Early Diagnosis Services

- Accessible screening and preventative programmes, designed with reasonable adjustments and inclusive communication to improve uptake among under-served population groups.
- Health improvement and lifestyle services commissioned to address inequalities in long-term health outcomes.

Engagement, Co-production and Insight Services

- Patient and community engagement services, including involvement of people with lived experience, to inform service design, procurement decisions, and continuous improvement.
- Equality-focused engagement and insight activity used to shape commissioning priorities and service specifications.

Overall, across commissioned services, NHS Shropshire, Telford and Wrekin ICB demonstrates that:

- Equality and health inequalities considerations are embedded at all stages of commissioning and procurement
- IIA's are used to identify and mitigate potential disadvantage
- Providers are expected to evidence inclusive practice, reasonable adjustments, and user involvement
- Commissioning decisions support the reduction of unwarranted variation and improved equity of outcomes.

This approach ensures that commissioned services are not only safe, effective and value-for-money, but also accessible, inclusive, and responsive to the diverse needs of communities across STW.

6. Alignment of STW Patient & Population Activity to the Public Sector Equality Duty (PSED)

This section of the report aligns the patient and population-focused data, activity and outcomes from Shropshire, Telford, and Wrekin (STW) to the three aims of the Public Sector Equality Duty (PSED):

1. Eliminating unlawful discrimination, harassment, and victimisation.
2. Advancing equality of opportunity between people who share a protected characteristic and those who do not.
3. Fostering good relations between people who share a protected characteristic and those who do not.

PSED Aim 1: Eliminate Discrimination, Harassment and Victimisation

- Systematic use of Integrated Impact Assessments (IIAs) across commissioning, procurement, and service redesign to identify and mitigate risks of exclusion or disadvantages for protected characteristic groups.
- Routine consideration of reasonable adjustments, accessibility, and inclusive service models within new or revised pathways, including CAMHS, maternity, autism, and learning disability services.
- Procurement processes require providers to provide evidence of compliance with the Equality Act 2010, inclusive practice, and safe, non-discriminatory service delivery.

PSED Aim 2: Advance Equality of Opportunity

- Use of granular population health and inequalities data to identify gaps in access, experience, and outcomes, particularly for Core20PLUS and other marginalised groups.
- Targeted, data-driven interventions have led to measurable improvements, including reduced inequalities in vaccination uptake, hypertension treatment for people with learning disabilities or severe mental illness, and improved access to mental health support for deprived children and young people.
- Perinatal Equity Analysis combining population data and service-user insight has informed a co-produced Equity and Equality Plan, with targeted actions to improve outcomes for women and families facing the greatest disadvantage.

PSED Aim 3: Foster Good Relations

- Expansion and diversification of engagement through the Maternity and Neonatal Voices Partnership (MNVP), ensuring lived experience directly informs service improvement and decision-making.
- Targeted engagement with underrepresented communities, including African and Caribbean families, LGBTQIA+ parents, young parents, and families with lived experience of social care, creating trusted spaces for dialogue and co-production.

- Partnership working with voluntary and community sector organisations and Healthwatch to strengthen relationships between communities and the health system.

7. STW ICB – Alignment of EDI Evidence to Equality Objectives

This section of the report aligns the patient and population-focused data, activity and outcomes from Shropshire, Telford, and Wrekin (STW) to the ICBs Equality Objectives.

Objective 1 – Embed Equality Impact Assessments in Decision-Making
Evidence of alignment: • Routine use of Integrated Impact Assessments (IIAs) across commissioning, service redesign, and procurement to assess impacts on protected characteristics and Core20+ populations. • IIAs are increasingly applied at the outset of reviews to proactively mitigate inequality risks
Measurement: Compliance monitored via governance and quality processes, with assurance through board and executive reporting.
Documentation: IIAs referenced within board papers, commissioning decisions, and annual reporting.
Objective 2 – Strengthen Inclusion and Health Equity Reporting
Evidence of Alignment: • Board and executive reports routinely include EDI and inequality narratives supported by impact assessments. • Annual population health and inequality analysis completed to meet NHS England Section 13SA duty.
Measurement: Annual audit of board and executive papers for EDI compliance and narrative quality.
Documentation: Findings published through the annual 'State of the Region / Knowing Our Patch' report.
Objective 3 – Enhance Engagement and Feedback Mechanisms
Evidence of Alignment: • Targeted engagement through MNVP, Healthwatch and VCSE partners to amplify voices of marginalised groups. • Co-production activity with African and Caribbean families, LGBTQIA+ families, young parents, and traveller communities.
Measurement: Number of engagement activities, diversity of participation, and actions taken reported annually.

Documentation: Engagement findings and lived experience insights captured within annual population and inequality reports.
Objective 4 – Leverage Data to Address Inequalities
Evidence of Alignment: • Development of granular population health dashboards to analyse access, experience and outcomes by deprivation, ethnicity, and inclusion health groups. • First comprehensive service access inequalities report completed January 2026. • Perinatal Equity Analysis combining population and service user data to inform targeted action.
Measurement: Dashboards reviewed regularly and targeted interventions tracked annually.
Documentation: Data insights and resulting actions published in the 'State of the Region / Knowing Our Patch' report.
Objective 5 – Strengthen Leadership Capacity and Accountability for EDI
Evidence of Alignment: • Clear leadership accountability for EDI through commissioning, quality, and maternity governance structures.
Measurement: Training completion rates monitored alongside WRES, WDES and staff survey outcomes.
Documentation: Leadership actions and impacts documented within annual EDI reports and governance minutes.

8. Summary - Conclusion

Across 2025–2026, Shropshire, Telford and Wrekin ICB have made progress in understanding and addressing inequalities in access, experience and outcomes across its diverse urban and distinct rural communities. The ICB's achievements demonstrate continued commitment to delivering fairer, safer and more equitable healthcare, with a strong focus on those most at risk of poorer outcomes.

The ICB's achievements demonstrate:

- Leadership in tackling inequality across rural, deprived and underserved communities
- Improvements to access and experience across priority services and population groups
- Targeted use of data to identify unwarranted variation and inform decision-making
- Increased focus on inclusive service design, including digital and non-digital access
- Strong partnership working to address the wider determinants of health

This PSED Patient–Population Equality Report reaffirms our commitment to building an inclusive, place-based and person-centered health and care system, ensuring people in Shropshire, Telford and Wrekin have fair access, equitable experiences and improved health outcomes.

9. Priorities for 2026-2028

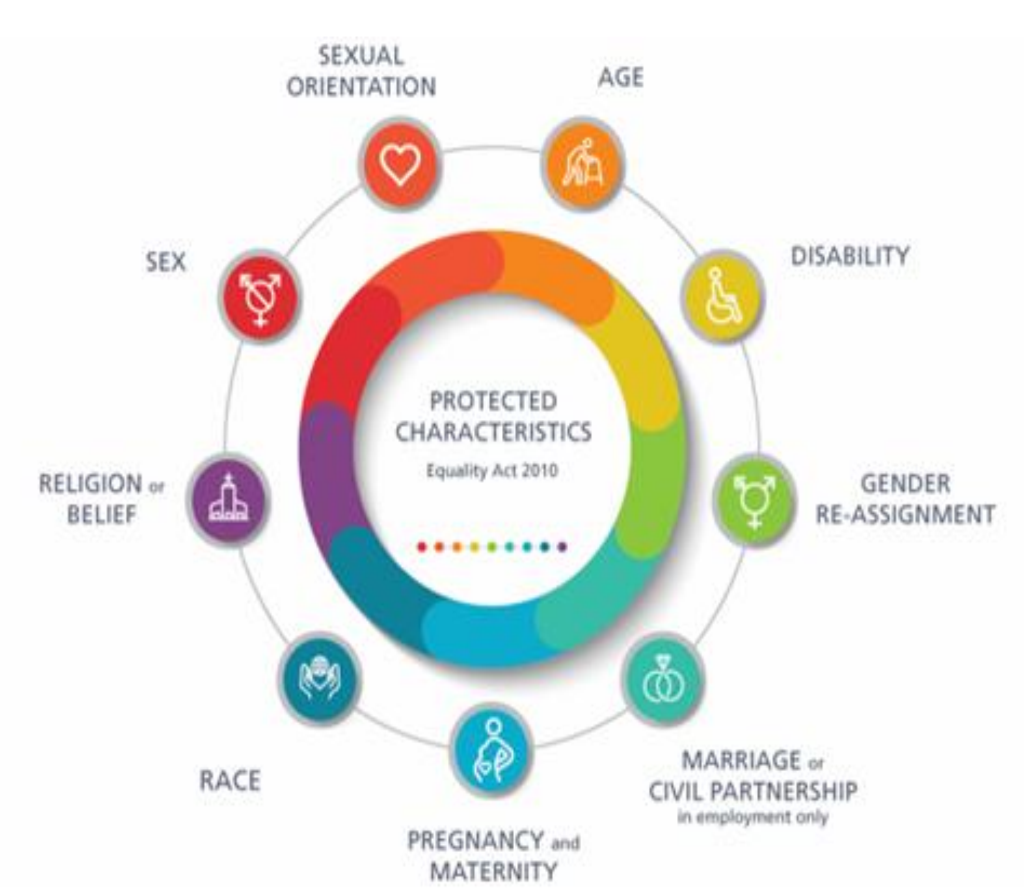
For 2026–2028, Shropshire, Telford and Wrekin ICB and Staffordshire and Stoke on Trent ICB share a priority to reduce avoidable inequalities in patient access, experience and outcomes, while responding to the distinct needs of each respective populations, including rurality, deprivation and diversity.

The ICBs will take a place-based approach informed by population health intelligence, disaggregated equality data and lived experience, alongside the development of shared system frameworks to strengthen consistency, reduce duplication and support robust assurance. This includes aligning approaches to leadership, governance, equality analysis, reporting and impact assessment to meet core EDI and Public Sector Equality Duty requirements.

These priorities provide the foundation for the development of joint ICB equality objectives, aims and actions, ensuring equality and health inequalities considerations are embedded within decision making, commissioning and service development and advancement.

Staffordshire & Stoke-on-Trent Integrated Care Board Integrated Care Board

PSED Patient – Population Equality Report 2025–2026



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1. Introduction

The Staffordshire & Stoke-on-Trent -Integrated Care Board (ICB) is committed to meeting its responsibilities under the **Public Sector Equality Duty (PSED)**. This annual Patient Equality Report provides an account of the actions we have taken during **2025–2026**

The report reflects progress made through service delivery, commissioning, digital transformation, workforce initiatives that directly affect patient experience, and programmes aimed at tackling **health inequalities**, consistent with the national **Core20PLUS5** framework and the ICS's own improvement priorities.

The ICB recognises that health inequalities across our geography are shaped by deprivation, long-term conditions, employment, housing, environment, ethnicity, disability, digital exclusion, and access barriers. This report sets out how we have addressed these barriers and delivered measurable improvements.

This report outlines key activities undertaken during 2025 by Staffordshire & Stoke-on-Trent ICB/ICS that demonstrate compliance with the **Public Sector Equality Duty (PSED)**, with a specific focus on **patient access, experience, and outcomes**, and actions to **reduce health inequalities**.

Evidence has been gathered from published ICB/ICS updates, operational programmes, and population health initiatives. The activities highlighted demonstrate how the ICB has shown **due regard to eliminating discrimination**, **advancing equality of opportunity**, and **fostering good relations** across diverse patient groups in alignment with **Equality Act 2010**, the **NHS Long Term Plan**, and local Health Inequalities priorities.

Strategic Context

As a statutory body, the ICB is responsible for the health and care of **1.1 million people**, spanning both urban and rural communities with marked variations in affluence, deprivation, and health inequalities. The ICB continued to embed an equality-led approach across planning, resource allocation, and service transformation throughout 2025.

Key system ambitions include:

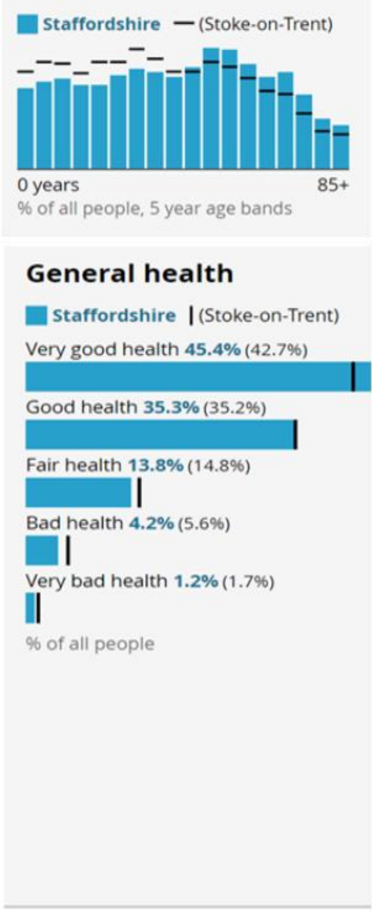
- Delivering better outcomes by reducing health inequalities
- Ensuring fair access to services
- Strengthening population health management
- Improving the quality of experience for protected groups

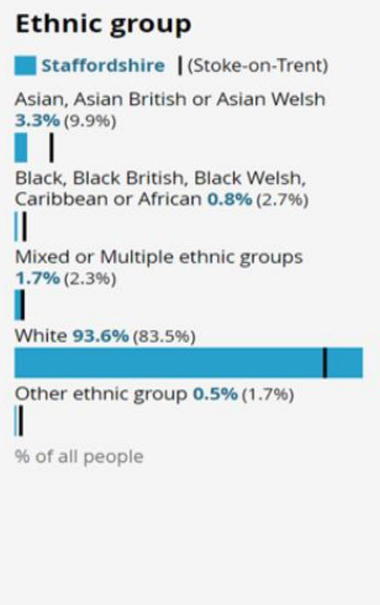
2. Population Profiles Staffordshire and Stoke-on-Trent.

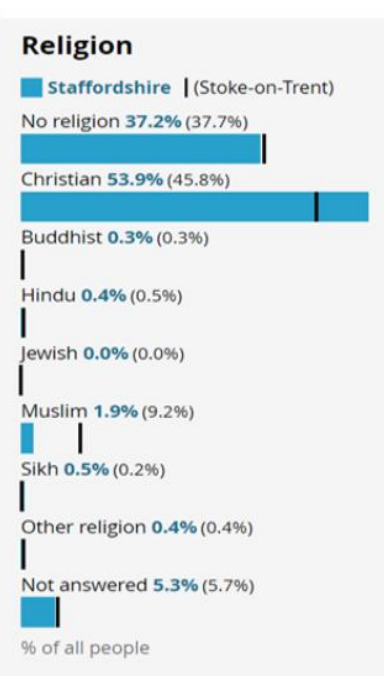
The populations of Staffordshire and Stoke-on-Trent (SSoT) are diverse with complex health and care needs, comprising both rural and urban areas, extremes of affluence, deprivation, as well as significant health inequalities. Nineteen percent of the SSoT population are in the two most deprived national deciles (i.e. the most deprived 20%, or the most deprived quintile). The majority (63%) of the most deprived population with SSoT reside in Stoke-on-Trent.

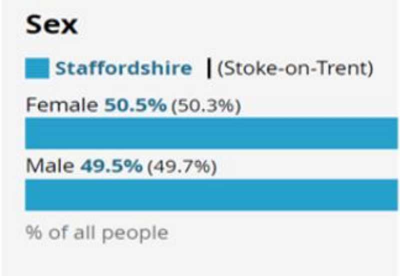
Population Profile

Staffordshire	Stoke-on-Trent
Population	**Population**
876,100	**258,400**









Sexual Orientation - Stoke-on-Trent highest LGBT population 3.1%. South Staffordshire highest heterosexual population 92.8%. People who identified as a bisexual person represent 1%.

Source: Staffordshire Live

Source: Office for National Statistics - Census 2021

3. Patient Equality Focusing on Access, Experience & Outcomes.

MEASURING PROGRESS & OUTCOMES

QUANTIFIABLE IMPROVEMENTS (2025–2026)

- 55% REDUCTION IN RESTRICTIVE 1:1 CARE.
- >95% OF END-OF-LIFE PATIENTS ACHIEVING PREFERRED PLACE OF DEATH.
- 40% → 75% IMPROVEMENT IN GP PRACTICE PATIENT EXPERIENCE AFTER TARGETED SUPPORT
- 1.7 MILLION SHARED CARE RECORD LOGINS
- SIGNIFICANT REDUCTION IN CONTINUING HEALTH CH(C) DISPUTE CASELOAD (59%)
- FASTER CHC AND FNC ELIGIBILITY DECISION-MAK(ING WITH IMPROVED FAIRNESS
- INCREASED AVAILABILITY U)GENT DENTAL APPOINTMENTS AND UEC ALTERNATIVES

From a patient equality objective perspective, a series of initiatives were developed throughout 2025 to advance the ICB monitoring, reporting and publishing equality information relating to patients' access, experiences and outcomes. This included developing the awareness and understanding behind equality data capture, development of mechanisms for analysing differential impacts across protected groups, and work to enhance the visibility of inequalities within assurance and decision-making processes.

Progress in fully implementing these developments was impacted by the wider ICB reform and restructure and introduction of the cluster arrangement with Shropshire, Telford and Wrekin ICB This has both highlighted variation in how each organisation approaches its Public Sector Equality Duty (PSED) and, specifically, how patient equality objectives are framed, monitored and delivered. This variation presents an exciting opportunity to further strengthen the equality agenda and to provide consistency and collective impact across respective ICB's

As the cluster model matures, it will be necessary to **review, refresh and align PSED equality objectives** across the participating ICBs to ensure:

- a shared set of priorities for improving patient access, experience and outcomes
- a consistent methodology for equality analysis and assurance
- clarity in reporting, governance and accountability
- a unified approach to identifying and reducing inequalities across the wider system

This alignment will form a critical part of the next phase of the ICBs equality diversity and inclusion work, enabling the cluster to operate with greater coherence and to meet its PSED obligations in a more integrated and impactful way.

4. Summary of Key Achievements 2025–2026

Across 2025–2026, the ICB delivered significant improvements in:

- Primary care access and patient experience
- Digital inclusion and shared care records
- Health inequalities and population health management
- Maternity and women's health outcomes
- Mental health access and crisis alternatives
- End of -life equity and personalised care
- Reducing restrictive practices in continuing healthcare
- Winter resilience for vulnerable cohorts
- Neighbourhood Health and community--based care models

Improving Access and Preventing Deterioration in Vulnerable Populations

Care Home Deterioration Resource Pack (published early 2026, part of 2025 programme delivery)
The ICS released an updated resource pack to support care homes in recognising and responding to early deterioration in residents primarily older adults, many of whom have disabilities or long-term conditions. This improves safety, ensures timely escalation, and enhances outcomes for groups most at risk.

Public Sector Equality Duty contribution: advances equality for older and disabled people by standardising high quality care and reducing preventable harms.[staffsstok...ics.org.uk]

Supporting Over 6,000 Patients via Community-Based Initiatives

The ICS reported that key partnership programmes—including the *Falls Response Team*—have supported **over 6,000 patients** since their launch in previous years, with significant delivery continuing throughout 2025. Many of the beneficiaries are older, frail, or disabled patients.

Public Sector Equality Duty contribution: targeted interventions addressing functional impairment, mobility limitations, and risk of injury among protected groups. [staffsstok...ics.org.uk]

Addressing Inequalities in Preventative Health: Winter Vaccinations

During 2025, the ICB issued strong calls to action to improve uptake among under vaccinated groups—highlighting that **320,094 people** in the area still needed their flu vaccination, and a further cohort had yet to receive COVID-19 vaccinations.

Public Sector Equality Duty contribution: contribution: reducing inequalities in preventative care, with focus on older adults, people with disabilities, long-term health conditions, and communities with historically lower uptake. [staffsstok...ics.org.uk]

Ensuring Fair Access Through Elective Treatment Prioritisation

In December 2025, the ICB clarified how elective treatments were prioritised to ensure fairness and transparency across the local population. Clear criteria support consistent and equitable decision making in an environment of high demand.

Public Sector Equality Duty contribution: improving fairness of access; reducing disproportionate delays for patients with conditions more prevalent in protected groups. [staffsstok...ics.org.uk]

Reducing Barriers to Primary Care Access Through Digital Inclusion

The ICS reported that **more than half a million people** in the area were using the NHS App to access GP services. Increased digital access supports:

- patients with disabilities
- working-age patients who struggle with in person appointments
- carers
- people facing transport or mobility challenges

Public Sector Equality Duty contribution: contribution: widening access channels and removing structural access barriers.

Ongoing Programmes Addressing Health Inequalities & Access

Across 2025, the ICS continued to implement programmes aimed at improving urgent care, mental health crisis response, and population health management, all of which prioritise reducing inequalities and improving outcomes in high need groups. These efforts reflect the system's commitment to advancing equality across service pathways.

PSED contribution: systemwide reduction in health inequalities; improved access and experience across protected groups.

5. Meeting the PSED Duties

Below is a detailed account of how each PSED duty has been met through programmes evidenced across internal communication networks and ICB portfolios.

Duty 1: Eliminate discrimination, harassment and victimisation

Reducing Restrictive and Inequitable Care (All Age- Continuing Care)

- The Integrated Holistic Assessment Team (IHAT) achieved a **55% reduction in unnecessarily restrictive 1:1 care**, removing **7,059 hours** of over -restriction for individuals with dementia, learning disability and mental health needs.
- New clinical review pathways eliminated outdated or blanket restrictions, ensuring proportional and person-centred- support.
- Patient stories (Mr S and Mrs C) demonstrated a shift from restrictive care to **dignity promoting -alternatives**, allowing individuals to regain independence and, in some cases, return home.

Safeguarding Equity Using Shared Care Record (One Health & Care)

- A pilot enabling GPs to cross-check ‘Child in Need’ and ‘Child Protection’ information created earlier identification of safeguarding risks.
- Enhanced multi-agency data sharing reduces discriminatory gaps between health and social care records.

Maternity Safety and Anti--Discrimination Measures

- New digital risk stratification tools improved early detection of stratification tools improved early detection of high- risk- pregnancies, addressing known ethnic disparities.
- Maternity Outcomes Signal System (MOSS) introduced to highlight stillbirth, neonatal death and brain injury risk in near -real time.

Freedom to Speak Up & Mentally Safe Workforce

- Expansion of **Mental Health First Aiders** supports a psychologically safe workforce, enabling staff to raise patient safety concerns without fear—directly impacting equitable treatment of patients.

Duty 2: Advance equality of opportunity

Primary Care Access Improvements

Significant improvements occurred in access routes known to disadvantage vulnerable groups:

- Ending the *8am queue* through digital telephony and multiple access routes.
- GP Access Survey shows rises from **40% to 75%** in positive experience following targeted intervention in a failing practice.
- Increased urgent dental appointments, extended community pharmacy roles and improved out of -hours- access.

Digital Inclusion – Protecting Non-Digital- Users

Despite rapid digital transformation, the ICB guaranteed that:

- People unable to use technology still access care traditionally.
- Digital inclusion support was built into commissioning and service redesign.
- Shared Care Record achieved **1.7m logins**, with benefits for continuity, reduced repetition for neurodivergent patients, and improved safety.

Health Inequalities Strategy & Locality Improvement Framework (LIF)

- **£1.7m recurrent funding** was ringfenced to address the priorities of eight Staffordshire and four fenced to address the priorities of eight Staffordshire and four Stoke--on---Trent localities.
- Localities required cross sector- collaboration, ensuring grassroots and VCSE involvement.
- Interventions targeted Core20PLUS5 groups, including:
    - frailty
    - obesity
    - long term- conditions
    - children and young people
    - homelessness
    - veterans
    - violence effected- women and families

Two approved LIF projects illustrate impact:

- **Tamworth Wellness GSB Project** – targeting obese households with long -term conditions *not accessing GP services*.
- **South Staffordshire Ageing Well** – reducing falls and frailty progression, yielding potential avoided costs of **£489k**.

Women's Health, Maternity & Children and Young People Equality

Actions from the 10-Year Plan delivered locally included:

- Homebased HPV and cervical screening pilot (improving uptake among based HPV and cervical screening pilot (improving uptake among -under screened- women).
- Maternity risk data used earlier for minority ethnic women.
- Expansion of Mental Health Support Teams in schools and digital access to talking therapies.

Mental Health Access, Crisis Alternatives & Young Futures Hubs

- 24/7 community mental health pilots increase access for those who avoid emergency settings.
- Digital self-referral- to talking therapies supports those unable to navigate GP routes.
- Young Futures Hubs ensure “no wrong front door” for CYP.

End of- -Life (EoL) Equity

- New EoL homecare pathway achieved **>95% of people** dying in their preferred place of care—transforming experience for frail, disabled and palliative patients.
- Reduced unnecessary admissions and improved dignity.

Duty 3: Foster good relations between different groups

Community-Centred Prevention & Inclusion Programmes

- Violence Reduction Alliance, Pause Partnership and Health Literacy Programme expanded work with communities disproportionately affected by poor outcomes.
- Cost of- living–related health harms (fuel poverty) were mitigated with targeted shared record datasets enabling clinicians to identify at- risk- households.

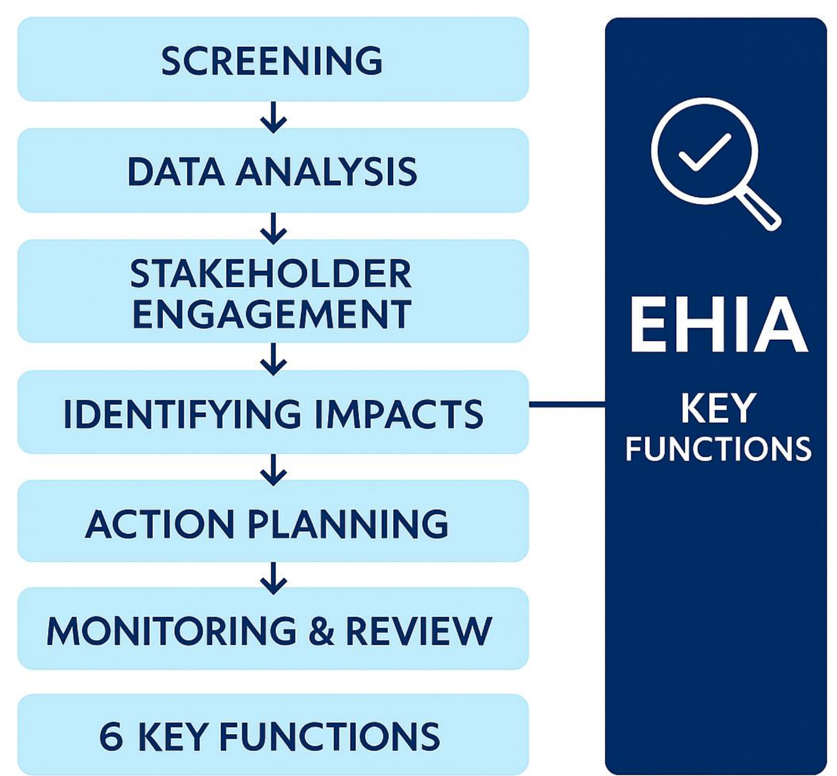
Neighbourhood Health Model

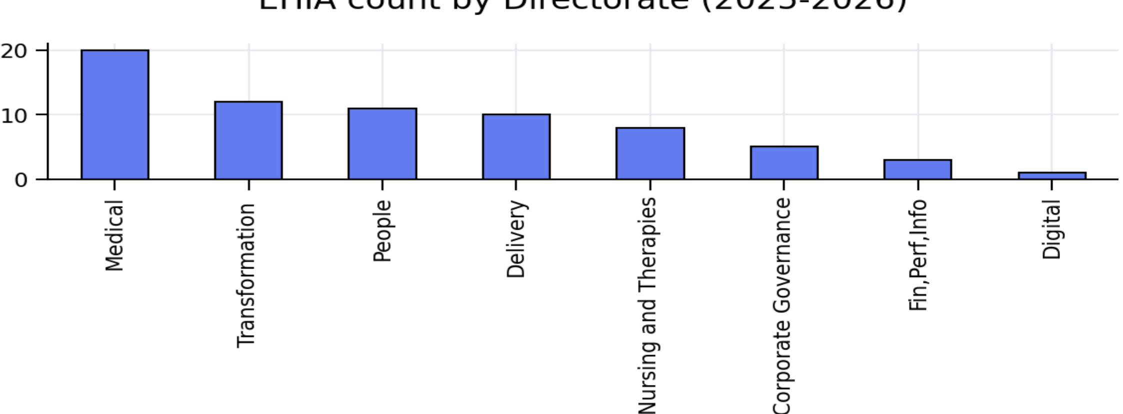
- Multi-professional neighbourhood teams organised around groups with the highest need.
- Co-location with pharmacies, mental health and diagnostics increased trust and inclusivity in underserved communities.

Patient Voice & Family Engagement

- Weekly collaboration between AACC and ICB patient experience teams improved responsiveness.
- Positive family testimonies highlight improved communication, shared decision-making- and dignity.

6. Equality and Health Inequality Impact Assessments (EHIAs) Completed in 2025–2026





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

Assessments were undertaken across the full breadth of ICB responsibilities, including **Medical**, **People**, **Corporate Governance**, **Delivery**, **Transformation**, **Finance/Performance/Information**, **Nursing & Therapies**, and cross-system **ICS/Collaborative** programmes. This demonstrates that equality and health inequalities considerations are embedded not just in clinical service change, but also in corporate, financial, workforce, digital and procurement functions.

A significant proportion of assessments were **Full EHIAs**, reflecting the scale of impact associated with organisational change programmes, clinical pathway redesign, procurement initiatives and major policy development. Examples include the Clinical Leadership restructure, Primary Care commissioning decisions, efficiency programme schemes, technology programmes, and a wide range of clinical policy updates. Where required, actions were embedded to ensure compliance with the Equality Act 2010 and to support targeted improvements, such as strengthening inclusive recruitment, enhancing access to consultation materials, improving monitoring frameworks, and ensuring reasonable adjustments for staff and patients.

The EHIA Tracker evidences strong governance oversight, with assessments routinely considered through appropriate committees such as the Finance and Performance Committee, Primary Care Forum, Quality & Safety Committee, Audit Committee, and Transformation governance groups. Many EHIAs were formally approved with actions, demonstrating transparent assurance processes and continuous improvement.

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

7. Embedding EDI into the Procurement Process

In 2025, Staffordshire and Stoke-on-Trent ICB embedded Equality, Diversity and Inclusion (EDI) and the Public Sector Equality Duty (PSED) across key procurements including:

- Ear Nose Throat Services
- Gateway Psychology
- Gordon Street General Practice, Minor Hand Surgery,
- Occupational Health and Needle Stick Injury Support, and
- Wheelchair Services.

A structured pool of EDI-focused questions was used (relevant to each service procurement) across all procurements, enabling robust assessment of how bidders meet statutory requirements, identify and mitigate inequalities, and support inclusive workforce and service delivery. Each question included clear pass/fail criteria, ensuring transparent and defensible evaluation. Mandatory criteria covered:

- Accessibility and reasonable adjustments, requiring bidders to evidence compliance with statutory accessibility standards and inclusive communication.
- Workforce equality and PSED duties, assessing policies, training, monitoring mechanisms, and equality objectives.

- Identification and mitigation of health inequalities, with an emphasis on targeted actions and equitable outcomes.
- Collection and use of disaggregated data, demonstrating how workforce and service user data informs improvement.
- EDI governance and leadership accountability, referencing EDI leads, committees, and alignment with CQC Well Led expectations.

This approach strengthened the quality and equity of procurement outcomes across all services. For example:

- **Wheelchair Service bidders** were evaluated on how they would ensure equitable waiting times and accessible home assessments.
- **Ear Nose Throat bidders** had to demonstrate inclusive pathways for people with sensory impairments or language needs.
- **Gateway Psychology bidders** were required to evidence actions addressing inequalities among children with SEND and minority groups.
- and **Occupational Health providers** were required to demonstrate workforce equality practices relevant to NHS settings.

Evaluation panels included the EDI Business Partner trained in EDI applied objective scoring, ensuring only providers demonstrating compliance and strong equality practice progressed.

Moderation ensures transparent, evidence-based decisions. This approach strengthened assurance that commissioned services can deliver equitable access, experience and outcomes while meeting statutory PSED duties.

8. Review of engagement activity and key themes from stakeholders, people and communities.

Mental Health

• Public engagement to seek views about adult mental health services through survey, in person and on-line involvement sessions (November 24 – March 25).

- Feedback from 180 participants used to shape delivery of Adult Mental Health Inpatient Strategy.
- A summary of the public engagement is available at Transforming adult mental health inpatient services in Staffordshire and Stoke-on-Trent Strategy, 2024-2027.
- A strong collective feedback theme to come out of the engagement was *'More services locally and in the community, more safe spaces and walk-ins'.*
- *'The right treatment first time, this would help to manage or stop a relapse. Shorter wait times, be able to access services in the community.'*

Community Transformation- Frailty

Professional and public engagement to shape Community Transformation strategies; New All-Age Palliative and End of Life Care, All-Age Respiratory, and Healthy Ageing and Frailty strategies launched for Staffordshire and Stoke-on-Trent - Staffordshire and Stoke-on-Trent, ICS

- Feedback from 600 members of the public and 174 health and care professionals
- *"The goals of [the] palliative care should align with mine, and I should be given options of where I want to receive care, particularly my end-of-life care."* All Age Palliative and End of Life Care Strategy 2025-2028
- *"I miss my reviews; it is so easy to do so. My GP sends a text to book an appointment, but I am too busy to make an appointment."* All Age Respiratory Strategy 2025 – 2030.
- *"To make best use of the clinical workforce, it's essential that the most appropriate professional provides the care."* Healthy Ageing and Frailty Strategy 2025-2030.

Urgent and Emergency Care

Engagement to seek feedback on urgent and emergency care services across Staffordshire and Stoke-on-Trent – including conversations about the range of services available and proposals for UTCs (July to October 2024).

- Feedback included intelligence on primary care services, such as Pharmacy First and dental access
- Mixture of locality meetings (in person and on-line), community focus groups, site visits and targeted engagement plus 1,553 responses to on-line survey: 1,281 to the main engagement survey, and 272 to the easy read version.
- Report of findings: staffsstoke.icb.nhs.uk/~documents/route%3A/download/3916/

Cancer

- Cancer Bus Tour – targeted approach based on data showing which areas had the lowest uptake for cancer screening and where people were presenting to the NHS with late-stage cancers

- Focus this year on engagement to target communities that are having less favourable outcomes, to try to educate them on symptoms and encourage them to come forward if they think they have symptoms and/or come forward for screening programmes

Primary Care

Engagement on messaging to support reduction of prescriptions for over-the-counter meds.

- Feedback shaped campaigns such as Only Order What you Need Campaign, including SMS messaging from practices and vitamins campaign (*Where to get medicines, creams, drops and vitamins that are no longer routinely prescribed by your GP - Staffordshire and Stoke-on-Trent, ICS)*- both support Value-Based Healthcare
- Regular pulse surveys with the People's Panel on NHS App and Primary Care Access

Maternity

Consultation on birthing services at County Hospital and Samuel Johnson Community Hospital

- Mixture of on-line and face to face events plus 1,403 responses to consultation survey
- Report of findings currently being developed

9. ICB Equality Objective 1 – Patient Equality

Advance reporting and publishing of patients' access, experience and outcomes by protected characteristics across services where inequalities persist.

Specific Action 1: Strengthen Governance, Accountability & Reporting

- Executive accountability and sponsorship are embedded across the ICB.
- Cross -directorate oversight strengthened (AACC, IPH/PHM, Digital, Primary Care) with routine review of patient equality impacts.
- Weekly case review between AACC and the ICB patient experience team improves escalation and learning.
- Shared Care Record (OHC) and Winter Plan governance prioritise high risk- cohorts.
- Population Health Management capability underpins locality level- leadership and systematic.
- Outcome tracking.

Specific Action 2: Improve Disaggregation of Service User Data

- OHC analytics support risk -stratified insights (frailty, safeguarding, EoL, lung screening, opioid risk, fuel poverty).

- PHM segmentation via the Locality Improvement Framework (Core20PLUS5) builds a minimum dataset by Age, Sex, Ethnicity, Disability, and IMD.
- Primary Care Patient Survey used to understand and track experience gaps; targeted practice moved from 40% to 75% positive.
- AACC/CHC datasets embed age, cohort, eligibility, and appeals trends to understand outcomes for older and disabled people.

Specific Action 3: Collaborate and Involve Stakeholders & Communities

- Locality Improvement Framework (LIF) codesigned with LA, PCNs and VCSE partners to define local Core20PLUS5 priorities.
- Co-production of Tamworth Wellness and South Staffordshire Ageing Well projects with community partners.
- Patient stories and family feedback in AACC visibly shape care planning and service improvements.
- Digital inclusion work ensured non-digital access routes remain available and promoted.

10. Tackling Health Inequalities

Summary of the Health Inequalities Report (2025)

Introduction

This summary provides a Public Sector Equality Duty (PSED) and Equality, Diversity & Inclusion (EDI)–focused overview of the Staffordshire and Stoke-on-Trent Health Inequalities Report (2025). It highlights where protected characteristic groups—specifically ethnicity, sex/gender, age, and disability—experience differential access, outcomes and service use. The aim is to support evidence-based decision-making and targeted action aligned to statutory equality duties and the Core20PLUS5 approach.

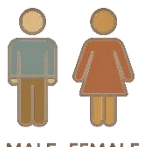
Key Inequalities by Protected Characteristic

Ethnicity

- Asian and Black patients face consistently poorer outcomes, including longer elective waiting times (16 weeks vs 14–15 for White groups) and higher proportions waiting more than 18 and 65 weeks.
- Higher DNA rates in outpatient and virtual appointments are seen in Asian, Black, Mixed, and Other groups.
- Mental Health Act detentions are significantly higher among Black and Mixed ethnicity groups, with higher restrictive interventions also reported in minority ethnic communities.
- Flu vaccination uptake is lowest among Black, Mixed and Other groups in deprived areas (27%).
- Asian patients have disproportionate Type 2 diabetes prevalence relative to population size and lower hypertension/AF treatment thresholds met.
- Ethnic minority children show lower mental health access rates.

Overall: Strong evidence of structural inequality affecting Asian, Black and Mixed ethnicity communities across multiple pathways.

Sex / Gender



Women face longer elective waits, higher proportions waiting >52 weeks, and higher outpatient and A&E attendance rates.

- Men have higher emergency admission rates for cardiovascular conditions (stroke, myocardial infarction) and are more likely to experience restrictive mental health interventions.
- Diabetes registration is higher among men for both Type 1 and Type 2.

Overall: Women experience inequality in access (longer waits), while men experience inequality in acute and restrictive health events.

Age

Adults aged 18–44 experience the longest waits and are most likely to breach 18, 52 and 65 weeks.

- Older adults have higher elective and emergency admission rates and better outcomes in Talking Therapies.
- Children and young people:
- Higher emergency admissions among the most deprived.
- Dental caries admissions disproportionately affect boys and children in deprived areas.
- Young people have lower mental health recovery rates.

Overall: Inequalities appear across the life course, with young adults facing delays and younger children facing higher avoidable admissions.

4. Disability / Long-Term Conditions

- People with Severe Mental Illness (SMI) receive better physical health checks in several localities compared to England yet remain a high-risk group.
- Learning disability health checks are strong (79–83% completed), though 1 in 5 remain unchecked annually.
- The ICB has the 6th lowest inpatient rate for LD/autism nationally—an area of strength.

Overall: SMI and LD populations remain priority groups, though local performance compares favourably to national patterns.

5. Deprivation (Core20)

- Although not a protected characteristic, deprivation materially interacts with ethnicity, gender and disability, driving multiple inequalities:
- Higher emergency admissions, outpatient DNAs, CYP mental health activity, poor oral health, and lower flu vaccination uptake.
- Significant deprivation gradients affect stroke, MI, and hypertension indicators.

Overall: Deprivation amplifies other inequalities and is central to any PSED-compliant approach.

Cross-Cutting Themes

- Ethnic minority groups are at consistent disadvantage across waiting times, mental health, long-term conditions and prevention uptake.
- Women face access-related inequality, particularly in elective waits.
- Men face risk-related inequality in emergency and restrictive pathways.
- Younger age groups face delays and poorer mental health outcomes.
- Deprivation intersects with all protected characteristics, worsening outcomes in multiple domains.

11. Digital Transformation with Equity at the Centre

Major digital programmes included:

- Digital ReSPECT ensuring personalised care planning.
- Remote monitoring and virtual wards enabling care at home for mobility -restricted patients.
- Data -driven maternity and frailty risk tools.
- Federated Data Platform adoption to track inequalities and unwarranted variation.
- Ensuring **non-digital access routes** remain available and promoted.

This transformation strengthened safe access, reduced delays and tailored care to need.

Winter Preparedness for Vulnerable Groups (Winter Plan 2025/26)

The ICS Winter Plan targeted equity by:

- Increasing urgent dental access.
- Deploying HIU (High Intensity User) programmes.
- Strengthening frailty response, falls services and EoL pathways.
- Increasing GP winter capacity and overnight support for 999 alternatives.
- Enhancing IPC 7-day cover, protecting clinically vulnerable patients.
- Increasing Enablement and Discharge to Assess productivity to avoid extended stays.

12. Summary/Conclusion

Across 2025–2026, Staffordshire & Stoke-on-Trent ICB have made progress in delivering fairer, safer and more equitable healthcare for all communities. The ICB's achievements demonstrate progress in delivering fairer, safer and more equitable healthcare for all communities. The ICB's achievements demonstrate-:

- Leadership in reducing restrictive practices
- Significant improvements to access and experience
- Innovative use of digital tools without widening inequalities
- New models of care supporting those most disadvantaged
- Shared commitment across partners to tackle health inequalities

This PSED Patient - Population Equality Report affirms our commitment to building an inclusive, person-centred health and care system where everyone has fair access, optimal experience centred health and care system where everyone has fair access, optimal experience- and the best possible outcomes.

13. Priorities for 2026–2028

For 2026–2028, Staffordshire and Stoke-on-Trent ICB and Shropshire, Telford and Wrekin ICB share a priority to reduce avoidable inequalities in patient access, experience and outcomes, while responding to the distinct needs of their respective populations, including rurality, deprivation and diversity.

The ICBs will take a place-based approach informed by population health intelligence, disaggregated equality data and lived experience, alongside the development of shared system frameworks to strengthen consistency, reduce duplication and support robust assurance. This includes aligning approaches to leadership, governance, equality analysis, reporting and impact assessment to meet core EDI and Public Sector Equality Duty requirements.

These priorities provide the foundation for the development of joint ICB equality objectives, aims and actions, ensuring equality and health inequalities considerations are embedded within decision making, commissioning and service development and advancement.

Enclosure No: 11

Report to:	Integrated Care Board
Date:	25th June 2026
Title:	WorkWell and Widening Access Demonstrator Programmes
Presenting Officer:	Mish Irvine, Chief of Staff
Author(s):	Gemma Treanor, Head of ICS People Function

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

Is the decision within SOFD powers & limits	**Yes**	☒	**No**	☐
Any potential / actual Conflict of Interest?	**Yes**	☒	**No**	☐
If Y, the mitigation recommendations:				
Any financial impacts: ICB or ICS?	**Yes**	☒	**No**	☐
If Y, are those signed off by and date:	*Chief Finance Officer, Grant Funding agreement, 03/06/26*			
Any impacts on ICB Undertakings?	**Yes**	☐	**No**	☒
Appendices:	None			

(1) Purpose of the Paper:

This paper provides an overview of the WorkWell and Widening Access Demonstrator programmes led by the People Team within the Chief of Staff Directorate. It sets out progress to date and highlights the strategic importance of both programmes in improving population health through strong partnership working and meaningful community engagement, in line with the ICS's fourth purpose.

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

(3) Implications:

Legal / Regulatory	The programme supports the statutory duty to reduce health inequalities.
CQC / Patient Safety	Clinical and professional expertise will be provided throughout the programme to ensure patient safety and quality outcomes.
Financial (CFO-assured)	Funding will be received quarterly over the three-year programme and receipt of funding is dependent on achieving the expected referral volumes and participant satisfaction rates. Funding is ringfenced and separate to ICB funding allocations.
Sustainability	n/a
Workforce / Training	Internal workforce infrastructure will support ICB strategic commissioning and leadership of the programme. Provider/partner workforce training will be required as part of service implementation and ongoing continuous professional development.
Equality & Diversity	The programme will ensure equality, diversity and inclusion principles are considered and at the heart of delivery and outcomes. An Equality Health Impact Assessment will be carried out as part of the design and implementation phases.
Due Regard: Inequalities	The programme supports the statutory duty to reduce health inequalities and is inextricably linked to the ICS fourth purpose, improving population health and supporting the prevention agenda.
Due Regard: wider effect	This programme will have a wider impact on the Clustered ICB aims and objectives, delivery of the 10-year plan and subsequent strategies. The programme will be delivered under the umbrella of 'Get Britain Working' plans locally.

(4) Statutory Dependencies & Impact Assessments:

	Completed?			If N - N/A, Rationale	If Y, Outcome / Date Reported & Signed off
	Yes	No	N/A		
DPIA	☐	☒	☐	To be undertaken as part of the programme	*Reported to IG Committee:* Click or tap to enter a date.
EIA	☐	☒	☐	To be undertaken as part of the programme	*Outcome and date of completion:* Click or tap here to enter text.
QIA	☐	☒	☐	To be undertaken as part of the programme	*SRO sign-off, outcome & date of completion:* Click or tap here to enter text.

	Yes	No	N/A	
Has there been Public / Patient Involvement?	☐	☒	☐	Will be undertaken as a significant part of service design and implementation

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

SBAF1	Responsive Patient Care - Elective	☐	**SBAF5**	High Quality, Safe Outcomes	☒
SBAF2	Responsive Patient Care - UEC	☐	**SBAF6**	Sustainable Finances	☐
SBAF3	Transforming Community Services	☒	**SBAF7**	Improving Productivity	☐

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

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

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

This paper provides an overview of the WorkWell and Widening Access Demonstrator (WAD) programmes, both of which are central to delivering the ICS's fourth purpose through improving population health, reducing inequalities and supporting social and economic development.

WorkWell is a three-year, system-wide programme focused on supporting individuals with health conditions or disabilities to access and sustain employment through early intervention, integrated pathways and strong multi-agency collaboration. The 12-month WAD programme targets those furthest from the labour market within Staffordshire and Stoke-on-Trent specifically, providing structured routes into employment in health and care, particularly for individuals from deprived and marginalised communities.

Both programmes are underpinned by a shared emphasis on partnership working and community engagement, recognising that improving access to employment requires coordinated action across the NHS, Local Authorities, DWP, VCSE sector, education providers and employers. Co-design with communities and those with lived experience is central to delivery, supported in WAD by dedicated external expertise to strengthen engagement with underserved groups. Together, these programmes create a coherent, system-wide pipeline from outreach and engagement through to sustained employment, supporting long-term improvements in health outcomes, workforce sustainability and the wider economic wellbeing of the population.

(7) Recommendations to Board:

Both Boards are asked to:

- Note the strategic importance of the WorkWell and Widening Access Demonstrator programmes in improving population health, delivering the ICS's fourth purpose and improving workforce sustainability
- Endorse the programme which will focus on strong system partnerships and community engagement
- Consider connections with wider skills, employment and health programmes (local authority partners especially) to align our approaches and better engage and involve our communities.

WorkWell & WAD Programme Overview

1. Introduction

1.1 This paper sets out an overview of the WorkWell and Widening Access Demonstrator (WAD) programmes, both of which form key components of the ICS's response to the wider determinants of health and delivery of its fourth purpose. Together, these programmes represent a significant opportunity to take a coordinated, place-based approach to improving population health, reducing inequalities and supporting economic participation across the system. They build on existing system strengths, partnerships and community assets, and reflect a shift towards more integrated, preventative and inclusive models of delivery that prioritise those most at risk of poor health and exclusion from employment.

2. WorkWell – STW and SSOT Clustered ICB

2.1 WorkWell is a three-year programme, jointly funded by the Department for Work and Pensions (DWP) and the Department of Health and Social Care (DHSC), designed to support individuals with health conditions or disabilities to remain in, return to, or access employment. It forms a central part of the national *Get Britain Working* agenda and represents a key opportunity for the ICB to address the wider determinants of health at scale.

2.2 The programme is focused on early intervention, recognising the strong relationship between employment, health outcomes and inequalities. It targets individuals who are economically inactive due to ill health, those at risk of leaving work, and individuals recently out of employment, providing timely and holistic support to address barriers before they become entrenched. In doing so, WorkWell directly contributes to improving healthy life expectancy and reducing inequalities across the system.

2.3 Across Staffordshire and Stoke-on-Trent and Shropshire, Telford and Wrekin, levels of economic inactivity driven by long-term sickness remain high, with significant variation linked to deprivation and access to services. WorkWell offers a structured and coordinated response to these challenges, aligning health, employment and social support to deliver better outcomes for local populations.

2.4 The model of delivery will be centred on a single, integrated pathway that brings together health and work-related support. Individuals will be able to access the service through multiple routes, including general practice, local authorities, Jobcentre Plus, employers and self-referral. Following an initial assessment, participants will receive a personalised plan supported by Work and Health Coaches, drawing on a wide range of services such as mental health support, musculoskeletal services, skills provision and financial advice. The programme acts as a gateway into existing provision, improving coordination and ensuring individuals receive the right support at the right time.

2.5 A critical enabler of WorkWell is meaningful community involvement and engagement. The programme is being designed and mobilised with input from local communities, VCSE partners and people with lived experience, ensuring that services are accessible, culturally appropriate and responsive to the needs of those who are often least likely to engage with traditional provision. This approach will be key to building trust, improving uptake, and achieving equitable outcomes across different population groups.

2.6 The success of WorkWell is fundamentally dependent on strong and effective partnership working across the system. Delivery requires collective action across the NHS, Local Authorities, the voluntary and community sector, employers, education providers and the DWP. No single organisation can address the complex interplay between health and employment outcomes in isolation. As such, the programme is being designed through a collaborative, place-based approach, with shared accountability for outcomes, aligned governance arrangements and integrated referral pathways. A formal Partnership Board will oversee delivery, supported by robust programme governance across the cluster.

2.7 WorkWell aligns closely with the ICS's fourth purpose, supporting social and economic development by helping more people to participate in and remain in work. It also reinforces existing system priorities, including the NHS 10-Year Plan, Get SSOT/Marches Working plans, Place and Neighbourhood health models, population health strategy and locality improvement frameworks. By focusing on prevention and early intervention, the programme is expected to reduce demand on health services over time while improving outcomes for individuals and communities.

2.8 Over the three-year period, the programme is expected to support more than 6,000 participants across the cluster. Implementation is progressing at pace, with delivery partners, service models and governance structures being co-designed with partners and communities ahead of a planned go-live of November 2026, when services are expected to be accessible across the full Clustered ICB footprint.

3 Widening Access Demonstrator – SSOT ICB only

3.1 The Widening Access Demonstrator (WAD) programme is an NHS England (NHSE) initiative, also aligned to the Government's *Get Britain Working* agenda. Staffordshire and Stoke-on-Trent (SSOT) ICB was invited by NHSE to apply for Phase 2 funding (12 months) based on levels of deprivation and need (IMD) within specific population cohorts – Central Stoke, Cannock Chase and Tamworth.

3.2 The programme is explicitly designed to address entrenched inequalities by targeting those furthest from the labour market, including care leavers, refugees and vulnerable migrants, people experiencing or at risk of homelessness, and residents of the most deprived communities. Within SSOT, one fifth of the population lives in the most deprived areas nationally, with high levels of economic inactivity and significant variation in life expectancy across localities. Employment is therefore recognised as a critical lever for improving health outcomes and reducing inequalities.

3.3 WAD takes a structured, end-to-end approach to supporting individuals into work. Our model will integrate targeted outreach and engagement, pre-employment preparation, work experience and placements, and supported progression into substantive roles. Participants will benefit from tailored programmes that develop employability, digital skills and health literacy, alongside practical support such as mentoring, workwear and travel assistance, with clear pathways into Band 2 and 3 roles across NHS and social care providers.

3.4 A defining feature of the WAD programme is its strong focus on community-based engagement and inclusion. Delivery builds on established outreach models working alongside community hubs, VCSE partners and Local Authority services to identify, engage and support individuals who may not traditionally access employment programmes or consider health and care careers. This ensures that the programme reaches those most in need and reduces barriers to accessing jobs.

3.5 To further strengthen this approach, the organisation has secured national support from NHSE to work with Co-Create, an external organisation specialising in engagement with marginalised communities. This support will enhance our ability to genuinely co-design approaches with underserved groups, improve access and participation, and ensure that delivery models are shaped by lived experience. This is a significant enabler in reaching priority cohorts and delivering equitable outcomes.

3.6 The programme builds on a strong foundation of existing system delivery in outreach and widening access, including previous "Step into Work" cohorts, 'summer schools' with asylum seekers and refugees, and a well-established virtual work experience hub supporting thousands of participants. The impact of these programmes can still be seen today through our work with local schools, colleges, Job Centre Plus and health and care organisations. The video and stories which will be shared with the Board in June will showcase this work and bring this expansion to life.

3.7 Previous successes and programme activity are enabling rapid mobilisation at scale, while retaining a strong focus on quality, inclusion and individualised support. Expected outcomes include over 100 pre-employment starts, progression into training and positive destinations, and at least 35 individuals moving into substantive employment roles.

3.8 Partnership working remains central to the success of the WAD programme. Delivery is underpinned by established relationships across NHS, Local Authorities, education providers, Jobcentre Plus and the VCSE sector. Close collaboration with DWP and Councils leading local employment and skills programmes ensures alignment of support, maximises available resources, and creates seamless pathways for participants.

3.9 The programme also aligns closely with wider system priorities and programmes, including population health, health inequalities, children and young people, WorkWell, Connect to Work, volunteering initiatives and other employment and skills provision. This creates a coherent pipeline of support from initial community engagement through to sustained employment, reducing duplication and maximising system impact.

3.10 WAD directly supports the ICS's fourth purpose by strengthening the role of the NHS as an anchor institution, creating employment opportunities and contributing to local economic development. In doing so, it advances system objectives to improve population health, reduce inequalities and support a sustainable health and care workforce.

3.11 The programme will be delivered through established governance arrangements, ensuring robust oversight, performance management and alignment to strategic priorities, with a strong emphasis on data, evaluation and continuous improvement.

4. Conclusion

4.1 In conclusion, WorkWell and the Widening Access Demonstrator programmes represent a significant opportunity for the ICS to deliver meaningful impact against its fourth purpose by addressing the root causes of poor health and inequality. Through strong partnership working, targeted community engagement and a focus on those most in need, these programmes will support more people into good work, improve health outcomes and contribute to a more inclusive and sustainable system. Continued focus on collaboration, co-design and delivery at pace will be critical to maximising their impact across the cluster.

4.2 The Board will be kept informed and engaged in the progress of both programmes at regular intervals.

Enclosure No: 12

Report to:	ICB Board
Date:	25/06/2026
Title:	Urgent Treatment Centre Designation
Presenting Officer:	Hayley Allison, Steve Fawcett
Author(s):	Tom Bailey, Hayley Allison

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

Is the decision within SOFD powers & limits	**Yes**	☒	**No**	☐
Any potential / actual Conflict of Interest?	**Yes**	☒	**No**	☐
If Y, the mitigation recommendations:	*Implications for provider colleagues. Mitigated by whole system assessment and NHSE review and scrutiny.*			
Any financial impacts: ICB or ICS?	**Yes**	☒	**No**	☐
If Y, are those signed off by and date:	*Cluster Executive Meeting 07/05/2026* *Commissioning Working Group 05/06/2026* *Strategic Commissioning & Transformation Committee 10/06/2026*			
Any impacts on ICB Undertakings?	**Yes**	☒	**No**	☐
If Y, are those signed off by and date:	*Strategic Commissioning Committee. June 2026.*			
Appendices:	Appendix 1: Report of Findings, Appendix 2: NHS England UTC standards			

(1) Purpose of the Paper:

The ICB Board is asked to ratify the decision to designate co-located Urgent Treatment Centres (UTCs) in Staffordshire and Stoke-on-Trent at Royal Stoke Hospital, County Hospital, Stafford and Queen's Hospital, Burton.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	**Date**
UTC System Technical Event – D	14/05/2025
UEC System Delivery Group – D	18/06/2025

ICB Executives – I/D	23/12/2025
Finance & Performance Committee - A	06/01/2026
UEC Board – D	22/01/2026
UEC Board – A	28/05/2026
Commissioning Working Group – A	05/06/2026
Strategic Commissioning & Transformation Committee - A	10/06/2026

(3) Implications:	
Legal / Regulatory	Designation of co-located UTCs is mandated within the NHSE Planning Guidance for 2025/26. Non-designation may be subject to challenge from patient groups/interested parties.
CQC / Patient Safety	All providers are CQC registered. All proposed UTCs must comply with national specification. All sites will be/have been subject to assurance visit and review of relevant clinical/patient safety standard operating procedures. The UEC Clinical Advisory Group (CAG) has been integral in proposed designation process.
Financial (CFO-assured)	Capital funding required for designation has been secured via national NHSE monies. There are no capital risks posed via designation as recommended, provided that capital funds are utilised in line with NHSE oversight and in a timely manner. Revenue costs have been subject to full scoping, development of business cases and approval. Provider Trusts have developed these proposals alongside the ICB. Revenue costings reviewed at Commissioning Working Group, Strategic Commissioning & Transformation Committee for approval.
Sustainability	Full assessment of sustainability and future funding included as part of business case and planning process.
Workforce / Training	Workforce risks are managed via System Workforce plan & escalated via Risk Register.
Equality & Diversity	All proposed sites for designation offer services presently and will be co-located with an emergency department (ED). Access to services in an equitable manner has formed a key pillar of the technical events, engagement activities and proposed designation in principle recommendations.
Due Regard: Inequalities	Geographic equity has been a key consideration to ensure equal access to services. Engagement has been undertaken to ensure representation and feedback from a wide cross section of the ICS population, this is captured within the Report of Findings (RoF) shared as an appendix to this paper.
Due Regard: wider effect	The designation of co-located UTCs will simplify the existing urgent and emergency care offer across SSOT and is designed to facilitate patients utilising the correct service at the correct time. The principles align to the

	SSOT UEC strategy and national NHSE planning guidance and have been tested extensively with a wide stakeholder group.

(1) Statutory Dependencies & Impact Assessments:					
	Completed?			If N - N/A, Rationale	If Y, Outcome / Date Reported & Signed off
DPIA	Yes ☐	No ☐	N/A ☒	Click or tap here to enter text.	*Reported to IG Committee:* Click or tap to enter a date.
EIA	Yes ☐	No ☐	N/A ☒	Click or tap here to enter text.	*Outcome and date of completion:* Click or tap here to enter text.
QIA	Yes ☒	No ☐	N/A ☐	*E.g. per QIA Policy, that it doesn't impact quality of services* Click or tap here to enter text.	*SRO sign-off, outcome & date of completion: QIA 6892 reviewed and approved at QIA panel 12/05/2026 QIA 7440 reviewed and approved at QIA panel 04/06/2026*
Has there been Public / Patient Involvement?		Yes ☒	No ☐	N/A ☐	*Extensive public & patient involvement as per the Report of Findings (included as an appendix)*

(2) Integration with SBAF (for NHS SSOT) / Strategic Risks (SR, for NHS STW)					
SBAF1	Responsive Patient Care - Elective	☐	SBAF5	High Quality, Safe Outcomes	☒
SBAF2	Responsive Patient Care - UEC	☒	SBAF6	Sustainable Finances	☒
SBAF3	Transforming Community Services	☒	SBAF7	Improving Productivity	☐
SBAF4	Reducing Health Inequalities	☒	SBAF8	Sustainable Workforce	☒

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

The ICB Board is asked to ratify the decision to designate co-located Urgent Treatment Centres (UTCs) in Staffordshire and Stoke-on-Trent at Royal Stoke Hospital, County Hospital, Stafford and Queen's Hospital, Burton.

Co-located UTCs have been designated and are operational in Shropshire and Telford and Wrekin (STW) at both Royal Shrewsbury and Princess Royal Hospitals.

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 recommendations are built upon engagement activities undertaken across the ICS area and neighbouring areas, including face to face drop-in sessions, engagement with local authority Health Overview and Scrutiny Committees (HOSCs), Members of Parliament, online and written surveys

and other associative activities. These engagement activities are captured and reported within the Summary Report of Findings; Improving urgent and emergency care in Staffordshire and Stoke-on-Trent (Appendix 1).

The designation of co-located UTCs is phase one of the wider ICB approach to urgent and emergency care (UEC). The subsequent phases of this approach will assess designation of 'standalone' UTCs (those sites that meet UTC criteria but are located at a separate site from an Emergency Department), the implementation of the ICB integrated neighbourhood model across SSOT and longer term aspects of transformation linked to Fit for the Future – the 10 Year Health Plan for England.

A summary of the work undertaken and the criteria that have been utilised to assess system proposals and recommendations for designation is included within this report and outlines key information and context relating to:

- National guidance and standards governing approval of and functionality of UTCs
- SSOT Development of UTC proposals
- Funding for co-located UTCs
- Future plans in SSOT
- Summary and Recommendations

The ICB will take forward transformation work in a phased approach across both SSOT and STW to ensure timely implementation and close alignment to national plans and priorities.

(4) Recommendations to Board:

The ICB Board is asked to ratify the decision to designate co-located Urgent Treatment Centres (UTCs) in Staffordshire and Stoke-on-Trent at Royal Stoke Hospital, County Hospital, Stafford and Queen's Hospital, Burton.

SSOT Urgent Treatment Centre Designation

1. National guidance and standards for Urgent Treatment Centres (UTCs)

NHS England introduced UTCs in 2017, "with the aim of standardising the range of urgent care services including walk in centres, minor injury units and urgent care centres".

In 2025/26 NHS Planning guidance, NHS England confirmed that all Type 1 Emergency Departments (EDs) should prioritise designation of a co-located UTC.

Co-located UTCs are intended to alleviate a degree of pressure placed upon EDs by effectively streaming patients to the setting that best meets their assessment and treatment needs. Patients receive timely care from the most appropriate service and patients with high acuity needs are prioritised within ED, reducing waits for those in the greatest need of urgent assessment and treatment.

As a priority UTCs are expected to:

- open 7 days a week, 12 hours a day as a minimum
- see both booked and walk-in patients
- see both minor injuries and minor illnesses
- see patients of all ages, including children under 2
- have a basic consistent investigative and diagnostic offering on site (with clear pathways if these are not available in the UTC)
- accept appropriate ambulance arrivals
- have access to patient records
- clearly communicate what the service is for via consistent urgent treatment centre signage, to ensure everyone understands the service

The full NHS England guidance and outline of UTC standards is available here.

For the proposed co-located UTCs at Royal Stoke University Hospital (RSUH) and Queen's Hospital, Burton (QHB) all standards will be met and assurance visits to confirm NHSE approval have been undertaken.

For County Hospital, Stafford, adherence to these standards is not possible due to the operating model for the site, the County Hospital ED is not 24-hours and does not provide paediatric care for minor illnesses (due to lack of provision of paediatric intensive care and other services).

Exemption has been sought from NHS England to enable designation of a UTC at County Hospital, and a full communications plan has been co-developed by UHNM and the ICB to ensure awareness of the conditions that can be treated at the County UTC (if/when designated) and the correct course of action for the public to take in the event of a child needing treatment for conditions that County Hospital is not equipped to provide for.

2. SSOT Development of UTC proposals

Consideration of UTCs across SSOT has been subject to engagement and extensive development work with local partners, stakeholders and patient and public representatives over a number of years.

The NHS 10 Year plan outlines the “3 big shifts” to how the NHS works:

- from hospital to community
- from analogue to digital
- from sickness to prevention

The ICB will take forward these three shifts with the aim of bringing care closer to home, facilitating improvements in access linked to digital innovation and prioritising prevention activities and opportunities, shifting the focus away from treating illness and seeking to address the root causes at the earliest opportunity.

Longer term transformation will be taken forward by the ICB to achieve these aims and deliver for the residents of Staffordshire and Stoke-on-Trent.

During the financial year 2023/24, three system technical events were held to consider revised national principles and standards issued by NHSE. It was agreed in principle at these events to proceed with designation of co-located UTCs at RSUH, QHB and County Hospital – subject to outline business cases being developed and approved – alongside agreement in principle for designation of several of the existing Minor Injury Units (MIUs) and Walk-In Centres (WICs) across the SSOT area as “standalone” UTCs.

NHS England undertook a series of designation assurance visits to prospective sites and approval was received for designation in principle of all proposed sites.

Public involvement activities were then undertaken to provide engagement with the public. These events and the accompanying activities are summarised within the Report of Findings (Appendix 1).

With the release of NHS England Planning Guidance for 2025/26, the system prioritised designation of co-located UTCs as outlined within the documentation for phase one of the ICB UEC strategic approach.

3. Funding for co-located UTCs

Capital funding for the proposed co-located UTCs at RSUH, County Hospital and QHB has been secured via NHS England.

The QHB site is functional and is awaiting formal designation. There are no additional revenue costs associated with delivery/designation of a UTC at the QHB site.

The RSUH UTC is nearing completion and is anticipated to be ready to open from July 2026. Revenue costs have been agreed within the system for 2026/27, with confirmation of revenue

funding received via agreement with System Chief Financial Officers and formally approved at Finance and Performance Committee in October 2025.

Revenue costings for County Hospital UTC have been reviewed at Commissioning Working Group, Strategic Commissioning & Transformation Committee for approval.

4. Future plans in SSOT and STW.

The subsequent phases of the ICB approach to the transformation of services are set out below and are underpinned by national guidance and plans. These plans will be assessed and taken forward across both SSOT and STW.

Phase 2: Designation of Standalone UTCs (2026/27) and development of our Integrated Neighbourhood Health Model

Phase 2 of the transformation programme will assess designation for prospective standalone UTCs, alongside the ICB implementation of the integrated neighbourhood health model.

Alongside the future assessment of designation for standalone UTCs, the ICB is taking forward associated work to support urgent and emergency care across Staffordshire and Stoke-on-Trent and Shropshire and Telford and Wrekin. The development of the ICB integrated Neighbourhood Health plan, aligned to the national Neighbourhood Health Framework and inclusive of Neighbourhood Health Centres, will facilitate improved access to services closer to patients' homes and delivery of integrated services.

The Neighbourhood Health plan will focus on prevention and proactive care management and will strengthen health and care services delivered in the community, to enable residents to access treatment and care closer to home. The plan will deliver improvements in continuity of care and better coordinated services for those with complex needs.

Concurrently, the improvements to care delivered in the community will reduce pressure on acute services (such as hospitals and care homes) by decreasing avoidable conveyances and admissions to hospital and facilitating more timely discharge to services or care closer to home. Acute services will be prioritised for those with the greatest and most urgent needs. Reducing pressure on these services will help those in the greatest need to access care faster and without undue delay.

The Neighbourhood Health plans across both SSOT and STW is being developed as a system priority. Further updates will be delivered to ICB Board and to the wider community imminently but will be taken forward in close alignment to wider assessment of UEC services and the designation of standalone UTCs.

Standalone UTCs at existing MIU and WIC sites across both SSOT and STW will be considered for approval in due course. Prospective sites will be assessed alongside proposals for service provision in other areas of SSOT and STW to ensure optimum utilisation of system estates and adherence to national UTC standards and principles. Standalone sites will be

prioritised based upon “hurdle criteria” as set out by NHS England and considered alongside emerging Neighbourhood Health proposals.

Any future designation proposals will be based upon engagement and involvement activities and subject to full governance oversight, scrutiny and approval.

5. Summary and recommendations

The ICB Board is asked to ratify the decision to designate co-located Urgent Treatment Centres (UTCs) in Staffordshire and Stoke-on-Trent at Royal Stoke Hospital, County Hospital, Stafford and Queen’s Hospital, Burton.

The proposals are based upon extensive engagement and involvement with the population of Staffordshire and Stoke-on-Trent, adhere closely to NHS England national planning and operational guidance and standards and are in line with consideration of system funding.

The proposals provide a significant step forward in achieving the system strategic aim of simplifying understanding and access to Urgent and Emergency Care and will help to deliver improved ED performance via more effective streaming and treatment of patients in the most appropriate setting and by the most appropriate service, reducing waits for high acuity services in ED.

6. Appendices

Appendix 1

Summary Report of Findings; Improving urgent and emergency care in Staffordshire and Stoke-on-Trent

Appendix 2

NHS England Urgent treatment centres – principles and standards – available via weblink: UTC standards

Enclosure No: 13

Report to:	Joint Boards in Common
Date:	25th June 2026
Title:	25-26 Operational Planning Outturn Position & reporting for 26/27
Presenting Officer:	Claire Skidmore, Chief Finance Officer
Author(s):	Angela Parkes, Associate Director of Planning, Performance Oversight and Assurance

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

Is the decision within SOFD powers & limits	**Yes**	☒	**No**	☐
Any potential / actual Conflict of Interest?	**Yes**	☐	**No**	☒
Any financial impacts: ICB or ICS?	**Yes**	☐	**No**	☒
Any impacts on ICB Undertakings?	**Yes**	☐	**No**	☒

Appendices:	A: NHSSTW Outturn Performance Tables, B: NHS SSOT M12 Performance Report, C: Performance Framework summary

(1) Purpose of the Paper:

To provide an overview of the 25/26 Operational Planning outturn position for NHSSTW and NHSSSOT and to provide assurance of progress made over the last 12 months. In addition the paper outlines the proposed future performance reporting and draft cluster performance framework for 26/27 which was reviewed and approved by the Joint Quality & Performance Committee in May.

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	**Date**
Joint Q&P Committee (performance section only)	27/05/26
First Review today (planning actions section only)	n/a

(3) Implications:

Legal / Regulatory	No identified legal/regulatory implications associated with the final reported outturn
CQC / Patient Safety	Performance against some IPC measures indicates that the plans have been exceeded. NHSE regional task and finish group looking at Fundamentals in IPC and patient placement to reduce infection.
Financial (CFO-assured)	No identified financial implications associated with the final reported outturn
Sustainability	*n/a*
Workforce / Training	No identified workforce implications associated with the final reported outturn
Equality & Diversity	*n/a*
Due Regard: Inequalities	No identified impact on inequalities associated with the final reported outturn
Due Regard: wider effect	No identified wider impact associated with the final reported outturn

(4) Statutory Dependencies & Impact Assessments:

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

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

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

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

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

This report brings together the final March 26 position for the performance metrics reported in year to each ICB and provides a summary of progress with actions from the 25/26 Operational Plan.

It represents the closedown of the 25/26 performance reporting and planning cycles.

A full Integrated Performance report will be available for the next Board meeting.

Operational Plan Actions Summary

The two ICBs have each monitored in-year delivery plans detailing the actions to achieve the 25/26 Operational Plan. This report summarises the year end position for the delivery of the actions within these plans. This information was reviewed by the Quality and Performance Committee at its meeting on 27th May 2026

Note that each ICB had a different approach to this monitoring, with SSOT including actions beyond 25/26 and STW focussing on actions expected to be delivered in year. This results in some differences in this year-end reporting. The team are working to harmonise reporting for 2026/27 onwards.

The table below shows the year end position by ICB.

	Total	Complete	Outstanding actions	26/27 Delivery and beyond	No longer required
SSOT	354	179	20	149	6
STW	389	339	50	n/a	n/a

If the longer-term actions are excluded from the analysis, both STW and SSOT completed 89% of the in-year actions.

All outstanding actions have been reviewed to ensure nothing is lost in the transition to a new operational planning year. A small number of actions have been closed as they are no longer required or have been replaced with more up to date actions for 26/27. The majority of outstanding actions have been carried forward and either transferred to business as usual or already form part of the 26/27 commissioning intentions.

No further action is required in relation to these delivery plans as agreed at QPC.

NHSSTW Metrics Summary

- **UEC:** Average ambulance handover time at 46mins was better than the local plan of 55 minutes but just missed the national target of 45 minutes. The percentage of patients discharged on their discharge ready date exceeded the plan at 90.8%. Work is still required

to improve the 4-hour A&E performance which has shown no material improvement (61.4% Mar 25 vs 61.5% Mar 26)

- **Elective care:** RTT waiting list has shown significant improvement decreasing by over 13,000 in 12 months. The 18-week target has improved from 51.1% in Mar 25 to 68.9% in Mar 26. Time to first appointment also exceeded the target. Work is still required to improve long waiters over 52 weeks.
- **Community waits:** Significant improvements in community long waits with adults over 52 weeks reducing from 46 to 2 and children reducing from 188 to 2.
- **Diagnostics:** Significant improvements in 6 week waits with 74.4% achieved in Mar 25 and 86.3% in Mar 26
- **Cancer:** ICB met all cancer standards with significant improvements across all metrics. 31-day standard compliance improved from 91.9% to 96.2%. 62-day standard improved from 53.2% to 76.2%. The number of people waiting more than 62 days for treatment at SaTH improved from 378 in Mar 25 to 142 in March 26. 28-day standard improved from 65.8% to 85.8%.
- **Primary care:** Percentage of GP appointments within 2 weeks improved from 83.7% in Mar 25 to 87.8% in Mar 26.
- **MHLDA:** Talking therapies met all targets. Significant improvements in people with eating disorders being seen within 4 weeks from 70% in Mar 25 to 97% in Mar 26. Note though that SMI physical health checks were below target and saw no improvement when compared with Mar 25. Work is also required to improve the number of out of area placements and LDA adult inpatients in MH settings.
- **Children and Young People (CYP) MH:** CYP access improved with 7,615 children accessing services compared to 6,470 in Mar 25.
- **Infection prevention and control:** The figures reported are for March only and with the exception of MRSA, all metrics were above plan this month. An NHSE regional task and finish group is looking at Fundamentals in IPC and patient placement to reduce infection.

The full performance tables can be found in Appendix A

NHSSSOT Metrics Summary

- **UEC:** A&E 4-hour performance at UHNM was below plan for most of the year while ambulance handover delays have been worse that plan since August 2025. Both non-elective average Length of Stay and ambulance average delay fluctuated throughout the year. General and acute bed occupancy over performed against plan in the first half of the year but deteriorated to a ‘red’ position in the second half. Virtual wards were underutilised throughout the year except November 2025.
- **Elective care:** The number of consultant led follow ups in 25/26 was lower than 24/25 but missed the plan by 3.5%. The number of long waiters continues to reduce but the 52 week waits missed the plan by 0.7% and 96 patients were still over 65 weeks.
- **Diagnostics:** 6 week waits achieved 79.8% which was significantly below the ambitious target of 94.2%.
- **Cancer:** Cancer standards improved compared with 24/25 but 62 day and 28 day fell short of the planned targets.
- **Community waits:** Only 2 patients remain waiting over 52 weeks for a community service

- **Primary care and medicines optimisation:** Urgent dental activity was below plan throughout the year due to low demand. Medicine optimisation is reported on a YTD cumulative basis and the absence of a Q4 update has contributed to its red rating.
- **MHLDA:** Talking therapies improvement metric performed well throughout the year however, the number patients discharged after treatment remained well below plan. The talking therapies recovery rates fell short of the 50% target. There are 30 out of area placements at year end, exceeding the plan of 24 patients. Reliance on inpatient care for adults with LDA was offtrack for most of the year.
- **CYP, Maternity and Neonates:** Epilepsy emergency admissions improved but still remained above plan. Brain injury rate deteriorated and moved into a 'red' position while the stillbirth rate worsened significantly. The full-term babies metric improved but remained above plan in the final quarter.
- **Community transformation:** Palliative and end of life care was marginally off track by 0.1%. Emergency admissions 65+ were largely managed effectively this year, but we were less successful in reducing care home and falls-related admissions.
- **Improving population health:** Flu vaccinations in February are slightly off track.

The full performance report can be seen in Appendix B

Future Cluster Performance Reporting

The new National Oversight Framework was released on the 11th June 2026. The Cluster BI team have mapped the full suite of ICB responsible metrics within this document to existing metrics and data flows and are now working through the new data definitions to identify and address any data flow issues with the respective providers/data sources.
A significant amount of work has been undertaken in the past 2 months to finalise a Single Cluster Data Dashboard consolidating STW and SSOT data (ICB and Provider level) and is now accessible within both ICBs. The first draft reporting against the new framework will commence in July. This will retain an individual ICB lens, for the time being, but will be in a single consistent format based on Making Data Count Methodology and national Board reporting best practice.
The Board can be assured that any additional metrics that subcommittees and/or working groups have identified that they require monitoring, to ensure full coverage of both our statutory duties and assuring quality of care for our population, will also be reported to the appropriate meeting and are all included within the Single Cluster Data Dashboard.

A Performance Framework is being developed to harmonise reporting across the cluster and governance strengthened to increase the assurance activities that will take place before metrics are reported to board. This reflects the key change that individual provider performance will be reported via the respective Contract Review Meetings which will then be reported by exception to the new System Performance Group. In addition this group will review the consolidated position for the performance as a whole for the ICB responsible populations for key metrics e.g. Cancer, RTT etc.

An overview of the Performance Framework can be seen in Appendix C. This was reviewed and approved at the Joint QPC in May and is also being shared with key providers.

(7) Recommendations to Board:

That the board:

- **Notes** the summary of the 25/26 Operational Plan delivery and acknowledges the assurance that all outstanding actions have been reviewed and that they are being effectively managed
- **Notes** the new Performance Framework and governance and that reporting to the next Board will be made under that framework.

NHSSTW 25/26 Outturn Performance Summary

01 May 2026

Summary

Summary:

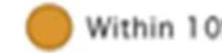
Although many of the metrics are rated red due to being more than 10% away from the target/plan the ICB has seen significant improvement across the metrics when compared to March 2025. Key areas of improvement include:

- **UEC:** Average handover time met the local plan. Patients discharged on their discharge ready date exceeded plan.
- **Elective care:** RTT waiting list decreased by over 13,000. 18 week target improved from 51.1% to 68.9% Time to first appointment
- **Community waits:** Adults over 52 weeks reduced from 46 to 2 and children from 188 to 2
- **Diagnostics:** Significant improvement in 6 week waits from 74.4% to 86.3%
- **Cancer:** ICB met all cancer standards with significant improvements across all metrics
- **Primary Care:** Percentage of GP appointments within 2 weeks improved from 83.7% to 87.8%
- **MHLDA:** Talking therapies met all targets. Significant improvements in eating disorders seen within 4 weeks from 70% to 97%. CYPMH access improved from 6,470 to 7,615

Key areas for focus in 26/27:

- **UEC:** 4 hour performance. 12 hour performance
- **Elective care**: Long waiters over 52 weeks
- **MHLDA:** SMI physical health checks. Inappropriate out of area placements and LDA adult inpatients in MH settings.

Key for ratings on the performance tables on the subsequent slides



Performance tables

Workstream	Metric Name	Metric Type	Actual	Plan	Variance Plan	Target	Variance Target	Latest Month	Target Type	Var. Plan YTD
UEC	Cat 2 Response Mean time	WMAS	00:25	00:23	8.7%	00:30	-16.7%	March 2026	National	
	Average handover time	WMAS	00:46	00:55	-16.4%	00:45	2.2%	March 2026	National	
	% of Ambulance Handovers within - 45 mins	WMAS	72.3%			100.0%	-27.7%	March 2026	National	
	A&E 4 hour performance achievement (Type 1&3)	SaTH	52.8%	60.0%	-7.2%	76.0%	-23.2%	March 2026	Local	
		STW	61.5%	67.7%	-6.2%	76.0%	-14.5%	March 2026		
	A&E 4 hour performance achievement (Type 1)	SaTH	45.1%	51.6%	-6.5%	76.0%	-30.9%	March 2026	National	
	% Type1 attends, 12hrs+ in ED	SaTH	18.8%	17.0%	1.8%	10.0%	8.8%	March 2026		
	Total A&E attendances against plan	SaTH	14,083	13,617	3.4%			March 2026		3.9%
	Proportion of PW split by discharge P1	SaTH	52.8%	75.0%	-22.2%			March 2026		
	Proportion of PW split by discharge P2	SaTH	29.1%	23.0%	6.1%			March 2026		
	Proportion of PW split by discharge P3	SaTH	18.1%	2.0%	16.1%			March 2026		
	% Patients discharged on Discharge Ready date	SaTH	90.8%	84.5%	6.3%			March 2026		
		RJAH	97.0%	96.6%	0.3%			March 2026		
	Average discharge delay (exc. 0 LOS)	SaTH	4.4	3.6	19.8%			March 2026		
		RJAH	11.3	10.7	5.4%			March 2026		
Planned Care	Referral to Treatment - Total Waiting list	RJAH	14,081	13,030	8.1%			March 2026		6.3%
		STW	64,420	74,675	-13.7%			March 2026		-13.7%
	Incomplete RTT pathways of 65+ weeks	SaTH	0	0		0		March 2026	National	-71.7%
		SCHT	0					March 2026		
		RJAH	31	0		0		March 2026	National	2007.5%
		STW	24	0		0		March 2026	National	467.6%
	Incomplete RTT pathways of 52+ weeks	SaTH	0	376	-100.0%			March 2026		-64.9%
		SCHT	0					March 2026		
		RJAH	254	130	95.4%			March 2026		24.5%
		STW	326	506	-35.6%	0		March 2026	National	-29.9%
	Incomplete RTT pathways of 52+ weeks where patient age is <=18	SaTH	0	42	-100.0%			March 2026		-72.3%
		SCHT	0					March 2026		
		RJAH	11	6	83.3%			March 2026		8.8%
		STW	24	44	-45.5%	0		March 2026	-	-40.8%
	Incomplete RTT <18 weeks at month end	SaTH	68.9%	60.0%	8.9%			March 2026		
		RJAH	62.1%	60.0%	2.1%			March 2026		

Performance tables

Workstream	Metric Name	Metric Type	Actual	Plan	Variance Plan	Target	Variance Target	Latest Month	Target Type	Var. Plan YTD
Planned Care	Incomplete RTT <18 weeks at month end	STW	69.5%	60.0%	9.5%	60.0%	9.5%	March 2026	National	
	RTT waitlist, ages 18 and under	SaTH	2,897	2,776	4.4%			March 2026		6.2%
		SCHT	472	297.6	58.6%			March 2026		16.2%
		RJAH	621	189	228.6%			March 2026		231.8%
		STW	4,693	4,229	11.0%			March 2026		9.8%
	Incomplete RTT <18 weeks at month end, ages 18 and under	SaTH	1,972	2,238	-11.9%			March 2026		-22.8%
		SCHT	321	67	379.1%			March 2026		251.6%
		RJAH	447	153	192.2%			March 2026		143.4%
		STW	3,156	3,149	0.2%			March 2026		-12.4%
	Time to first appointment <18 weeks	SaTH	78.8%	67.0%	11.8%	67.0%	11.8%	March 2026		
		RJAH	74.4%	67.4%	7.0%	67.0%	7.4%	March 2026		
		STW	77.0%	67.1%	9.9%	67.0%	10.0%	March 2026	National	
	Incomplete RTT pathways of 52+ weeks as a proportion of all incompletes	STW								
	Outpatients - PIFU%	SaTH							Local	
		RJAH	9.5%	6.4%	3.1%	5.0%	4.5%	March 2026	Local	
		STW							Local	
Planned Care	Outpatients - Virtual % of Total OPA	SaTH	14.4%	16.6%	-2.2%	25.0%	-10.6%	March 2026	Local	
		RJAH	11.2%	11.3%	-0.1%	25.0%	-13.8%	March 2026	Local	
		STW	13.4%	15.3%	-1.9%	25.0%	-11.6%	March 2026	Local	
	Outpatients - A&G requests % of Total OPA	STW	22.1%					March 2026		
Community	% Urgent Community Response patients seen within 2hrs	SCHT	88.5%			70.0%	18.5%	March 2026	National	
		STW	88.7%			70.0%	18.7%	March 2026	National	
	Community Waits of 52 or more weeks for CYP services	SCHT	2	2	0.0%	0		March 2026	National	79.0%
	Community Waits of 52 or more weeks for adult services	SCHT	2	0		0		March 2026	National	1.7%
	Community Waits for CYP services, total	SCHT	2,966					March 2026		
	Community Waits for adult services, total	SCHT	5,768					March 2026		
	Attended community care contacts	STW	54,435	60,079	-9.4%			March 2026		-10.5%
Diagnostics	All Diagnostics - <6ww against target	SaTH	86.2%	99.1%	-12.9%	95.0%	-8.8%	March 2026		
		SCHT	99.7%					March 2026		
		RJAH	96.7%	100.0%	-3.3%	95.0%	1.7%	March 2026		
		STW	86.3%	99.2%	-12.9%	95.0%	-8.7%	March 2026	National	

Performance tables

Workstream	Metric Name	Metric Type	Actual	Plan	Variance Plan	Target	Variance Target	Latest Month	Target Type	Var. Plan YTD
Diagnostics	All Diagnostics - <13ww against target	SaTH	99.0%	100.0%	-1.0%	100.0%	-1.0%	March 2026		
		SCHT	100.0%					March 2026		
		RJAH	99.7%	100.0%	-0.3%	100.0%	-0.3%	March 2026		
		STW	98.5%	100.0%	-1.5%	100.0%	-1.5%	March 2026	-	
	Diagnostic waits of 13+ weeks	SaTH	152					March 2026		
		SCHT	0					March 2026		
		RJAH	3					March 2026		
		STW	265	0		0		March 2026	National	3417.1%
Cancer	28 Day Faster Diagnosis Standard	SaTH	86.0%	80.0%	5.9%	80.0%	6.0%	March 2026		
		RJAH	80.8%	89.2%	-8.4%	80.0%	0.8%	March 2026		
		STW	85.8%	80.1%	5.7%	80.0%	5.8%	March 2026	National	
	Waits >62 days for treatment	SaTH	142	112.1	26.7%			March 2026		78.9%
	FIT - % of suspected Lower GI cancers with FIT	STW	87.0%	88.0%	-1.0%	80.0%	7.0%	March 2026	Local	
	Referral to treatment < 62 days %	SaTH	74.5%	70.1%	4.4%	85.0%	-10.5%	March 2026	National	
		RJAH	100.0%	100.0%	0.0%	85.0%	15.0%	March 2026	National	
		STW	76.2%	70.3%	5.9%	85.0%	-8.8%	March 2026	National	
Cancer	Diagnosis to First Treatment< 31 days	SaTH	97.6%	96.1%	1.5%	96.0%	1.6%	March 2026	National	
		RJAH	100.0%	100.0%	0.0%	96.0%	4.0%	March 2026	National	
		STW	96.2%	96.1%	0.2%	96.0%	0.2%	March 2026	National	
	104 day breaches of 62 day pathway	SaTH	29.5	29	1.7%	0		March 2026	Local	-40.2%
		RJAH	0			0		March 2026	Local	
Primary Care	Total Primary care appointments	STW	281,843	272,619	3.4%			March 2026		-1.2%
	Total Face to Face appointments	STW	175,325					March 2026		
	% of GP appointments attended within 2 weeks (ACC-08)	STW	87.8%	85.0%	2.8%	85.0%	2.8%	March 2026	National	
	% of GP appointments attended same or next day	STW	53.9%					March 2026		
	ARRS - WTE	STW	439.5					March 2026		
	GPs in Post (FTE)	STW	236.0					March 2026		
	Direct Patient Care in Post (FTE)	STW	165.8					March 2026		
	Pharmacy First consultations (CP,BP,OC)	STW	4,943	4,150	19.1%			March 2026		24.0%
Mental Health	Talking Therapies reliable recovery after 2+ contacts	STW	52.0%	50.0%	2.0%	48.0%	4.0%	March 2026	National	
	Talking Therapies patients reliably improved after 2+ contacts	STW	73.0%	68.1%	4.9%	67.0%	6.0%	March 2026	National	
	Talking Therapies First seen <18 weeks	STW	93.0%			95.0%	-2.0%	March 2026		

Performance tables

Workstream	Metric Name	Metric Type	Actual	Plan	Variance Plan	Target	Variance Target	Latest Month	Target Type	Var. Plan YTD
Mental Health	OAP – Active inappropriate out of area adult placements	STW	5	3	66.7%	0		March 2026	National	
	Patients accessing perinatal mental health	STW	985	540	82.4%	501	96.6%	March 2026	Local	41.5%
	Referrals aged u18 from A&E to liaison psychiatry <1 hour	STW	50.0%					March 2026		
	CYP Eating Disorders (Routine) seen within 4 weeks	STW	97.0%			95.0%	2.0%	March 2026		
	CYP – persons U18 supported with at least 1 contact	MPFT	7,615					March 2026		
		STW	7,615	8,341	-8.7%	8,341	-8.7%	March 2026	Local	-13.9%
	Proportion of Adult SMI having Physical Health Checks (provisional)	STW	58.5%	67.0%	-8.5%	60.0%	-1.5%	March 2026	Local	
	Data Quality Maturity Index	MPFT							National	
	Data Quality SNOMED CT	MPFT							National	
		STW							National	
	Number of people accessing IPS (rolling 12 months)	STW	570	441	29.3%			March 2026		34.9%
	Average length of stay in acute MH bed (rolling 3 months)	STW	58	58.1	-0.2%			March 2026		
LDA	% Annual Health checks per LD register aged 14 or over	STW	80.6%	76.8%	3.8%	75.0%	5.6%	March 2026	Local	
	CYP – ASD Total waits (5-17)	STW	0					March 2026		
	CYP – ADHD Total waits (5-17)	STW	76					March 2026		
	Adult – ASD Total waits	STW	2,272					March 2026		
	Adult – ADHD Total waits	STW	2,663					March 2026		
LDA	CYP – Total Neurodevelopmental waits	STW	4,394					March 2026		
	Autistic adults currently inpatient in MH setting	STW	18	9	100.0%	18	0.0%	March 2026		29.2%
	LD adults currently inpatient in MH setting	STW	6	7	-14.3%	14	-57.1%	March 2026		12.2%
	LDA children currently inpatient in MH setting	STW	1	1	0.0%	2	-50.0%	March 2026		72.2%
Continuing Healthcare	Decisions within 28 days (quarterly)	STW	86.0%			80.0%	6.0%	March 2026		
	Referrals waiting 12+ weeks for assessment (quarterly)	STW	0			0		March 2026	National	
	Appeals outstanding at month end	STW	97			0		March 2026		
Quality	Number of cases – C-difficile	SaTH	24					March 2026		
		RJAH	0					March 2026		
		STW	25			12	108.3%	March 2026	Local	
	Number of cases – E-coli	SaTH	35					March 2026		
		RJAH	1					March 2026		
		STW	40			36	11.1%	March 2026	Local	
	Number of cases – Pseudomonas aeruginosa	STW	4			2	100.0%	March 2026	Local	
	Number of cases – Klebsiella	STW	14			7	100.0%	March 2026	Local	

Performance tables

Workstream	Metric Name	Metric Type	Actual	Plan	Variance Plan	Target	Variance Target	Latest Month	Target Type	Var. Plan YTD
Quality	Number of cases - MRSA	RJAH	0					March 2026		
		STW	0			0		March 2026	Local	
	Number of cases - MSSA	STW	12					March 2026		
	Mixed Sex Accommodation	SaTH	59			0		March 2026		
		SCHT	0					March 2026		
		RJAH	0					March 2026		
	FFT: Inpatient % Responded	SaTH	1.9%					March 2026		
		RJAH	100.0%					March 2026		
	FFT: Inpatient % Positive	SaTH	94.3%					March 2026		
		RJAH	100.0%					March 2026		
	FFT: Community % Responded	SCHT	0.8%					March 2026		
	FFT: Community % Positive	SCHT	95.7%					March 2026		
	FFT: Maternity Antenatal Care % Positive	SaTH	40.0%					March 2026		
	FFT: Maternity Birth % Responded	SaTH	0.3%					March 2026		
	FFT: Maternity Birth % Positive	SaTH	*					March 2026		
	FFT: Maternity Postnatal Ward % Positive	SaTH	*					March 2026		
Quality	FFT: Maternity Postnatal Community % Positive	SaTH	*					March 2026		
	FFT: AE % Responded	SaTH	6.6%					March 2026		
	FFT: AE % Positive	SaTH	71.5%					March 2026		
	FFT: MH % Responded	MPFT	0.8%					March 2026		
	FFT: MH % Positive	MPFT	89.5%					March 2026		
	Total Number of LFPSE Reported	STW	3,593					March 2026		
	Total Number of No Physical Harm Reported	STW	1,841					March 2026		
	Total Number of Low Physical Harm Reported	STW	964					March 2026		
	Total Number of Moderate Physical Harm Reported	STW	154					March 2026		
	Total Number of Severe Physical Harm Reported	STW	8					March 2026		
	Total Number of Fatal Physical Harm Reported	STW	20					March 2026		
	Total Number of Not Specified Physical Harm Reported	STW	606					March 2026		
	Total Number of No Psychological Harm Reported	STW	2,137					March 2026		
	Total Number of Low Psychological Harm Reported	STW	723					March 2026		
	Total Number of Moderate Psychological Harm Reported	STW	102					March 2026		

System Performance Report 2025 / 2026

Month 12 (March 2026)

Prepared by the Integrated Care Board (ICB) Intelligence Team, with drivers of underperformance and actions set out and signed off in the relevant Portfolios.

Executive Summary

- This report details how we are performing against the 2025/2026 national priorities and local delivery plan measures, as defined by the portfolio leads.

Current areas of underperformance at Month 12, March 2026:

Of the 79 metrics captured in this report, 33 are underperforming in the final month of 2025/2026 (unless specified):

- Planned Care 8 of the 19 metrics were offtrack: The number of consultant-led follow-ups in 2025/2026 was lower than 2024/2025 but missed the plan by 3.5%. Total diagnostic activity was 16.9% below plan in 2025/2026, and with only 79.8% of patients within the 6-weeks standard in March 2026, 14.4% below the ambitious target of 94.2%. For RTT, the number of long waiters continues to reduce, however, 52 week waits missed the plan by 0.7%, and 96 patients were still waiting over 65 weeks at year end. Cancer standards improved compared with 2024/2025; however, both the 62-day and 28-days fell short of planned targets. In addition, 2 patients remain waiting over 52 weeks for a community service.
- Urgent and Emergency Care (UEC) 6 of the 14 metrics were off track. A&E 4-hour performance at UHNM was below plan for most of the year, while Ambulance handover delays (15 mins) have been worse than planned since August 2025. Both non-elective average Length of Stay (LOS) and ambulance average delay fluctuated throughout the year, frequently moving between red and green ratings. General and acute bed occupancy overperformed against plan in the first half of the year but deteriorated to a sustained 'red' position in the second half. Virtual Wards were underutilised throughout the year, except November 2025.
- Primary Care & Medicines Optimisation 2 of the 7 metrics are underperforming: Urgent dental activity delivered has been below plan throughout the year due to low demand. Medicine Optimisation is reported on a YTD cumulative basis, and the absence of a Q4 update has contributed to its red rating.
- Mental Health (MH) and Learning Disabilities & Autism (LDA) 9 of the17 metrics were offtrack: At the end of 2025/2026, there were 30 Out of area placements, exceeding the plan of 4 (by 24 patients). Talking Therapies performed well (for the improvement metric) throughout the year, however the number of patients discharged after treatment remained well below plan. Recovery rates also fell short of the 50% target. Reliance on MH inpatient care for adults with a learning disability or autistic was offtrack for most of the year, while CYP autism assessment waiting times remained persistently under pressure. As of March 2026, the latest position available, both average length of stay for adult acute beds and IPS access remained in a red position.
- Children and Young People, Maternity and Neonates 4 of the 7 metrics were underperforming: Epilepsy emergency admissions improved to 12, down from 14 the previous month, however this metric remined over plan by 4 in March 2026. The brain injury rate deteriorated and moved into a red position in March 2026, while the stillbirth rate worsened significantly. The full-term babies metric improved but remained above plan in the final quarter.
- Community Transformation 4 of the 9 metrics were offtrack: Palliative and end of life care was marginally offtrack by 0.1%, likely reflecting a natural celling. Emergency admissions all 65+ were largely managed effectively this year, but less successful in reducing care home and falls-related admissions.
- Improving Population Health 1 of the 6 metrics was offtrack: Flu Vaccinations in February 2026 was slightly offtrack as most months reported this year.

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	Mar-26	2,129	▲	n/a		-	1,952	177	
	Elective - day case spells	Number	ICB	Mar-26	16,812	▲	n/a		-	16,625	187	
	First outpatient attendances - Consultant-led	Number	ICB	Mar-26	47,491	▲	n/a		-	43,364	4,127	
	Follow-up outpatient attendances - Consultant-led	Number	ICB	Mar-26	74,370	▲	n/a		-	66,932	7,438	
Referral to Treatment (RTT)	Time to first attendance, waiting less than 18 weeks	%	ICB	Mar-26	73.5%	▲	71.8%	March 2026	1.7%	71.8%	1.7%	
	Total waiting list (Referral to Treatment - Incomplete Pathways)	Number	ICB	Mar-26	137,294	▼	147,032	March 2026	-9,738	147,032	-9,738	
	% Patients waiting less than 18 weeks (Referral to Treatment - Incomplete Pathways)	%	ICB	Mar-26	66.0%	▲	63.4%	March 2026	2.6%	63.4%	2.6%	
	% Patients waiting more than 52 weeks (Referral to Treatment - Incomplete Pathways)	%	ICB	Mar-26	1.5%	▼	0.8%	March 2026	1%	0.8%	0.7%	
	Number patients waiting more than 65 weeks (Referral to Treatment - Incomplete Pathways)	Number	ICB	Mar-26	96	▼			96	0	96	
Diagnostics Tests	Diagnostic test activity	Number	ICB	Mar-26	51,618	▲	n/a		-	66,256	-14,638	
	Diagnostic Test Waiting List less than 6 weeks	%	ICB	Mar-26	79.8%	▼	n/a		-	94.2%	-14.4%	
Cancer	People treated beginning first or subsequent treatment of cancer within 31 days	%	ICB	Mar-26	94.8%	▲	94.0%	March 2026	0.8%	94.0%	0.8%	
	Total patients seen within 62 days (on cancer 62 day pathway)	%	ICB	Mar-26	69.8%	▲	75.2%	March 2026	-5.4%	75.2%	-5.4%	
	Cancer 28 day waits (faster diagnosis standard)	%	ICB	Mar-26	79.4%	▼	80.0%	March 2026	-0.6%	80.1%	-0.7%	
	Lower gastrointestinal (GI) referrals with an Faecal Immunochemical Test (FIT) result (Year to Date Cumulative)	%	ICB	Mar-26	83.0%	▲	n/a		-	80.0%	3.0%	
Procedures Completed (Local Metric)	Increase the proportion of procedures completed in outpatients or as a day case (UHNM)	%	UHNM	Mar-26	89.5%	▲	n/a		-	89.3%	0.2%	
Community	Community care contacts	Number	ICB	Feb-26	163,720	▼	n/a		-	145,924	17,796	
	52+ weeks in community services	Number	ICB	Mar-26	2	▼	n/a		-	0	2	
	Combined elective/non-elective length of stay (LOS) - community beds	Bed days	ICB	Mar-26	19.0	⇨	n/a		-	19.7	-0.7	

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

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

Notes on data:

- Community care contacts – latest position available as at February 2026

Urgent and Emergency Care

Programme	Measure Name	Currency	ICB / Provider	Reporting period	Current Month & direction from previous month		Target		Variance	Plan / baseline	Variance	Trend from April 2024 to current month
Urgent and Emergency Care (UEC)	A&E Type 1-3 - less than 4 hours	%	UHNM	Mar-26	66.3%	▲ (green)	78.0%	March 2026	-11.7%	78.0%	-11.7% (red)	
	A&E Types 1 & 2 - more than 12 hours	%	UHNM	Mar-26	14.4%	▼ (green)	16.65%	2025/26	-2.2%	19.5%	-5.1% (green)	
	Ambulance handover time (average)	Minutes	UHNM	Mar-26	01:08:06	▼ (green)	00:43:00	March 2026	00:25:06	00:43:00	00:25:06 (red)	
	Total Non-Electives spells	Number	UHNM	Mar-26	6,235	▲ (red)	n/a		-	7,825	-1,590 (green)	
	Non-elective average of Length of Stay	Bed days	UHNM	Mar-26	7.40	▼ (green)	n/a		-	6.70	0.70 (red)	
	General and Acute bed occupancy	%	UHNM	Mar-26	96.4%	▼ (green)	n/a		-	93.9%	2.5% (red)	
	Average delay - bed days lost through discharge delays	Days	UHNM	Mar-26	3.6	▲ (red)	n/a		-	3.4	0.2 (red)	
	Virtual Ward Occupancy	%	ICB	Mar-26	64.3%	▼ (red)	n/a		-	85.0%	-20.7% (red)	
	Urgent Community Response (UCR) referrals	Number	ICB	Mar-26	895	▼ (red)	n/a		-	713	182 (green)	
Urgent and Emergency Care (UEC) (Local Metrics)	Childrens A&E Type 1 - 4hr performance	%	UHNM	Mar-26	78.5%	▼ (red)	78.0%	March 2026	0.5%	-	-	
	Urgent community response (UCR) - patients seen within 2 hours	%	ICB	Mar-26	78.1%	▲ (green)	70.0%		8.1%	70.0%	8.1% (green)	
	Ambulance Hours lost due to Handover delays > 15min (UHNM)	Minutes	ICB	Mar-26	5,019	▼ (green)	n/a		-	5,971	-952 (green)	
	Ambulance Compliance - % Handovers within 45 minutes	%	UHNM	Mar-26	67.2%	▲ (green)	100%	March 2026	-32.8%	-	-	
	Readmissions	Number	ICB	Mar-26	302	▼ (red)	n/a		-	340	-38 (green)	

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

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

Provider Overview at Trust Site Level – Key Urgent and Emergency Care (UEC) Metrics for Out of ICB providers, March 2026

Metric	University Hospitals of Derby & Burton (UHDB) **Queens Hospital Burton** *(NHS Derby and Derbyshire Integrated Care Board)*	The Royal Wolverhampton (RWT) **New Cross Hospital** *(Black Country Integrated Care Board)*
4-hour Performance (%) Type 1-3 *[Provider level]*	• March 2026 reported performance of 73.3%, an increase of 1% on February 2026 (72.3%).	• March 2026 was 79.2%, an increase of 0.6% on February 2026 (78.6%).
A&E Attendances Type 1 *[Site level]*	• 6,963 attendances during March 2026, a 15.6% increase against the previous month which equates to 10 patients more per day (in real terms) due to the longer month.	• 11,416 attendances during March 2026, an 8.6% increase against the previous month which equates to 7 patients less per day (in real terms) due to the longer month.
4-hour Performance (%) Type 1 Paediatrics *[Site level]*	• March 2026 reported performance of 89%, an improvement of 2.8% on the previous month (86.2%).	• March 2026 reported performance of 85.8%, an improvement of 0.4% on the previous month (85.4%).
12-hour Performance Type 1 & 2 (%) *[Provider level]*	• 11.3% of Type 1 & 2 attendances breached the 12-hour mark for 'Time in Department' in March 2026, down 3.6% on February 2026.	• 11.1% of Type 1 & 2 attendances breached the 12-hour mark for 'Time in Department' in March 2026, down 0.1% on February 2026.
Bed Occupancy (%) - General & Acute (G&A) *[Site level]*	• G&A Bed Occupancy decreased 1.3% during March 2026 to 94.5% from 95.8% the previous month.	• G&A Bed Occupancy decreased during March 2026 to 95.9% from 96% the previous month.
Virtual Wards *[Provider level]*	• UHDB – 41 occupancy out of 40 bed capacity (102%) for last submission in month (3rd April 2026).	• RWT – no submission was made for the last submission in month (3rd April 2026).
Average Ambulance Handover Time *[Site level]*	• West Midlands Ambulance Service (WMAS) and East Midlands Ambulance Service (EMAS) combined average handover time for March 2026 was 26 minutes 21 seconds, 5 minutes 46 second better than February 2026.	• WMAS average handover time for March 2026 was 51 minutes 47 seconds, down 4 minutes 31 seconds on February 2026.
Ambulance Compliance % Handovers within 45 minutes *[Site Level]*	• WMAS and EMAS combined handover compliance for March 2026 was 92.4%, up 5.1% on February 2026.	• WMAS handover compliance for March 2026 was 74.1%, up 6.5% on February 2026.
Time Lost due to handover delays > 15 mins *[Site level]*	• 30% decrease in time lost due to handover delays during March 2026, dropping to a combined total of 286 hours between WMAS and EMAS.	• Decrease of 0.8% during March 2026 in time lost, dropping the time lost by WMAS to 2,344 hours from 2,363 hours during February 2026.

Primary Care and Medicines Optimisation

Programme	Measure Name	Currency	ICB / Provider	Reporting period	Current Month & direction from previous month		Target	Variance	Plan / baseline	Variance	Trend from April 2024 to current month
Primary Care	Appointments in General Practice	Number	ICB	Mar-26	612,955	▲	n/a	-	569,863	43,092	
	Unique patients seen by a NHS dentist - adult	% (quarterly)	ICB	Q4	43.5%	▲	n/a	-	43.4%	0.1%	
	Unique patients seen by a NHS dentist - children	% (quarterly)	ICB	Q4	65.8%	▼	n/a	-	62.7%	3.1%	
	Units of Dental Activity delivered	% (quarterly)	ICB	Q4	102.0%	▲	n/a	-	82.2%	19.8%	
	Urgent Dental Activity delivered	Number	ICB	Mar-26	5,620	▼	n/a	-	6,797	-1,177	
	Pharmacy First consultations	Number	ICB	Mar-26	16,696	▼	n/a	-	13,000	3,696	
Medicines Optimisation (Local Metrics)	Structured medication reviews (SMRs) conducted in general practice. (Year to Date Cumulative)	% (quarterly)	ICB	Q4	86.3%	▲	n/a	-	100.0%	-13.7%	

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

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Yellow	No change / equal
Black	Not applicable / not available

Notes on data:

- Structured medication reviews (SMRs) conducted - as Q3, the latest data available

Mental Health and Learning Disabilities & Autism

Programme	Measure Name	Currency	ICB / Provider	Reporting period	Current Month & direction from previous month		Target		Variance	Plan / baseline	Variance	Trend from April 2024 to current month
Mental Health	Active inappropriate adult acute mental health out of areas placements (OAPs)	Number	ICB	Mar-26	30	▼	n/a		-	4	26	
Mental Health	Average length of stay for adult acute beds	Bed days	ICB	Mar-26	49	▲	41.1	2025/26	7.9	40.3	8.7	
Mental Health	Number of people who are discharged having had at least 2 NHS talking therapy appointments	Number	ICB	Mar-26	1,167	▲	n/a		-	1,228	-61	
Mental Health	Access to NHS talking therapies for anxiety and depression - reliable recovery	%	ICB	Mar-26	49.7%	▲	50.0%	March 2026	-0.3%	50.0%	-0.3%	
Mental Health	Access to NHS talking therapies for anxiety and depression - reliable improvement	%	ICB	Mar-26	71.0%	▲	68.0%	2025/26	3.0%	68.0%	3.0%	
Mental Health	Access to Specialist Community Perinatal Mental Health Services	Number, Rolling 12 months	ICB	Mar-26	1,465	▲	1,216	March 2026	249	1,216	249	
Mental Health	Access to Children and Young People Mental Health Services	Number, Rolling 12 months	ICB	Mar-26	18,565	▲	17,273	March 2026	1,292	17,273	1,292	
Mental Health	Access to Individual Placement Support	Number, Rolling 12 months	ICB	Mar-26	890	▲	891	March 2026	-1	1,015	-125	
Learning Disabilities & Autism (LD&A)	Learning disability registers, Annual health checks delivered by GPs	% (YTD)	ICB	Q4	83.58%	▲	n/a		-	77.01%	6.6%	
Learning Disabilities & Autism (LD&A)	Reliance on MH inpatient care for adults with a learning disability	Number (quarterly)	ICB	Q4	17	⇨	n/a		-	13	4	
Learning Disabilities & Autism (LD&A)	Reliance on MH inpatient care for autistic adults	Number (quarterly)	ICB	Q4	17	▲	n/a		-	6	11	
Learning Disabilities & Autism (LD&A)	Reliance on MH inpatient care for people with a learning disability and/or autism - children	Rate (quarterly)	ICB	Q4	0.0	▼	n/a		-	13.3	-13	
Learning Disabilities & Autism (LD&A) (Local Metrics)	Mean wait to complete autism assessment - Children and Young People (CYP) North	Weeks	ICB	Mar-26	100	▼	26	March 2026	74	26	74	
Learning Disabilities & Autism (LD&A) (Local Metrics)	Mean wait to complete autism assessment - Children and Young People (CYP) South	Weeks	ICB	Mar-26	103	▼	26	March 2026	77	26	77	
Learning Disabilities & Autism (LD&A) (Local Metrics)	Learning from Lives and Deaths Review (LeDeR) reviews within 6 months of notification of death.	%	ICB	Mar-26	100.0%	⇨	100%	2025/26	0.0%	100%	0.0%	
Learning Disabilities & Autism (LD&A) (Local Metrics)	Oliver McGowan training - Tier 1 (NHS staff)	%	ICB	Mar-26	32.1%	▲	30%	2025/26	2.1%	30%	2.1%	
Learning Disabilities & Autism (LD&A) (Local Metrics)	Oliver McGowan training - Tier 2 (NHS staff)	%	ICB	Mar-26	39.3%	▲	30%	2025/26	9.3%	30%	9.3%	

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▲ (green)	Improved with a higher value than the previous month,
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Notes on data:

- Average length of stay for adult acute beds, Perinatal MH services access, CYP MH services access, IPS access - latest data available as at February 2026

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	Mar-26	12	▼	n/a	-	16	-4	
	Epilepsy emergency admission (≤18)	Number	ICB	Mar-26	12	▼	n/a	-	8	4	
	Diabetes emergency admission (≤18)	Number	ICB	Mar-26	3	▼	n/a	-	3	0	
Maternity and Neonates	Stillbirth rate	rate per 1,000	UHNM	Mar-26	10.2	▲	n/a	-	2.0	8.2	
	Neonate Mortality rate per 1000	rate per 1,000 (quarterly)	UHNM	Mar-26	2.0	▼	n/a	-	3.9	-1.9	
	Brain injury rate per 1000	rate per 1,000 (quarterly)	UHNM	Mar-26	2.0	▼	n/a	-	2.0	0.1	
	The % of full - term babies admitted to a neonatal unit	rate per 1,000 (quarterly)	UHNM	Mar-26	3.9%	▼	n/a	-	0	0.0	

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Community Transformation

Programme	Measure Name	Currency	ICB / Provider	Reporting period	Current Month & direction from previous month		Target	Variance	Plan / baseline	Variance	Trend from April 2024 to current month
Community Transformation	Palliative and End of Life Care (PEoLC): Prevalence rate of patients on palliative care registers to 1%.	%	ICB	Mar-26	0.9%	⇨	n/a	-	1.0%	-0.1%	
	Increase patients receiving all 8 care processes for Diabetes, receiving 3 treatment targets - Type 1 (Year to Date Cumulative)	%	ICB	Mar-26	57.7%	▲	n/a	-	53.4%	4.3%	
	Increase patients receiving all 8 care processes for Diabetes, receiving 3 treatment targets - Type 2 (Year to Date Cumulative)	%	ICB	Mar-26	64.8%	▲	n/a	-	62.5%	2.3%	
	Long-term conditions: Ensure referrals are made to the National Diabetic Prevention Programme – support for patients who are pre-diabetic	Number	ICB	Feb-26	570	▼	n/a	-	520	50	
	Urgent community response (LTC): Ensure patients commence on the National Diabetic Prevention Programme (NDPP) following referral	Number	ICB	Feb-26	365	▼	n/a	-	261	104	
	Reduction in number of conveyances for falls by WMAS	Number	ICB	Mar-26	743	▲	n/a	-	800	-57	
	Falls, Reduction in number of falls related emergency admissions - 65+	Number	ICB	Feb-26	271	▼	n/a	-	161	110	
	Care Home, Reduction emergency admissions - 65+	Number	ICB	Feb-26	784	▼	n/a	-	713	71	
	Reduction emergency admissions - all 65+	Number	ICB	Feb-26	6,211	▼	n/a	-	5,836	375	

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Notes on data:

- National Diabetic Prevention Programme, Reduction in emergency admissions 65+ - positions across all metrics for both areas are based on the latest available data as at February 2026

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	Dec-25	89.5%	⇨	n/a	-	87.7%	1.8%	
	Children and Young People Vaccination uptake - Pertussis maternal vaccination	%	ICB	Dec-25	78.9%	▼	n/a	-	76.1%	2.8%	
	Hypertension (CVDP007HYP): Patients treatment to recommended age specific thresholds	% (quarterly)	ICB	Dec-25	68.9%	▲	n/a	-	66.5%	2.4%	
	Cholesterol (CVDP003CHOL):Patients with QRISK 20% or more treated with lipid lowering therapy	% (quarterly)	ICB	Dec-25	65.9%	▲	n/a	-	64.4%	1.5%	
	Respiratory: Flu Vaccinations (65+years)	%	ICB	Feb-26	75.9%	⇨	n/a	-	76.3%	-0.4%	
	Respiratory: COVID Vaccinations (75+years)	%	ICB	Jan-26	65.7%	▲	n/a	-	64.4%	1.3%	

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Notes on data:

- MMR2 - latest position available as at December 2025. Q4 data expected June or July 2026.
- Pertussis maternal vaccination, Hypertension and Cholesterol - latest data available to December 2025. Q4 data expected June or July 2026.
- Flu vaccinations - latest data available to February 2026.
- COVID vaccinations - latest data available to January 2026.

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

Cluster Performance Delivery & Assurance Framework

Draft V2

NOF/MTPF metric/data mapping

- Full mapping of newly released National Oversight Framework (NOF) 26/27 completed
- Data definitions being cross referenced to existing reporting
- Single Data Dashboard being finalised consolidating STW and SSOT data (ICB and Provider level) and is accessible within both ICBs
- First draft reporting against 26/27 NOF July 26.

ICB Performance Management Matrix of Accountabilities & Responsibilities for Delivery and Assurance

Assurance

	ICB
Oversight	Integrated Care Board
Assurance Sub-Committee	Quality & Performance Committee
Management Escalation	NHS STW Exec Team
Management Assurance	System Performance Group

Delivery

	ICB
Oversight	Integrated Care Board
Sub-Committee	Strategic Commissioning & Transformation Committee Quality & Performance Committee Finance Committee People, Culture & Inclusion Committee
Management Escalation	NHS STW Exec Team via Senior Leadership Team
Management Delivery	Population Health Improvement Group, TBC for people, Efficiency Oversight Group, System Quality Group, Primary Care Forum + PCCG, UEC delivery groups, Neighbourhoods' group, MH LDA delivery group Provider related performance via Contract Review Meetings (CRMs)

NHS

Governance Structure – mapped to performance delivery & assurance

SSOT & STW
Integrated Care Boards in Common

JOINT People, Culture & Inclusion Committee	JOINT Quality & Performance Committee	Audit Committees IN COMMON	JOINT Finance Committee	JOINT Strategic Commissioning & Transformation Committee	JOINT Remuneration Committee	SSOT Health & Care Senate
Sub-Committees TBC	Sub-Committees e.g. System Quality Group / System Performance Group	IG & Data Sub-Committee	Sub-Committees TBC	Sub-Committees = Efficiency Oversight Group / Commissioning Working Group / Pop Health Improvement Group / Transformation & Digital Group / Primary Care	Sub-Committee (VR Panel)	

Weekly Executives / Senior Leadership Team /

Performance reporting – management delivery

- Detailed performance reporting of monthly delivery vs plan – using MDC (Making Data Count) methodology to drive proactive anticipation of failure and associated mitigation rather than reactive recovery – BI /Performance /Quality /Population Health Improvement
- Including actions/plans for recovery where required (ICB responsible metrics)
- **Provider responsible metrics** will be reported via **Contract Review Meetings** (CRMs)

Performance reporting – management assurance

- Performance assurance report to QPC will consist of two parts :-
  - ICB performance by NOF domain / operating plan
  - Summary of System Performance Group exception reports from CRMs by provider
  - Including relative performance (benchmarking) where available

- Integrated Performance Report to Board – will consolidate performance, quality, finance and people subcommittee outputs into a single integrated report again using MDC methodology where appropriate.

Next steps

- Seek final feedback from Execs/Board (individual execs already consulted)
- Finalise delivery reporting arrangements with People & Primary Care by end of June
- Finalise timetable of data receipt and reporting to schedule the SQG and SPG
- Finalise performance reporting via Provider CRMs
- Mock up draft QPC report in June, for feedback
- First month of new reporting July 26.
- Establish cluster system performance group July/August.
- First month of new consolidated IPR Sept 26.

Agenda Item

(17) Enc.14-22

Triple A Board Committee

Highlight Reports

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

Board Assurance Committee
"Triple A" Escalations & Highlights Assurance Report

Report To:	ICB Boards in Common
Date:	25th June 2026
Reporting Committee:	Finance Committee in Common – Part 1 (ICB) & Part 2 (System)
Date of Meeting:	28th April 2026
Meeting Quorate Y/N?	Yes (both)
Presenter:	Mike Lawton, ICB Deputy Chair
Author:	Kelly Weatherill, Executive Assistant

Summary of Key Discussions & Decisions from the Committee Meeting

ALERT – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

There were no items to alert the ICB Board from the meeting.

ADVISE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

Finance Committee in Common Part 1 (ICB)

ICB Finance Performance

STW Month 12 Finance Report

The Committee received an update on the latest month 12 position regarding STW ICB for revenue, efficiency and capital. The ICB reported a £65k surplus which is a £2m favourable variance compared to a £2m deficit plan due to prior year benefits and increased efficiency delivery after £38.6m of deficit support funding. Efficiency delivery was £45.3m compared to £39.2m plan, over delivery of £6.1m due to prior year benefits and individual commissioning.

The ICB's CDEL BAU capital spend was in line with plan for 2025/26, £1.1m, the ICB is reporting an underspend against the national programme, Primary Care Utilisation and Modernisation Fund (PCUMF) of £0.752m.

SSOT Month 12 Finance Report

At month 12 SSOT ICB reported a year ending surplus position of £0.7m, which is favourable to the breakeven plan for 2026/27, subject to audit. As at February 2026, the SSOT system agreed control totals to maintain a balanced financial position, with the ICB set a control total of a £0.8m surplus. While the ICB reported an immaterial shortfall of £0.1m against this control total, the system has achieved an overall breakeven position in aggregate.

The ICB's CDEL BAU capital spend was in line with plan for 2025/26.

SSOT 2025/26 Efficiency Report

The Committee received an update on the progress against the ICB's £169.9m efficiency programme. The level of plans implemented or fully developed by the ICB reflects a positive position (£150.3m/88%) however, a £17.9m risk of unidentified plans has remained throughout the financial year which has necessitated for the identification of mitigations, mostly non recurrent in nature.

Finance Committee in Common Part 2 (System)

Chief Finance Officer Update
The Committee received a verbal update from the Chief Finance Officer which covered aspects such as strategic commissioning planning, neighbourhood capital funding, and details of a planned visit from NHS England's national team with regards to neighbourhoods.

Medium-Term Financial Plan & Long-Term Financial Plan - Capital and Revenue

The Committee received an update on the confirmation that NHS England have now supported the Medium Term Finance and Operational Plans for both Integrated Care Systems. The Committee were also updated on the financial conditions issued by NHS England on 7th April 2026 alongside their confirmation of compliance.

Joint Capital Resource Use Plans 2026/27
The National Health Service Act 2006, as amended by the Health and Care Act 2022 requires ICBs and their partner Trusts to prepare and publish their Joint Capital Resource Use Plan (JCRUP) each financial year. NHS England request that capital plans are published and shared within 6 weeks of final financial plans being submitted to NHS England, i.e. by the 30th April 2026. In response to this requirement, the JCRUP's for both STW and SSOT were shared with the Committee for approval.
The Committee **approved** both sets of plans.

System Finance Performance

STW Month 12 System Finance Report
The system reported a £10.6m full year surplus against a breakeven plan, giving a £10.6m favourable variance, largely due to additional £8.2m deficit support funding earned and received in month 12. The total deficit support funding received in 2025/26 was £92.0m. The system has delivered full year efficiency savings of £99.5m against a plan of £91.6m which is £7.9m favourable to plan.

Overall provider workforce full year expenditure is adverse to plan by £22.3m, with bank full year overspend at £15.8m. NHS Infrastructure Support costs favourable to plan by £5.8m/6.0% YTD.

The system met its capital financial plan limit for the year. At year end the system is reporting a £0.4m underspend against plan namely due to the deferral of ICB Primary Care Utilisation and Modernisation Fund (PCUMF) (£0.8m) offset by additional Provider PDC to fund Estates safety schemes at SATH and RJAH.

SSOT Month 12 System Finance Report
The system is reporting a £6.6m surplus breakeven position (£4.9m adverse at month 11). This includes a deficit of £4.7m for UHNM, offset by a surplus of £7.1m at MPFT, and £3.4m at NSCHT and £0.7m for the ICB. The surplus was driven by the late receipt of additional deficit support funding earned and received from NHS England.

The reported system efficiency delivery YTD is £26.3m behind the submitted plan of £306.3m, this comprises of MPFT £0.3m and UHNM £26.7m. As a system this equates to 91% delivery YTD.

The system workforce numbers across providers and ICB (substantive + bank + agency) were 25,528 WTE in March 2026, an increase of 255 WTE from month 11 which is attributed to an increase in bank staff at UHNM and MPFT. Month 12 workforce numbers were 836 WTE above plan.

The system met its capital financial plan limit for the year.

ASSURE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions
Finance Committee in Common Part 2 (System) STW Finance Strategy Delivery Plan Q4 Update The Committee were provided an update on the 2025/26 Q4 implementation of the System Finance Strategy following approval of the strategy by the Integrated Care Board in June 2025. The plan was broken down into 9 sections and consisted of 52 specific actions. This was the final deep dive update report, the purpose of which was to provide assurance to the Committee that 100% of actions had been completed during 2025/26.

Key Risks & Mitigations (ref. System Board Assurance Framework: SBAF)
The SBAF and Risk Register updates are reviewed by the Committee on a quarterly basis therefore no updates were shared this time.

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

Decisions to be Escalated to ICB Board
There were no items for escalation originating from Part 1 or Part 2 of the Finance Committee.

Board Assurance Committee
"Triple A" Escalations & Highlights Assurance Report

Report To:	ICB Boards in Common
Date:	25th June 2026
Reporting Committee:	Finance Committee in Common – Part 1 (ICB) & Part 2 (System)
Date of Meeting:	26th May 2026
Meeting Quorate Y/N?	Yes (both)
Presenter:	Mike Lawton, ICB Deputy Chair
Author:	Kelly Weatherill, Executive Assistant

Summary of Key Discussions & Decisions from the Committee Meeting

ALERT – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

There were no items to alert the ICB Board from the meeting.

ADVISE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

Finance Committee in Common Part 1 (ICB)

STW/SSOT Month 1 Finance Report
The Committee received an update on the latest position regarding ICB finance for revenue, efficiency and capital. Month 1 reporting contained a very high-level submission covering income, expenditure, efficiency performance, contract status and a capital spend update. A breakdown for each ICB is provided below: -

<u>STW</u>
Month 1 position was breakeven and in line with plan. The efficiency plan has delivered £8.4m savings against a target of £8.0m, a favourable variance of £0.4m. The ICB has revenue risks of circa £22.9m (£8.9m Efficiency and £14.0m Cost) which have been fully mitigated.

The ICB has a total capital allocation of £3,221k, of which £1,047k is designated for General Practitioner Services Capital, £1,674k for STW ICB Strategic Capital and £500k for STW ICB Primary Care Modernisation and Utilisation Fund.

<u>SSOT</u>
Month 1 position was breakeven and in line with plan. The efficiency plan has delivered £2.4m savings against a target of £2.2m, a positive variance of £0.2m. Key risks remain centred on the delivery and maturity of the efficiency programme, with £8.6m of savings still under development. Appropriate mitigations have been identified and are being actively managed, providing confidence in the ability to deliver the 2026/27 plan.

The ICB has a total capital allocation of £7,003k, of which £2,310k is designated for General Practitioner Services Capital, £3,693k for STW ICB Strategic Capital and £1000k for STW ICB Primary Care Modernisation and Utilisation Fund.

<u>Efficiency Risk Update</u>
The Committee received a detailed update on the Efficiency Programme, which covered both ICBs.

<u>CHC Individual Commissioning (STW)</u>
The Committee were provided an update on the current and forecast budget performance of the All Age Continuing Care (AACC) and Individual Commissioning team for NHS STW ICB.

STW ICB 2025/26 had an end of year adverse variance to budget of £7.9m due to an increase in cost of commissioning care for residents eligible for NHS Continuing Healthcare and also an increase in cost and volume for residents eligible for Section 117 aftercare and out of area inpatient rehabilitation.

The committee noted that there is a significant risk of an adverse spend to budget for 2026/27 if no action is taken. This is due to an increase in the cost of commissioning care; a carryover of the impact on 2025/26 and is exacerbated by increasing numbers of vacancies within the AACC team.

Mitigating actions have been considered by the executive team and are in the process of being implemented. It is expected that if actions are mobilised as soon as possible, the risk to the forecast could be mitigated.

Finance Committee in Common Part 2 (System)

Chief Finance Officer Update
The Committee received a verbal update from the Chief Finance Officer which covered aspects such as the month 1 financial position including the risks and pressures, year-end audit, and the current work underway relating to the Neighbourhood Capital funding bid and the Frontline Digital Capital and Revenue funding bid.

STW/SSOT Month 1 System Finance Report
The Committee were provided with an update on the latest position regarding the STW & SSOT system finance for revenue and efficiency. Month 1 reporting contained a very high-level submission covering income, expenditure and efficiency.

At this point in the year, all in-system NHS partners expect to deliver their planned forecast outturn position with SATH (STW) and UHNM (SSOT) highlighting negative variation against plan in month 1, though this is deemed to be recoverable by year end.

It was confirmed that in-system contracts are signed, and out of system contract values are agreed but not yet all signed.

ASSURE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

There were no items of assurance from the meeting.

Key Risks & Mitigations (ref. System Board Assurance Framework: SBAF)

The SBAF and Risk Register updates are reviewed by the Committee on a quarterly basis therefore no updates were shared this time.

Policies & Procedures Approved

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

Decisions to be Escalated to ICB Board

There were no items for escalation originating from Part 1 or Part 2 of the Finance Committee.

Board Assurance Committee
"Triple A" Escalations & Highlights Assurance Report

Report To:	ICB Boards in Common
Date:	25th June 2026
Reporting Committee:	Transition Committee in Common
Date of Meeting:	22nd April 2026
Meeting Quorate Y/N?	Yes
Presenter:	Paul Edmondson– Jones Transition Director
Author:	Kirsten Owen Associate Director – Special Projects

Summary of Key Discussions & Decisions from the Committee Meeting

ALERT – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

1: Workforce capacity and organisational resilience risk due to scale and pace of change, with ~50% workforce reduction and ongoing exits impacting delivery and staff wellbeing.

2: Uncertainty in national merger guidance and timelines, including risk of legislative delay (April to July 2027), creating planning and capacity pressures

3: CSU Service continuity risks in key areas (e.g. CSU services, All Age Continuing Care, statutory functions) due to vacancies, TUPE transitions and redundancy impacts.

ADVISE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

1: The Transition Committee has maintained strong oversight of the programme, supporting delivery across governance, workforce, operating model, and financial priorities. Good progress has been made, with focus now shifting to completion of transition activity and preparation for merger.

2: Importance of strengthening multi-professional leadership and ensuring the operating model fully reflects statutory responsibilities and system expectations.

3: Ongoing engagement required with partners (Local Authorities, providers, NHS England) to maintain inclusive governance and effective collaboration within revised structures

ASSURE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

1: Strong progress in delivery of voluntary redundancy and management of change processes, with robust governance and minimal escalation of formal grievances.

2: Financial trajectory remains controlled, with clear plans to achieve cost per head targets through workforce changes and vacancy management

3: Governance and transition infrastructure in place, including approved constitutions, transition glide path, refreshed risk register (reduced and strengthened), and structured programme oversight

Key Risks & Mitigations (ref. System Board Assurance Framework: SBAF)

Policies & Procedures Approved

☑ No additional formal policy approvals were escalated in the period.

Decisions to be Escalated to ICB Board

There are no formal decisions requiring escalation; however, the Board is asked to note:

- ☑ The scale of workforce change and associated organisational risk
- ☑ Emerging risks relating to merger timelines and national guidance
- ☑ Need for continued oversight of organisational resilience and prioritisation
- ☑ The Committee is reflecting on the work of the last twelve months and considering the next phase of work

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

Board Assurance Committee
"Triple A" Escalations & Highlights Assurance Report

Report To:	ICB Boards in Common
Date:	25 June 2026
Reporting Committee:	Remuneration Committee in Common
Date of Meeting:	16th March 2026
Meeting Quorate Y/N?	Yes
Presenter:	Shokat Lal
Author:	Stacey Robinson

Summary of Key Discussions & Decisions from the Committee Meeting

ALERT – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

N/A

ADVISE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

N/A

ASSURE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

The Staffordshire and Stoke-on-Trent Remuneration Committee and Shropshire, Telford and Wrekin Integrated Care Board Remuneration Committee met in common to discuss the following:

Business Case: Concluding elements of the formation of SSOT & STW Cluster 2025/26 – 2026/27
The Committees received a paper providing a clear narrative relating to the total WTE, financial planning and anticipated costs associated with the ICB government reform for 2025/26 to enable the STW/SSOT cluster to function with an establishment within the 2026/27 running cost budget of £19.55 per head of weighted population. The Remuneration Committees approved the overall expected redundancy costs as modelled, recognising that funding for double running costs is secured within the 2026/27 financial plan.

SSOT Public Health Alliance
The Committee received an update in relation to an historical arrangement set up within Staffordshire and Stoke-on-Trent relating to a secondary employment by Midlands Partnership University Foundation Trust (MPUFT) and noted the conclusion to this arrangement.

VSM Salary Cluster Chief Finance Officer
The Committees received a follow up paper to the previous paper received in January 2026 in relation to a retrospective Business Case submission to NHS England for the Cluster Chief Finance Officer. Committee members noted the update and approved the recommendations within the paper.

Key Risks & Mitigations (ref. System Board Assurance Framework: SBAF)

Policies & Procedures Approved
N/A

Decisions to be Escalated to ICB Board
N/A

Board Assurance Committee
"Triple A" Escalations & Highlights Assurance Report

Report To:	ICB Boards in Common
Date:	25 June 2026
Reporting Committee:	Remuneration Committee in Common
Date of Meeting:	1st April 2026
Meeting Quorate Y/N?	Yes
Presenter:	Shokat Lal
Author:	Stacey Robinson

Summary of Key Discussions & Decisions from the Committee Meeting

ALERT – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

N/A

ADVISE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

N/A

ASSURE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

The Staffordshire and Stoke-on-Trent Remuneration Committee and Shropshire, Telford and Wrekin Integrated Care Board Remuneration Committee met in common to discuss the following:

Voluntary Redundancy Scheme for the Senior Leadership Team and the Clinical and Professional Leadership Team
The Committees received an update in relation to the Management of Change process for the Senior Leadership Team and the Clinical and Professional Leadership Team. The paper presented Committee members with information around the number of voluntary redundancy applications received and costs, with assurance provided around the robust decision-making process. The Committees endorsed the decisions made by the Moderation Panel and approved submission to NHS England.

VSM Pay Award
The Committees received an early update around the VSM Pay Framework and agreed to discuss further at a future Remuneration Committee when more information is available.

Key Risks & Mitigations (ref. System Board Assurance Framework: SBAF)

Policies & Procedures Approved

N/A

Decisions to be Escalated to ICB Board
N/A

Board Assurance Committee
"Triple A" Escalations & Highlights Assurance Report

Report To:	ICB Boards in Common
Date:	25 June 2026
Reporting Committee:	Strategic Transformation & Commissioning Committee
Date of Meeting:	13 May 2026
Meeting Quorate Y/N?	Yes
Presenter:	Trevor McMillan, Non-Executive Director
Author:	Vanessa Ridout, Executive Assistant

Summary of Key Discussions & Decisions from the Committee Meeting

ALERT

Terms of Reference for Strategic Commissioning and Transformation Committee *(for approval)*
The Committee reviewed and discussed the Terms of Reference (ToR) for the Committee which were approved subject to some minor changes

The full ToR can be found via these links:

https://www.shroandtel.co.uk/terms-of-reference/

Hybrid SCTCinC TORs 13.05.2026 v4.3 (003)

The Board are asked to **ratify** the ToR.

ADVISE

Response to Jim Mackey letter *(for discussion)*
Sir Jim Mackey's letter (1 April 2026) requests each Integrated Care Board (ICB) to submit a single, system-aligned narrative describing how strategic commissioning will evolve over the next three years, with particular emphasis on:
• The definition and development of strategic commissioning.
• The ambition and delivery of neighbourhood care models.
• Required changes to financial flows and payment systems.
• Actions NHS England should take to accelerate local delivery.

A joint cluster response has been developed across STW and SSOT, working with our provider and Local Authority partners to articulate a shared strategic intent to move from operational recovery to long-term system redesign. The response positions neighbourhood-based care, outpatient transformation and urgent and emergency care (UEC) reform as the primary levers for improving outcomes, productivity and financial sustainability. The response also sets out a clear set of national asks, particularly in relation to payment reform, capital investment, workforce alignment and simplification of assurance, to enable the pace and scale of transformation required.

A detailed discussion took place at the Committee and the final version would be shared with all staff.

Primary Care Action Plan (PCAPs) for Medium Term Plan *(for approval)*
As part of the Medium-Term Planning Framework (MTPF), ICBs are asked to prepare and submit an action plan for Primary Care, signed off by ICBs Boards.

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

Primary Care is critical to delivering overall NHS transformation and reform, including the 'three shifts' in the 10 Year Health Plan. The plan has been developed at Cluster level for SSTOP and STW ICBs. The plan covers primary care work across a three to five-year period at a high level, in line with the ISCP, but with a detailed focus on 2026/27 (Year 1).

The Committee approved the Primary Care Action Plan for final submission to NHSE by 22 May subject to some minor changes.

Transformation
System Transformation and Service Change Update *(for information)*
The Committee received the monthly overview of the clinical areas included within the system transformation and service change programme.
Maternity
- A 4-week engagement took place in February 2026 to gather the views of women and their families on elements of antenatal care that were in place prior to COVID19 at Samuel Johnson Community Hospital and have not been reinstated.
- A further technical event took place on 23 April 2026 and the programme will now progress to the development of the Decision Making Business Case (DMBC) and reviewing impact assessments.
- Once finalised, the DMBC will proceed to ICB Board for final decision making. This is expected in Autumn 2026.

UEC
- There is a process ongoing in terms of urgent treatment centre designation. This programme has changed several times due to changes with national guidance. Some challenges remain in terms of temporary closures that were taken through COVID which remain in place
- Cannock - A draft pre-consultation business case has been developed and the clinical model is going to the West Midlands Clinical Senate (WMCS) on 22 May 2025 for discussion. The pack includes an update on the travel impact assessment and full data refresh. Following any feedback from the WMCS the business case would be refined and then presented to the Staffordshire Overview and Scrutiny Committee. Engagement meetings are taking place with Cannock PCN leads to guide the clinical model and communicate proposals and align to neighbourhood team workstreams.
- UTC business case for Royal Stoke approved with County Hospital business case to be reviewed pending final amendment and assessment of revenue funding.
- Further meetings planned with system partners and NHSE UEC lead to assess Service Change proposals.

Neighbourhood Health and Care Update *(for information)*
The Committee received a detailed report which included the highlight reports that were submitted to the Neighbourhood Health and Care Strategic Group in March. There has been a lot of focus over the last month with system partners on some of the core standardised community services that are required within neighbourhood health.

ASSURE

Place and Neighbourhood Update *(for information)*
The Committee received a verbal update from Phil Smith on Place and Neighbourhood. Further detail would be available at the next meeting in terms of next steps.

Highlight reports/updates
The Committee received highlight reports/updates from the following groups which were presented for information only. There were no alerts for the Board to be aware of.
- Commissioning Working Group
- Mental Health, LD & A programme
- Neighbourhood Health

- MSK Transformation Programme
- Primary Care Forum (SSoT)
- Primary Care (STW)
- Equality and Involvement Committee

Key Risks & Mitigations (ref. System Board Assurance Framework: SBAF)

There were no risks or mitigations to alert to the Board.

Policies & Procedures Approved

There were no policies or procedures for approval

Decisions to be Escalated to ICB Board

The Board are asked to ratify the Terms of Reference for the Strategic Commissioning and Transformation Committee.

TERMS OF REFERENCE

Joint / Committees-in-Common
Strategic Commissioning & Transformation Committee (SCTC)

(1) Introduction

1.1 The Strategic Commissioning & Transformation Committee (the Committee or SCTC) is established by the Integrated Care Board ('Board' or 'ICB') in accordance with its Constitution and the Health & Care Act 2022 / associated Statutory Guidance to adopt a more joined-up approach to Strategic Commissioning / Strategy & Prevention, building on collaborative relations and using collective resources to improve health and well-being.

1.2 These Terms of Reference (ToR), which must be published on the ICB's website, ensure that it can effectively discharge its statutory functions and duties. This includes establishing committees to support the Board in the exercise any delegated functions, to help effective discharge of those.

1.3 The SCTC will help create an ICB Strategic Commissioning infrastructure which enables system-wide decisions to be integrated with "Place" (Joint Commissioning with Local Authority and Neighbourhoods); supporting strategic collaboration between Partners to address Health Inequalities, improving outcomes and sustaining joined-up value for money services.

1.4 The Committee will ultimately be responsible for planning, commissioning, and delivering Health & Care services that continue to build and maintain broader coalitions across all Partners to promote health & wellbeing, thus influencing the wider determinants of health.

(2) Authority

2.1 The SCTC is a Non-Executive Committee of the Board, bound by the ICB Constitution, Standing Orders and policies as set out in the Scheme of Reservation & Delegation and Delegated Financial Limits. These may be amended by Board from time to time.

2.2 The Committee holds only those powers, duties and responsibilities as delegated in these TORs (section 3 / Appendix One) to enable Statutory Commissioning Duties decision-making, collaborating on Strategic Commissioning (including policy) matters and overseeing jointly agreed programmes of work to ensure their delivery. Further may be delegated over time with approval of the Board, following which these TORs will be updated and approved by Board.

2.3 The Committee is authorised by the ICB Board to:-

- Investigate any activity within these ToRs including oversight of reference assigned Risk Management / System Board Assurance Framework (SBAF) activities within its lead area;
- Seek any information it requires within its remit, from any employee or member, including those who are not members of the Board (who are directed to co-operate with any request);
- Commission any reports it deems necessary to help fulfil its obligations;
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions (in doing so it must follow any procedures put in place for obtaining such advice);
- Create dedicated Sub-Committees to take forward specific duties as deemed necessary by Committee Members - the SCTC shall determine the memberships & roles of these in

accordance with the Scheme of Reservation & Delegation (SoRD). Who may in turn, but only where necessary, establish further "feeder" Task & Finish sub-groups for completing specified areas of work; but Sub-Committees may not delegate decisions to these.

(3) Purpose, Responsibilities and Core Duties

3.1 The Committee is established to exercise the ICB's statutory duties and powers to commission certain health services, including scrutiny and assurance of the way we perform our function as a Strategic Commissioner. This will need to include things like seeking assurance around major service change, prioritisation, commissioning and decommissioning decisions.

3.2 This includes the discharge of duties and powers in accordance with s65Z5 of the NHS Act for any requirements as set out, including Delegation Agreements between NHS England and the ICB, including under supra-regional arrangements, re. Primary Care & Specialised Services).

3.3 As well as in the development of ICS Strategic & Collaborative Commissioning arrangements, supporting priority Commissioning Programmes at Place, Provider Collaboratives, Health & Wellbeing Boards (HWBBs) Joint Local Health & Wellbeing Strategies and aligned Delivery Plans, helping to broker ICB commissioning decisions through Collaborative Commissioning.

3.4 In supporting the ICB to discharge its statutory commissioning duties and deliver strategic priorities at whole ICB / System level, the Committee will, in turn, be supporting ICB (ICS) with the achievement of the four core purposes of the "Quadruple Aim", including:

- Oversight of Transformational / Productivity outcomes for the ICB, ensuring that health inequalities are addressed in ICB's strategic objectives and that ICB strategies improve the outcomes in population health (Population Health Management: PHM) by using data available in the system as a key enabler to help drive data-led focus on person-centred care through integrated, locally commissioned services at Place & Neighbourhoods;
- Delivery of ICB Statutory Commissioning Duties that support strategic Transformation, Prevention, Strategic Commissioning;
- Liaising with ICB Exec and/or ICB Board Assurance Committees on matters of significance, to ensure consistency in the delivery of sustainable Financial Plans / financial performance;
- The development and implementation of ICB (ICS) responses to integrated strategies / aligned plans required for Strategic Transformation of health & care services, by benchmarking against local / regional / national population health outcomes data to develop future commissioning or decommissioning opportunities;
- Taking all necessary steps to support delivery of ICB's / ICS's objectives by determining relevant actions to remediate any initiatives where intervention is resisted or contradicting agreed ways of working, agreeing how we support each other to mitigate any impacts.

3.5 The duties of the Committee will be driven by ICB Strategic Objectives and associated risks. An annual programme of business will be agreed before the start of the financial year; however this will be kept flexible to new and emerging priorities and risks.

(4) Membership, Attendance and Decision-Making

4.1 A full list of responsibilities is provided in Appendix One. In carrying these out, the Committee must have 'due regard' to the wider effect of its decisions on health & wellbeing / addressing health inequalities, the quality of services provided and efficiency in the use of resources.

4.2 ***Membership***

Committee members will be appointed by the Board in accordance with the ICB Constitution; and shall be a broad membership, including those from organisations other than the ICB (until replaced by any substantive Joint Committee of all Partners). This is permitted by the ICB's Constitution and amendments made to the 2006 Act by the Health & Care Act 2022.

Members should be of a calibre to conduct core business, including for non-ICB, Part B members, without having to take items back to their host organisation – unless the decision is a non-delegated matter from those, and required under ICB governance frameworks.

Core Membership (Voting Members) =

- ✓ ICB Non-Executive Member (NEM): as Chair
- ✓ ICB NEM: as Vice-Chair
- ✓ ICB Chief Officer of Strategy & Improving Outcomes or deputy
- ✓ ICB Chief Officer of System Development & Integration or deputy
- ✓ ICB Chief Finance Officer or deputy
- ✓ ICB Chief of Staff or deputy
- ✓ ICB Chief Medical Officer or deputy
- ✓ ICB Chief Nursing Officer or deputy

Participant Members (Non-Voting Members) =

- ✓ ICB Chief Executive Officer
- ✓ Audit NEM / Audit Committee Chair

Others may be invited to attend all or part of any meeting as / when appropriate to assist with Committee discussions – e.g. ad hoc, co-opted individuals pertaining to specialist "deep dive" topics or as 'Subject Matter Expert' input, from Primary & Secondary Care, Work Programme Directors or SROs, etc.

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion.

4.4 ***Frequency, Quoracy and Decisions***

The Committee will meet bi-monthly. Additional, exceptional meetings may take place as required. A minimum of two working days' notice shall be given by the Chair for extraordinary meetings.

To be quorate, the Chair or Vice-Chair must be present, plus two Exec Members. If any Member has been disqualified from participating in an item on the agenda, by declaration of a Conflict of Interest, then that individual shall no longer count towards the quorum.

If a quorum has not been reached, a meeting may still proceed if those present agree. Binding decisions may be taken but shall be deemed pending confirmation by absent Members via virtual methods outside of the meeting and before the next scheduled one.

Meetings may be attended by individuals who are not members of the committee, however only ICB members have the right to attend Committee meetings.

Decisions taken will be in accordance with ICB Standing Orders and be reached by consensus. Unless the issue is so exceptional it requires a vote. Only ICB members may vote; and each is

allowed one vote. A majority will be conclusive on any matter. Where there is a split vote or no clear majority, the Chair will hold the casting vote. Results will be recorded in the minutes.

(5) <u>Conflicts of Interest and Conduct</u>

5.1 The Committee and all members or attendees present shall fully and continuously satisfy itself that all matters of ICB policy, systems and processes for the management of conflicts (including gifts & hospitality and bribery) are upheld in all meetings.

5.2 For the avoidance of doubt, any additional national or statutory policy requirements shall also guide the Committee's processes and procedures. This shall include sending any reports relating to non-compliance with ICB policy and procedures to the ICB Audit Committee.

5.3 ***Etiquette, Behaviours and Conduct***
All present will conduct business in line with ICB's stated values and objectives; and in accordance with the Constitution, Standing Orders and Standards of Business Conduct Policy.

5.4 ***Equality and Diversity***
All members must demonstrably consider the Equality Diversity & Inclusion implications of any or all decisions they make; upholding the Equality Act and Public Sector Equality Duty in any business. In addition to these, members and attendees will adhere to the Integrated Care System (ICS) Partnership Leadership Compact key principles of 'Trust', 'Courage', 'Openness & Honesty', 'Leading by Example', 'Respect', 'Kindness & Compassion', 'System First' and 'Looking Forward'.

(6) <u>Accountability and Reporting</u>

6.1 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these TORs. The Chair shall also report to the Board on how it discharges its responsibilities. Actions shall be formally recorded by the Secretariat.

6.2 The Chair will provide assurance reports to the Board after each meeting, using Highlight & Escalation Reports, drawing to the attention of the Board any issues that require disclosure or further action, including when ratifying any Committee decisions made.

6.3 Due to the nature of the item on an agenda the Chair may direct that items are taken in confidential session where this is in the public interest. Only voting members will be invited to this part of a meeting; which will be minuted separately and approval of the confidential minutes by voting members present at the next confidential meeting.

This includes but not limited to, sensitive Primary Care commissioning decisions, commercially sensitive contractual discussions or intent to award via Provider Selection Regime.

(7) <u>Secretariat</u>

7.1 The Committee shall be supported with a Secretariat, which will ensure that:

- Good quality agendas, papers and minutes are prepared / distributed in accordance with Standing Orders; having been agreed by Chair with support of Governance if required;
- Actions are taken forward between meetings, and progress against those is monitored;
- Supporting the Chair is supported to prepare and deliver reports to the Board (section 6.2);

- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements;
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary;
- The Committee is updated on pertinent issues/ areas of interest/ policy developments;

(8) Review

8.1 The Committee will formally review its effectiveness at least annually, using ICB Committee effectiveness tools and processes.

8.2 These TORs will be reviewed at least annually; and in its early, formative stages, more frequently (e.g. bi-annually) and as required by circumstances. Any proposed amendments will be submitted to the Board for approval (and will not be deemed as operational until that agreement has been confirmed).

Date Approved:

Date of Next Review:

Appendix One - Responsibilities of the Committee

1.1 Providing scrutiny and assurance of the ICB's Strategic Commissioner function (where necessary involving ICS Partners) to:-

- Develop ICB priorities, key strategies / plans and Commissioning priorities and outcomes as may be set out in plans / contracts;
- Facilitate and oversee commissioning, service planning, delivery and transformation between Partners to drive integration and value;
- Support ongoing development of collaborative arrangements to maximise benefits for the ICB in terms of driving integration and efficiency in how services are commissioned / delivered; giving regard to wider System arrangements;
- Establish robust relationships with the other ICB & System (statutory or non-statutory) decision-makers to promote integrated working and avoid duplication;
- Promote Climate Change / Greener NHS objectives are built into the development and delivery of our strategies & plans, and leading system wide action on climate change, working with partners to put in place foundations to address climate change risks;
- Promote strategic alignment across decision-making by working with appropriate partners who deliver and commission services for the same population.

1.2 ***Service Planning and Commissioning***

The Committee will approve arrangements and related strategies, plans, policies and procedures on behalf of the Board to ensure that the ICB discharges its statutory and mandated responsibilities and duties with respect to the following operational functions:-

- To lead the ICB's Strategic Commissioning work, ensuring compliance with relevant statutory obligations in assuring all commissioning aspects relating to IFRs, general Security & Policy Management, Strategic Commissioner aspects of IT & Digital transformation and Primary Care management of estate leased by the ICB;
- To seek assurance that appropriate patient & public engagement / involvement is in place and best meets the needs of the population regarding the development / design of services;
- To ensure Commissioning decisions achieve value for money, efficiency and effectiveness in the sustainable use of resources, focus on cost reduction and achieve efficiency targets.

1.3 ***Service Delivery and Transformation***

- To provide Strategic Leadership to facilitate delivery of Strategic Commissioning priorities and outcomes;
- Oversight of Transformation activities, programmes and groups in locally implementing Strategic Commissioning outcomes and priorities set out in SCTC-overseen plans, as agreed for their roles and responsibilities;
- To oversee delivery of all Transformation Programmes, by providing strategic direction, challenge, championing and management of risks against delivery by receipt of exception reports and/or rectification plans, in support of their objectives, as required;
- To have assurance oversight review of Commissioning & Transformation risks / proposals for mitigation, aligned to the ICB Risk Register and System Board Assurance Framework;
- To resolve issues between programmes that need input / agreement to ensure success; by exceptions-monitoring of progress against objectives and benefits realisation metrics;
- To identify strategic integration opportunities between schemes by taking an overview of & demonstrating compliance with strategic planning assumptions / documentation;
- To act as prime vehicle for ICB's statutory duties in involving / engaging the population;
- To assist the Audit Committee / IG, Data & Digital Group in the forward delivery of Programme-related Data & Digital transformation objectives.

1.4 ***Population Health Management (PHM) and Prevention***

The Committee will oversee the ICB / Strategic Commissioner aspects of development of all principal ICB-ICS strategies (to ensure strategic alignment with ICB Commissioning Intentions + Strategic Priorities), meeting the needs of the population and the NHS mandated priorities:-

- To promote engagement to support the delivery of the core strategies, accelerating the delivery of the ICB's strategic aims, objectives and plans with the ambition of driving improvement in quality & safety, strengthen workforce resilience, reduce duplication and drive productivity improvements / cost reductions;
- To promote a system-wide approach and cross functional alignment to the ICB's strategic activities, ensuring effective alignment of strategic activities within the ICSs and their objectives;
- To ensure that the roles and individuals required to support the delivery of agreed strategically focused PHM tasks, projects, work-streams or actions are identified and resourced and that the requirement to provide sufficient resources is understood at all levels;
- To provide strategic oversight of the 5 year Commissioning Plan for health & care services by the ICB, which includes currently delegated to ICB Primary Care services from NHS England; including General Medical Services (GMS), Pharmacy, Optometry & Dentistry and prescribed

Specialised Commissioning services, as well as future flexibility for further areas like Vaccs & Screening (when delegated) and other Specialist Commissioning functions delivered via OPIC, such as Health & Justice;

- To provide oversight of key PHM / Prevention initiatives at ICB-ICS system level, ensuring risks associated with the remit of the Committee are incorporated in the SBAF and the Risk Register as appropriate, and oversight of mitigations / actions on gaps in control is maintained;
- To provide strategic oversight, alignment and scrutiny to the Commissioning Development of all programmes of work, ensuring a Strategic Commissioner focus underpins data & digital, estates, procurement, People & Culture, Primary Care Services, health inequalities, PHM and climate change:-
  - To provide strategic leadership and oversight to ensure that decision-making done by Collaboratives, Places & Neighbourhoods (however arranged) are underpinned by PHM data and intelligence;
  - To ensure data is shared to contribute to a single evidence base across the Collaborative;
  - To align to any Health & Care Senate collaboratively designed clinical care models, ensuring these are tailored to local population need and evidence-based on effective interventions through the wider work of the SCTC;
  - To ensure the effective use of resources, value for money and improved outcomes for our population;
  - To provide strategic leadership for the Population Health, Inequalities & Prevention programmes, and ensuring that decision making is aligned to relevant strategic documents;
  - To oversee NHS services related to Health Inequalities, Prevention and Long-Term Conditions; ensuring that all decisions align with Joint Local Health & Wellbeing Strategies, Health & Wellbeing Boards, etc;
  - To promote joint working arrange and integration of Place Partnerships to enable decisions to be made about allocation / sharing of resources and most suitable delivery models at Neighbourhood - PCN - Place level;
  - To support Quality & Performance Committee (QPC) as Lead Committee, with any Quality-Performance Management implications arising from Commissioning or Transformation matters, by providing escalation & reassurance reports for its lead scrutiny and oversight;
  - To support Finance Committee (FC) as Lead Committee, with any Finance or Financial Management implications arising from Commissioning or Transformation matters, by providing escalation & reassurance reports for its lead scrutiny and oversight.

1.5 ***Commissioning and Contracting Functions***

- To support strategic oversight of contracts / contract variations at Place, Programmes & Provider Collaboratives, with regard to its lead role in Commissioning for any healthcare services by reviewing in-year monitoring reports and assessment of delivery against plans within approved budgets;
- SCTC shall oversee ICB procurement & contracting decisions pre-Board Award, including the timelines for these, ensuring that all Provider Selection Regime (PSR) obligations have been conducted in a manner that meets ICB’s obligations, whilst also delivering best value for patients & taxpayers. The SCTC will link proactively with Finance Committee to ensure that procurement decisions taken are made within financial envelopes;

- Approval of the award of healthcare services procurements, including of extensions of healthcare contracts where there is provision for an extension made within contact terms (there will be separate provision in the Scheme of Financial Delegation for delegated sign off limits for goods & services procurements);
- Approval of ICB policies & procedures to support arrangements for discharging statutory / delegated duties associated with its clinical and non-clinical commissioning functions;
- Approval of the ICB's Commissioning Intentions and proposed plans for service change decommissioning provided these are within the scope of the Joint Forward Plan / 5 Year Commissioning Plan and recommending the ICB's Commissioning Intentions to the Board for approval where these are out of scope of the Joint Forward Plan;
- Arranging for the provision of health services in line with allocated resources by putting contracts and agreements in place to secure delivery of its plan by providers, working where required or established with Local Authority + VCSE partners;
- Approvals in relation to the commissioning and management of Primary General Medical Services, co-ordinating a common approach to the commissioning / delivery / reviews of Primary Medical Services with other health & care bodies where appropriate / permissible;
- Such other ancillary activities that are necessary in order to exercise the Primary Medical delegated functions, including approval of budget plans for managing delegated and strategic management of funds outside approved budget;
- Provide oversight and approval of the arrangements for managing IFRs;
- Provide oversight, assessment and approval of non-financial elements of Business Cases / PIDs that include reference to Commissioned Services – health & non-health;
- Provide oversight to ensure that commissioning decisions remain compliant with the investment requirements of the national Recovery Support Programmes and adhere to the agreed SFC-led process, by considering the Commissioning Prioritisation Framework at least annually, including of any integrated commissioning plans and arrangements.

1.6 ***ICB People & Governance Functions***

- The Committee will link with PCI Committee to ensure that SCTC approvals of commissioning arrangements (inc. related strategies, plans, policies & procedures) ensure that the ICB discharges its statutory responsibilities as an employer and is correctly discharging its statutory responsibilities for involvement of its population in Commissioning / Service Planning & Decision-Making per Public Sector Equality Duty / Equalities Act 2010;
- The Committee will support other lead ICB Board Assurance Committees' assurances of the effective discharge of related Operational Commissioning functions in respect of statutory duties relating to the following:- EPPR & Business Continuity, FTSU, IG & IT / Digital, Health & Safety / Security Management.

1.7 ***Patient Involvement Functions***

- The Committee will approve arrangements and related strategies, plans, policies and procedures on behalf of the Board related to Strategic Commissioning aspects of patient involvement, engagement and consultation.

1.8 The following, aligned Working Groups (Sub-Committees) and any further to be established supporting those, will report into this Committee:-

- ✓ Commissioning Working Group (ICB staff only)
- ✓ Primary Care Commissioning Group (potentially ICB staff only - TBC)
- ✓ Efficiency Oversight Group (ICB staff only)
- ✓ Financial Improvement Group (ICB & ICS membership)
- ✓ Population Health Improvement Group (ICB & ICS membership)
- ✓ Transformation & Digital Group (ICB & ICS membership)

The Chairs of these will be responsible for escalating issues or risks to the Committee.

SCTC and supporting governance structure

ICB only

Strategic Commissioning & Transformation Committee (SCTC)

ICB only

Efficiency Oversight Group

Delivery of agreed efficiency schemes and MTFP targets
Triangulation of System Efficiency Programmes.
Identification of new efficiency opportunities f
Reporting progress of new plans through the PMO Gateway Process

ICB & partners

Financial Improvement Group

Early Year Pipeline development
Prioritisation of high-impact opportunities
Focus on value adding and cost-effectiveness
Share best practice and align approaches
Transparent reporting and insight

ICB only

Commissioning Working Group

5 yr Commissioning Plan
Commissioning operations
Commissioning policy

ICB & partners

Population Health Improvement Group

Popn Health Improvement Plan
Strategy
Prevention
PHM implementation
Place-based Outcome Frameworks
Green/Sustainability

ICB & partners

Transformation and Digital Group

Major transformation programmes inc HTP
Community Transformation Programme
Place & neighbourhood development
Provider Collab programmes
Digital

TBC

Primary Care

Primary care commissioning
Locally Commissioned Services
Improved Access
POD

Phase 1: The agenda of these two groups can be divided into segments according to Place so that providers can attend the relevant discussions

Phase 2: As Place Boards mature, oversight of population health metrics, prevention and neighbourhood health plans can be delegated to Place Boards leaving the SCTC subgroups to oversee Cluster or system level work

Board Assurance Committee
Escalations & Highlights Assurance Report

Report To:	Integrated Care Board
Date:	25 June 2026
Reporting Committee:	Quality and Performance Committees in Common
Date of Meeting:	27.05.26
Meeting Quorate Y/N?	Yes
Presenter:	Cheryl Etches, Non-executive Director and Committee Chairperson
Author:	Vanessa Whatley, Chief Nursing officer, NHS STW

Summary of Key Discussions & Decisions from the Committee Meeting

ALERT – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

- The Diabetes risk (STW) remains the only extreme risk for quality, safety and performance. this particularly relates to uncertainty about risk reduction due to insufficient assurance/data risk reduction due to insufficient assurance/data around primary care 8 care processes. The Cardiovascular, Renal, and Metabolism (CVRM) Strategy is currently in the process of approval and will support on going data and assurance.
- An Ophthalmology waiting list backlog at UHDB has been noted to be causing prolonged waits affecting Staffordshire residents. Harm is currently unqualified due to limited data due to associate commissioning arrangements. The risk is currently being scoped and data sought though NHS Derby and Derbyshire ICB.
- Mental Health pressures are resulting in increased out-of-area placements, this is being addressed though subcontracted arrangements with provider organisations, and the development of long-term strategic plans in the cluster.
- Infant mortality is previously reported as is higher than national average in Staffordshire and Stoke-on-Trent and is being addressed though a collaborative system steering group. Child death oversight panel arrangements have been strengthened across the cluster so that improved public health themes can be identified for action.

ADVISE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

- This Committee was the first Quality and Performance Committee in Common for STW and SSOT.
- The Committee remains focussed on improving the overall quality of assurance presented at the Committee with movement toward single cluster-wide risk narrative and improved consistency of risk management.
- Terms of reference were presented and agreed at the meeting.
- A revised Performance & Assurance Framework (2026/27) was discussed with clear separation of delivery and assurance and the introduction of exception reporting and triangulated data approach. This supports the NHS Oversight Framework 2026/27 and local areas where additional quality or performance assurance is required.

ASSURE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

- Urgent & Emergency Care (UEC) risk has reduced from extreme (20) to high (16) in STW sustained overall STW system performance (2025/26) in Ambulance handovers & Category 2 response times.
- Overall improvement was reported in Elective and diagnostic waits, Cancer performance (though 62-day remains challenged), Primary care access and Community waits.
- The completed STW System Integrated Improvement Plan (SIIP) was approved by the Committee, and 2025/6 performance was closed down by the Committee.
- Independent mental health sector oversight (SSOT) was assured as having robust governance arrangements in place, with strong partnership working.
- Mental Health Intensive and Assertive Outreach Self-Assessment Q4 (STW & SSOT) returns were presented, providing assurance of provider mitigations arising from capacity constraints within the nationally proposed intensive outreach model. However potential risk remains under regular review with national oversight of the agenda.

Key Risks & Mitigations (ref. System Board Assurance Framework: SBAF)

Policies & Procedures Approved
N/A

Decisions to be Escalated to ICB Board
N/A

Board Assurance Committee
"Triple A" Escalations & Highlights Assurance Report

Report To:	ICB Boards in Common
Date:	25 June 2026
Reporting Committee:	SSOT ICB People Culture and Inclusion Committee Part B
Date of Meeting:	13th May 2026
Meeting Quorate Y/N?	Yes
Presenter:	Shokat Lal
Author:	Stacey Robinson

Summary of Key Discussions & Decisions from the Committee Meeting

ALERT – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

N/A

ADVISE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

N/A

ASSURE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

The Staffordshire and Stoke-on-Trent ICB's People, Culture and Inclusion (PCI) Committee has currently paused its quarterly meetings in order to form a cluster wide meeting with Shropshire, Telford and Wrekin ICB.

As an interim arrangement to allow for policy amendments to be made where necessary the Staffordshire and Stoke-on-Trent ICB PCI Committee agreed policy updates to four policies, detailed below, virtually. These changes related only to Staffordshire and Stoke-on-Trent at this point in time and are now in line with Shropshire, Telford and Wrekin ICB.

Moving forward, policies will be considered on a cluster wide basis, aligning where possible and governed via the cluster wide meeting.

Key Risks & Mitigations (ref. System Board Assurance Framework: SBAF)

Policies & Procedures Approved

Policy	Changes
Family Leave Policy	Update to special leave (pages 18-19) HR-P-010 Family Leave Policy v5.pdf
Recruitment and Selection Policy	Update to Establishment Control Process (page 7) Update to pre-employment checks (page 9-10) Update to applications made by refugees and asylum seekers (page 10-11) Professional Registration (page 10)

	DBS Checks (page 12-14) HR-P-021 Recruitment Selection Policy v5.pdf
Retirement Policy	Full review and update to Retire and Return (page 13) and Partial Retirement (page 14) HR-P-022 Retirement Policy and Procedure v6.pdf
Mandatory Learning Policy	New national policy HR-P-041 SSOT Mandatory Learning Policy- September 2025 v1.pdf

Decisions to be Escalated to ICB Board
N/A

Board Assurance Committee
“Triple A” Escalations & Highlights Assurance Report

Report To:	ICB Boards in Common
Date:	25.06.2026
Reporting Committee:	ShIPP Joint Committee
Date of Meeting:	16.04.2026
Meeting Quorate Y/N?	Y
Presenter:	Tanya Miles, Shropshire Council, Chief Executive
Author:	Rachel Robinson, Shropshire Council, Executive Director

Summary of Key Discussions & Decisions from the Committee Meeting

ALERT – the “Top 3 Issues” ref. Alignment to ICB Objectives & Core Functions

ShIPP Accelerator Group: ShIPP agreed to escalate the following alerts to the ICB under this item:

- **Diabetes Transformation:** raise the issue of lack of clarity around next steps and request engagement from the SRO of the programme, Lorna Clarson.
- **ICB Management of Change and impact on capacity to support priority programmes**: the committee acknowledged the challenges and agreed to escalate this concern to the ICB
- **Place and Neighbourhood Governance**: agreed to escalate concerns whilst acknowledging that there would be a focussed discussion on Neighbourhoods at the next Integrated Care Board

ADVISE – the “Top 3 Issues” ref. Alignment to ICB Objectives & Core Functions

The Group wished to advise the Board on the following items:

- **National Neighbourhood Health Implementation Programme (NNHIP) update** - despite strong recent progress and relationship-building, delivery is now constrained by a lack of joined-up system direction and a clear digital vision, creating a risk of fragmentation.
- **CVRM Strategy**: an update was given on the cardiovascular, renal and metabolic (CVRM) strategy and delivery plan highlighting a multi-morbidity approach to cardiovascular risk and changing population risk profiles.
- **SaTH/ShropCom Group transformation**: an overview was given of the newly formed Shropshire, Telford and Wrekin Community and Hospitals NHS Group and what it is intended to achieve. The Chair noted the need to reset ShIPP’s role, membership and purpose, with a focus on becoming a decision-making forum. There were also discussions on increasing the pace of delivery in Shropshire and not being held back by different rates of development in other parts of the system.

ASSURE – the “Top 3 Issues” ref. Alignment to ICB Objectives & Core Functions

Assure - positive assurances and highlights of note were given on

- **ShIPP Prevention Funding**: an update was given on the prevention fund, now moving into mobilisation. Delivery will be coordinated through a pillar model to reduce duplication and maximise impact.
- **Shropshire Council Corporate Plan:** a presentation was given on the plan, which is designed as an overarching framework that reflects current financial constraints, while still setting out clear ambitions and priorities.
- **Place Universal Bid:** an update was given on the Place Universal (Sport England / Energize) investment for Shropshire.

Key Risks & Mitigations (ref. System Board Assurance Framework: SBAF)

Policies & Procedures Approved

It was agreed that updates on the CAMHS contract would now go to the ShIPP Accelerator group.

Decisions to be Escalated to ICB Board

Discussions were had around the alerts which the committee decided to escalate to the ICB Board:

- **Diabetes Transformation:** raise the issue of lack of clarity around next steps and request engagement from the SRO of the programme, Lorna Clarson.
- **ICB Management of Change and impact on capacity to support priority programmes**: the committee acknowledged the challenges and agreed to escalate this concern to the ICB
- **Place and Neighbourhood Governance**: agreed to escalate concerns whilst acknowledging that there would be a focussed discussion on Neighbourhoods at the next Integrated Care Board.

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

Board Assurance Committee
"Triple A" Escalations & Highlights Assurance Report

Report To:	ICB Boards in Common
Date:	25 June 2026
Reporting Committee:	Telford and Wrekin Integrated Place Partnership (TWIPP)
Date of Meeting:	08-06-2026
Meeting Quorate Y/N?	Y
Presenter:	David Sidaway Chief Executive TWC / Chair of TWIPP
Author:	Louise Mills Neighbourhood Health Lead (TWC / ICB)

Summary of Key Discussions & Decisions from the Committee Meeting

ALERT – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

The TWIPP Committee reviewed the emerging Neighbourhood Health system architecture report and proposed delivery model, aligned to national policy and the ICBs 5-year Strategic Commissioning intentions.

The Committee supported the development of a single, integrated system vision and delivery model for neighbourhood health.

Assurance was provided that a clear operating model is being established, with defined roles for the ICB as strategic commissioner, Place-based Partnerships (including TWIPP) as delivery and oversight bodies, and neighbourhoods as the primary unit for integrated, population-focused care.

The Committee agreed a set of priority themes for the TWIPP Neighbourhood Health Implementation Plan and received updates from ST&W Community & Hospitals Group, MPFT and RJAH on their progress towards delivering neighbourhood community care shift.

ADVISE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

The Committee agreed the following themes as a framework for the TWIPP Neighbourhood Health Implementation Plan:

1) System leadership and governance
2) Prevention and early intervention
3) Shift from hospital to neighbourhood community care
4) Integration of clinical pathways
5) Digital enablement and shared intelligence
6) Tackle health inequalities through place-based collaboration

All system partners have been involved in the development of the Neighbourhood Health Implementation Plan and partners are currently reviewing the detailed actions in the draft plan. Responsibility for delivery of the implementation plan will sit with the Accelerator Group with assurance reporting to TWIPP.

ASSURE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

ST&W Community and Hospitals Group, MPFT and RJAH demonstrated good strategic and operational progress in delivering neighbourhood health, with a clear shift from hospital-based care towards integrated, community-based models.

Progress includes development of Integrated Neighbourhood Teams; Health Visitor and Speech & Language Therapy involvement on the Best Start in Life agenda; the phased development of Mental Health Neighbourhood Centres; expansion of community and assertive mental health outreach services; MSK transformation and self-management and strengthened partnership working across primary care, local authority and VCSE sectors.

Key Risks & Mitigations (ref. System Board Assurance Framework: SBAF)

Policies & Procedures Approved

N/A

Decisions to be Escalated to ICB Board

TWIPP is requesting that agreement on governance and delegation is accelerated by the ICB to enable progress on neighbourhood health implementation to progress more rapidly.

Board Assurance Committee
"Triple A" Escalations & Highlights Assurance Report

Report To:	ICB Boards in Common
Date:	25th June 2026
Reporting Committee:	Staffordshire and Stoke on Trent Health and Care Senate
Date of Meeting:	9th April 2026
Meeting Quorate Y/N?	Y
Presenter:	Dr Rachel Gallyot, Chief Medical Officer and H&C Senate Chair
Author:	Dr Rachel Gallyot, Chief Medical Officer and H&C Senate Chair

Summary of Key Discussions & Decisions from the Committee Meeting

ALERT – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

None.

ADVISE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

1) Integrated Medicines Optimisation Group (IMOG) Approvals February 2026

The Senate received an update of the decisions from the IMOG meeting held on 4th February 2026.

a) IMOG discussed several NHS Funded NICE TAs and approved them for inclusion on the formulary as RED drugs, for specialist prescribing only. There was one ICB funded drug, Delgocitinib, for severe chronic hand eczema. In Staffordshire and Stoke on Trent (SSoT) there are IFPS arrangements in place, which means that the budget for that would be met by the acute Trust. Delgocitinib has only been approved by NICE if the company provides it at an agreed price and that price is only available to Trusts, which is why it is RED on the formulary for specialist prescribing only.

b) The palliative care section of the formulary was reviewed, and updated, to include some additional medications, all of which are existing standard drugs used in palliative care.

c) IMOG approved the 'Oral antipsychotic medication Effective Shared Care Agreement (ESCA) - for adults with a Learning Disability (LD) whose Behaviour Challenges', which was proposed by Midlands Partnership University Foundation Trust (MPFT) and North Staffordshire Combined Healthcare Trust (NSCHT). As this is not a mental health condition, and is to manage behaviour, it is classed as 'off label' which is supported by NICE and the Royal College of Psychiatrists. Prescribing and monitoring will be undertaken in primary care, as part of the Learning Disability Annual Health Checks, which align with the monitoring requirements for antipsychotic drugs.

d) IMOG approved the 'Quick Reference Guide - Prescribing Requests from Out of the Area Scenario Guide'. Different systems have different formularies, and the guide provides GPs with advice for scenarios when the RAG rating of a drug is different to ours and provides different scenarios which are largely based on instances when GPs are asked to prescribed products that would not normally be prescribed in primary care (e.g. low priority medicines or specialist only medicines) or would not be prescribed without the support of a specialist in SSOT.

In response to comments/questions from the Senate the following clarification points were provided: -

- The lead commissioner in the Quick Reference Guide refers to the fact that the RAG rating of the ICB, which commissions the hospital, should be honoured, when patients are seen outside of their system.
- There is a clear expectation to minimise the use of antipsychotics in people with learning disabilities, supported by initiatives such as the STOMP agenda, and the ESCA makes it clear

that antipsychotic treatment should only be initiated, when non-pharmacological interventions have been unsuccessful. AM added that the ESCA strengthens safety and governance and formalises the commitment between the GP, and the consultant, to ensure regular review of patient care and provides a safer and more structured framework.

- The Quick Reference guidance provides sensible options and support to GPs in challenging some of the out of area prescribing recommendations.

The Senate **approved** IMOG decisions (a)–(d) from the IMOG meeting held on 4th February 2026.

ASSURE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

None.

Key Risks & Mitigations (ref. System Board Assurance Framework: SBAF)

Policies & Procedures Approved

None.

Decisions to be Escalated to ICB Board

☑ The Senate **approved** IMOG decisions (a)–(d) from the IMOG meeting held on 4th February 2026.

Board Assurance Committee
"Triple A" Escalations & Highlights Assurance Report

Report To:	ICB Boards in Common
Date:	25th June 2026
Reporting Committee:	Staffordshire and Stoke on Trent Health and Care Senate
Date of Meeting:	14th May 2026
Meeting Quorate Y/N?	Y
Presenter:	Dr Rachel Gallyot, Chief Medical Officer and H&C Senate Chair
Author:	Dr Rachel Gallyot, Chief Medical Officer and H&C Senate Chair

Summary of Key Discussions & Decisions from the Committee Meeting

ALERT – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

None.

ADVISE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

1) Integrated Medicines Optimisation Group (IMOG) Approvals March 2026

The Senate received an update of the decisions from the IMOG meeting held on 4th March 2026.

a) IMOG discussed 5 NHS Funded NICE TAs and approved them for inclusion on the formulary as RED drugs for specialist prescribing only.

b) IMOG approved the change of formulary status of Mounjaro (Tirzepatide) to GREEN to enable general practice to prescribe Mounjaro in line with the NHSE Quality Outcome Framework (QOF) expectations. The existing hubs are working through their current patient workload and, when the patients are stable on treatment, or decide to come off treatment, they will be transferred into general practice.

c) National Ophthalmology Pathways are available, for the use of biological anti-vascular endothelial growth factor treatments, for conditions like Wet AMD. UHNM have confirmed that they are adopting those pathways and that all national requirements will be met. This item is presented for information.

Questions were raised by the Senate in respect of **item b)**. In response to comments/questions from the Senate the following clarification points were provided: -

- Templates and the local Quality Improvement Framework will be utilised to ensure that practices are adhering to the cohort requirements set by NHSE.
- The ICBs interpretation of the Quality and Outcomes Framework (QOF) is that practices should be providing weight loss treatment. A survey has been completed, the results of which will inform the ICB if practices will not be participating and that money can be reinvested, into establishing hubs that can provide the service.
- If the full demand for cohort 1 and 2 were met, then that would cost between £6m and £7m per year and this cost would increase as further cohorts join over the years. The cost is on the risk register, as initial implementation funding provided by NHSE, does not meet the full cost.
- Whilst it is expected that there will be huge savings longer term, any savings will be difficult to demonstrate during the initial few years.

The Senate **approved** IMOG decisions (a)–(b) from the IMOG meeting held on 4th March 2026. There was no representation from Adult Social Care present at the meeting. This approval will be sent to a representative from Adult Social Care for ratification.

2) Hybrid Closed Loop (HCL) Policy
National guidance was released in December 2023 for NICE TA 943, which had to be implemented by April 2024. It was a 5-year programme so a pan-Staffordshire working group was established and an implementation and mobilisation plan was approved by all parties. In the first year the priority patients were determined by NHSE and included children and young people, people already on insulin pumps and people who are pregnant or trying to get pregnant. It was agreed that Blueteq would be utilised to monitor funding arrangements because there was reimbursement for new starters. The aim of the policy is to ensure equity of access, consistency and clarity and it has been developed jointly by ICB and providers. NHSE have asked ICBs to identify priority cohorts going forward, to the end of the implementation plan, and these cohorts have been agreed by clinicians, from within the system and neighbouring systems. The policy includes young people up age 18.

In response to comments/questions from the Senate the following clarification points were provided: -

- The Senate highlighted the positive impacts on people's lives and benefits in terms of control and their outcomes.
- The Senate is not an assurance board and will be approving the Policy from a clinical perspective.
- A Quality Impact Assessment (QIA) and Equality Impact Assessment (EIA) have been completed and there has been patient and public involvement throughout the development of the policy.
- The priority groups have been designed by clinicians based on what is safest and most needed.
- The policy is implemented in prisons by secondary care.
- The planning of pregnancy is assessed by asking questions at the annual reviews around whether people are thinking of conceiving in the next 6 months as it is important to try and optimise control with both Type 1s and Type 2s.

The Senate clinically **approved** the Hybrid Closed Loop (HCL) Policy. There was no representation from Adult Social Care present at the meeting. This approval will be sent to a representative from Adult Social Care for ratification.

These items for approval were sent to Adult Social Care for ratification and were **ratified** by Ian Clarke of Stoke City Council on 22/05/2026.

ASSURE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

None.

Key Risks & Mitigations (ref. System Board Assurance Framework: SBAF)

Policies & Procedures Approved

The Senate clinically **approved** the Hybrid Closed Loop (HCL) Policy.

Decisions to be Escalated to ICB Board

☑ The Senate clinically **approved** the Hybrid Closed Loop (HCL) Policy.
☑ The Senate **approved** IMOG decisions (a)–(b) from the IMOG meeting held on 4th March 2026.