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

NHS Shropshire, Telford and Wrekin and NHS Staffordshire and Stoke-on-Trent Boards in Common

24th September 2026

Agenda

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

1.00pm on Thursday, 24th September 2026
Newcastle Suite, The Beaconside Group, Stafford Enterprise Park, Weston Road, Stafford, Staffordshire, ST18 0BF

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

	Agenda Item	Lead	Purpose	Format	Time
Welcome and Opening Matters					
1.	Welcome and Apologies	Chair	I	Verbal	1.00
2.	Leadership Compact	Chair	A	Enc.01	
3.	Declarations of Interest	Chair	A	Verbal	
4.	Minutes of the previous meeting/s	Chair	A	Enc.02	
5.	Matters arising and meeting action list from previous Meetings	Chair	D	Enc.03	
6.	Questions submitted by members of the public in advance of the meeting	Chair	I	Verbal	1.05
Resident's Experience					
7.	Digitalisation of Diabetes Care	Dr Lorna Clarson	D	Enc.04	1.10
Strategic Development and Oversight					
8.	Chair's Report	Ian Green OBE	I	Enc. 05	1.30
9.	Chief Executive's Report	Simon Whitehouse	I	Enc.06	1.40
10.	Commissioning Board Assurance Framework (CBAF) and Risk Management Report	Mish Irvine	A/S	Enc.07	1.50
11.	NHS Shropshire, Telford and Wrekin 2025/26 Annual Report and Accounts	Ian Green OBE	S/I	Enc.08	2.05
12.	NHS Staffordshire and Stoke-on-Trent 2025/26 Annual Report and Accounts	Ian Green OBE	S/I	Enc.09	2.10

13.	5 Year Strategic Commissioning Plan Delivery	Dr Lorna Clarson	S/I	Enc.10	2.15
Break					**3.00**
14.	Cluster Winter Plan 2026/27 and Board Assurance Statement	Phil Smith	A/S	Enc.11	3.10
15.	Decision-making business case for birthing services previously provided at County Hospital, Stafford and Samuel Johnson Community Hospital, Lichfield	Vanessa Whatley	A	Enc.12	3.20
Governance and Performance					
16.	Integrated Performance Assurance Report	Claire Skidmore	S/R	Enc.13	3.40
17.	Joint Remuneration Committee 'Triple A' Highlight Report	Shokat Lal	S/I	Enc.14	3.50
18.	Audit Committee in Common 'Triple A' Highlight Report	Roger Dunshea	S/I	Enc.15	3.55
19.	Joint Finance Committee 'Triple A' Highlight Report	Mike Lawton	S/I	Enc.16	4.00
20.	Joint Strategic Commissioning & Transformation Committee 'Triple A' Highlight Report	Prof Trevor McMillan OBE	S/I	Enc.17	4.05
21.	Joint Quality and Performance Committee 'Triple A' Highlight Report	Cheryl Etches OBE	S/I	Enc.18	4.10
22.	Joint People, Involvement and Inclusion Committee 'Triple A' Highlight Report	Shokat Lal	S/I	Enc.19	4.15
23.	Shropshire Place Partnership Committee 'Triple A' Highlight Report	Rachel Robinson	S/I	Enc.20	4.20
24.	Telford & Wrekin Place Partnership Committee 'Triple A' Highlight Report	David Sidaway	S/I	Enc.21	4.25

25.	Staffordshire & Stoke-on-Trent Health and Care Senate 'Triple A' Highlight Report	Dr Salma Reehana	S/I	Enc.22	4.30
26.	Stoke-on-Trent Place Board 'Triple A' Highlight Report	Phil Smith	S/I	Enc.23	4.35
Any Other Business					
27.	Items notified in advance to the Chair	Chair	D	Verbal	4.40
28.	Review of new or amended risks following discussions in the meeting	Chair	D/A	Verbal	4.45
29.	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	4.50
30.	Date and time of next meeting:	Chair	I	Verbal	4.55
Meeting Closed					

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

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

Enclosure No: 01

Cluster Leadership Compact

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

Respect, Inclusion and Compassion

- Value all partners equally
- Listen actively and seek to understand different perspectives
- Treat one another with kindness, empathy and respect

Openness, Honesty and Psychological Safety

- Be open about what we can deliver
- Foster psychological safety and constructive challenge
- Share knowledge, insight and expertise freely

Trust and Integrity

- Act as trusted partners and do what we say
- Act with integrity, transparency and consistency
- Build trust through openness and mutual support

Courage, Ambition and Shared Risk-Taking

- Be ambitious and pursue new ideas
- Make difficult decisions together
- Adapt course collectively when evidence requires

Collaboration and System-First Leadership

- Prioritise system outcomes over organisational interests
- Use resources responsibly and collectively
- Present a united approach to communities and partners

Leading by Example

- Model collaborative leadership
- Champion integrated working
- Encourage and empower colleagues and partners

Consistency, Accountability and Shared Stewardship

- Apply shared standards fairly
- Hold ourselves and others to account
- Maintain a solutions-focused attitude

Forward Focus, Innovation and Constructive Challenge

- Focus on possibilities not past barriers
- Stay optimistic and committed to improvement
- Challenge constructively and resolve conflict openly

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

Enclosure No: 02

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	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 CBE (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 (IG)	Chair (Meeting Chair), NHS STW & NHS SSOT
Prof. Trevor McMillan OBE	Non-Executive Member, NHS STW

Shokat Lal (SL)	Non-Executive Member, NHS SSOT
Joanne Williams (JW)	Trust Partner Member and Chief Executive Officer, The Shrewsbury and Telford Hospital NHS Trust and Shropshire Community Health NHS Trust
Patrick Flaherty (PF)	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.

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

ICB Master COI Register - 2026

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

NHS Shropshire, Telford and Wrekin
NHS Staffordshire and 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, 25 June 2026 at 13:30
Virtually via Teams

Present:

Ian Green OBE (IG)	Chair (Meeting Chair), NHS STW & NHS SSOT
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 & SSOT
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 (SC)	Trust Partner Member and Chief Executive, University Hospitals of North Midlands
Mish Irvine (MI)	Chief of Staff, NHS STW & NHS SSOT
Jon Rouse CBE (JR)	Local Authority Partner Member and Chief Executive Officer, Stoke-on-Trent City Council
Phil Smith (PS)	Chief Officer for System Development and Integration, NHS STW & NHS SSOT
Prof Trevor McMillan OBE (TM)	Non-Executive Member, NHS STW
Shokat Lal (SL)	Non-Executive Member, NHS SSOT
Joanne Williams (JW)	Trust Partner Member and Chief Executive Officer, The Shrewsbury and Telford Hospital NHS Trust and Shropshire Community Health NHS Trust

In Attendance:

Duncan Spilsbury (DSY)	Presenter, Resident Experience
Lynn Cawley (LCY)	Participant Member and Chief Officer, Healthwatch Shropshire
Dr Tony Ahmed (TA)	Participant Member, Dentistry, NHS STW and SSOT

Paul Edmondson-Jones (PEJ)	Transition Director, NHS SSOT
Clare Trenchard (CT)	Participant Member, Healthwatch Staffordshire
Katie Weston (KW)	Emergency Preparedness Resilience and Response (EPRR) Strategic Lead, NHS SSOT
Ruth Beard (RB)	Project Manager, NHS SSOT
Adele Edmonson (AE)	Head of Communications and Involvement, NHS STW & SSOT
Hayley Allison (HA)	Director of Place, NHS SSOT
Steve Fawcett (SF)	Strategic Clinical Director, NHS SSOT
Liz Lockett (LL)	Chief Nurse, Midlands Partnership University NHS Foundation Trust
Paul Winter (PW)	Associate Director of Corporate Governance, NHS STW & SSOT
Laura Case (LCE)	Digital Communications Specialist, NHS STW
Claire Colcombe (CC)	Board Secretary, NHS STW

Apologies:

Neil Carr OBE	Trust Partner Member and Chief Executive Officer, Midlands Partnership University NHS Foundation Trust
Dr. Lorna Clarson	Chief Officer of Strategy and Improving Outcomes, NHS STW & NHS SSOT
Patrick Flaherty	Local Authority Partner Member and Chief Executive Officer, Staffordshire County Council
Tanya Miles	Participant Member and Interim Chief Executive, Shropshire Council
Dr Jessica Harvey	Participant Member, Joint Chair GP Board, Shropshire, Telford and Wrekin
Dr Charlotte Hart	Participant Member, Joint Chair GP Board, Shropshire, Telford and Wrekin

Minute No. ICB-25-06-001 – Welcome & Apologies

001.1 The Chair welcomed members to the meeting. Given the exceptionally warm weather and pressures being experienced across health and care services, it was agreed that the meeting would be held virtually. Apologies for absence were received and noted above.

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Minute No. ICB-25-06-002 – 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-25-06-003 – Minutes from Previous Meetings

003.1 The minutes of the Public Meeting held on 30 April 2026 and the Extraordinary Meeting held on 12 June 2026 were presented for approval.

003.2 Members requested a minor amendment to the April minutes to reflect SC's status as Trust Partner Member rather than a Local Authority Partner Member.

ACTION: *Meeting secretary to amend the April minutes to* reflect *SC's status as an NHS Partner Member*

RESOLVE: **The NHS Shropshire, Telford and Wrekin and NHS Staffordshire, Stoke-on-Trent Cluster Integrated Care Board, subject to the amendment above, APPROVED the minutes of 30 April 2026 and 12 June 2026 as an accurate record.**

Minute No. ICB-25-06-004 – Matters Arising / Actions from previous meeting

004.1 The Board reviewed the action log and received updates on progress against outstanding actions.

004.2 Members noted that actions relating to end-of-life care and neighbourhood development, the Working with People and Communities Strategy, and the joint leadership statement on anti-racism, anti-Semitism and Islamophobia remained open. The Board noted that a future development session would consider end-of-life care and neighbourhood working in more detail. Members also noted that the cluster-wide risk appetite framework had been completed and could be closed, and that a WorkWell Programme update would be received later in the meeting.

RESOLVE: **The NHS Shropshire, Telford and Wrekin and NHS Staffordshire, Stoke-on-Trent Cluster Integrated Care Board noted the progress made against the action log and agreed the actions for closure.**

Minute No. ICB-25-06-005 – Questions from members of the public

005.1 The Board was advised that one public question had been received. A written response would be provided in accordance with the agreed process and published alongside the meeting papers.

Minute No. ICB-25-06-006 – Resident Experience

006.1 VW introduced the resident experience presentation from Duncan Spilsbury, supported by Healthwatch colleagues. Mr Spilsbury described his recent experience of urgent and emergency care, inpatient treatment and subsequent support through the Virtual Ward service. He reflected positively on the care received from clinical teams and praised the support provided through the Virtual Ward following discharge.

006.2 Whilst reflecting positively on the care received, Mr Spilsbury highlighted challenges associated with discharge processes, including delays and communication issues. Members welcomed the balanced feedback and emphasised the importance of learning from lived experience, particularly from vulnerable and seldom-heard groups. The Board acknowledged Healthwatch's ongoing contribution in capturing patient insight and thanked Mr Spilsbury for sharing his experiences.

RESOLVE: **The NHS Shropshire, Telford and Wrekin and NHS Staffordshire, Stoke-on-Trent Integrated Cluster Care Board CONSIDERED Duncan's experience and insights and AGREED to reflect these in the continued development and expansion of the Virtual Ward**

model, including improvements to discharge processes and patient communication; in the context of plans to expand the service to new pathways (including paediatrics).

Minute No. ICB-25-06-007 – Chair's Report

007.1 IG provided an update on matters arising since the previous meeting. Members noted the publication of the Ockenden Review into maternity services and the importance of continuing to learn from findings across the wider NHS.

007.2 The Board also received an update regarding the Board development arrangements, annual appraisal activity and ongoing work supporting the transition towards a Strategic Commissioning model. IG acknowledged the significant challenges presented by the recent period of hot weather and thanked staff and partners for their continued commitment in supporting residents and communities.

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

Minute No. ICB-25-06-008 – Chief Executive Report

008.1 SW presented his report, highlighting progress against national policy developments, the NHS reset programme and emerging proposals relating to the future merger of the two Integrated Care Boards (ICB). Members were advised that engagement continued with local authorities, MPs and wider stakeholders, with formal responses being coordinated through the agreed consultation process.

008.2 Members received updates on leadership changes, including the appointment of Vanessa Whatley as Chief Nursing Officer, and paid tribute to colleagues leaving the organisation, recognising their contribution to the ICBs and wider system. The Board also noted progress in responding to the Lord Mann review, locality and neighbourhood transformation programmes, and priorities including planned care, urgent and emergency care, medicines optimisation and community services. Discussion considered the implications of the national reset programme and ongoing organisational change, with assurance provided that engagement with stakeholders continued throughout the process. Members congratulated colleagues receiving national awards and honours and thanked staff for their continued professionalism during a period of significant change.

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

Minute No. ICB-25-06-009 – EPRR Annual Assurance 2025-26

009.1 PS and KW presented the annual Emergency Preparedness, Resilience and Response (EPRR) Assurance Report. Members noted that Staffordshire and Stoke-on-Trent had achieved a compliance rating of 93.6%, whilst Shropshire, Telford and Wrekin had achieved 91%, representing substantial compliance for both organisations.

009.2 The report outlined continued improvements in governance arrangements, exercising programmes, training compliance and incident management processes. Members discussed preparedness for major incidents, including cyber threats, supplier resilience and the risks associated with prolonged loss of utilities.

009.3 JR sought assurance regarding preparedness for significant disruptive events, including prolonged power outages and cyber incidents. Members were advised that these scenarios formed part of current planning arrangements and future exercising programmes.

009.4 The Boards welcomed the progress made through joint working across the cluster and recognised the significant maturity of EPRR arrangements now established.

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

SSOT ICB Annual EPRR Report (Part 1)

- **NOTED the EPRR resources outlined to support delivery of EPRR and incident response functions**
- **NOTED the cluster EPRR governance alignment with Audit Committee in Common going forwards.**
- **NOTED the 2025 EPRR annual assurance compliance rating of substantial compliance.**
- **NOTED and SUPPORTED the EPRR annual assurance 2026/27 priorities as listed in part 1 section 5.**

STW ICB EPRR Report (Part 2)

- **Were 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.**

STW ICB EPRR and Business Continuity Policy, SSOT ICB EPRR Policy, and SSOT ICB Business Continuity Policy

- **NOTED the minor updates made to the Policies as set out above, to support compliance with the 2026 NHS Core Standards for EPRR, and the intention for all EPRR Policies and associated documentation to be harmonised across the Cluster within the next year.**

Minute No. ICB-25-06-010 – Annual FTSU and Whistleblowing Review (NHSE Report) 2025-26

010.1 MI presented the Annual Freedom to Speak Up and Whistleblowing Review and noted continued development of Freedom to Speak Up arrangements across both organisations.

010.2 Members reviewed themes arising from concerns raised during the year, including organisational culture, management practices and staff wellbeing. Assurance was provided that concerns were managed appropriately, support mechanisms remained in place and themes continued to be reviewed by senior leaders. Members welcomed the ongoing focus on strengthening psychological safety and openness across both organisations.

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

- **Were ASSURED of the Cluster ICBs' proactive and effective FTSU approaches;**
- **NOTED the planned FTSU activities for the forthcoming year.**

Minute No. ICB-25-06-011 – Fit and Proper Person Test annual declarations / attestations

011.1 IG presented the annual report regarding Fit and Proper Person Test declarations and attestations.

011.2 Members noted that all required annual reviews and declarations had been completed and that no issues had been identified which would prevent any Board member from meeting the required standards.

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

- **Were ASSURED that the annual Fit and Proper Persons Test (FPPT) assessment had been completed and that the annual submission will be submitted to NHS England by 30 June 2025 (Appendix 1 &2).**
- **NOTED that the process had 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.**

Minute No. ICB-25-06-012 – The Involvement Strategy (Working with People and Communities)

012.1 MI and AE presented the Working with People and Communities Strategy and supporting delivery plan. Members noted that the strategy had been developed jointly across the cluster and provides a framework for strengthening community involvement, supporting co-production and meeting statutory public involvement responsibilities.

012.2 Members welcomed the strategy and emphasised the importance of meaningful, inclusive engagement that is clearly linked to decision-making. Discussion highlighted the need to reduce duplication, demonstrate the impact of community feedback, avoid engagement fatigue and ensure that seldom-heard voices inform commissioning decisions. The Board welcomed the strategy's alignment with the transition to strategic commissioning and received assurance regarding future delivery arrangements

ACTION: *Progress update on delivery of the Working with People and Communities Strategy to be presented to a future Board meeting.(MI/AE)*

RESOLVE: **The NHS Shropshire, Telford and Wrekin and NHS Staffordshire, Stoke-on-Trent Cluster Integrated Care Board APPROVED the ICBs' 'Working with People and Communities Strategy' and ENDORSED the plan for further engagement to shape the delivery plan**

Minute No. ICB-25-06-013 – The PSED reports for the population across the cluster

013.1 MI presented the Public Sector Equality Duty reports for the cluster populations. Members noted progress against statutory responsibilities and reviewed equality data relating to local populations and protected groups.

013.2 Members discussed the importance of using population insight and equality data to inform commissioning decisions and reduce health inequalities. The report was welcomed as providing a stronger evidence base for understanding the needs of diverse communities and ensuring equality considerations remain central to service redesign, transformation and strategic commissioning. Members also noted the alignment between the Equality Objectives and the Working with People and Communities Strategy

ACTION: *Bring item back to September's meeting (MI)*

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

- **Were ASSURED in relation to compliance with the statutory Public Sector Equality Duty in relation to Patients and Population**
- **APPROVED the proposed joint PSED equality objective – Patients and Population**
- **APPROVED the publication of the full reports on each ICB's respective platforms.**

Minute No. ICB-25-06-014 – Workwell and Widening Access Demonstrator Programme

014.1 MI and RB presented the WorkWell Programme and Widening Access Demonstrator Programme. Members noted the successful award of demonstrator funding and the focus on supporting access to employment and improving outcomes for individuals experiencing barriers to work.

014.2 Members recognised the close relationship between employment, wellbeing and population health outcomes and welcomed the partnership approach being adopted across health, local authority and voluntary sector organisations.

014.3 Members welcomed the opportunities presented by the programme and recognised the strong relationship between good employment, wellbeing and improved health outcomes. Discussion highlighted the importance of supporting individuals facing the greatest barriers to employment and ensuring that learning from the demonstrator programme informs future delivery.

014.4 IG welcomed the partnership approach being adopted and the programme's potential contribution towards reducing health inequalities across local communities.

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

- **NOTED 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**
- **ENDORSED the programme which will focus on strong system partnerships and community engagement**
- **CONSIDERED connections with wider skills, employment and health programmes (local authority partners especially) to align our approaches and better engage and involve our communities.**

Minute No. ICB-25-06-015 – Urgent and Emergency Care – Urgent Treatment Centre Designation

015.1 PS, HA and SF presented the report seeking ratification of Urgent Treatment Centre designations. Members noted the national requirements relating to co-located Urgent Treatment Centres and the work undertaken to ensure local services met the required standards.

015.2 Discussion focused on the benefits associated with improved patient flow, reduced pressure on Emergency Departments and improved access to urgent care services. Members emphasised the importance of clear and consistent public communication regarding service access arrangements.

015.3 Members welcomed the progress made and discussed the importance of ensuring consistent public messaging regarding Urgent Treatment Centres, including how services should be accessed and how they differ from Emergency Departments. Assurance was provided that communication and engagement activity would continue alongside implementation.

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

Minute No. ICB-25-06-016 – Integrated Performance Report

016.1 CS presented the Integrated Performance Report and noted development of the new integrated performance dashboard.

016.2 Members reviewed performance across quality, finance, urgent and emergency care, planned care and mental health services. Positive improvements were noted in a number of areas, including reductions in mental health out-of-area placements and

improving outcomes in relation to infant mortality. Members also noted the development of the integrated dashboard and welcomed the increased alignment of quality and performance reporting arrangements.

016.3 Discussion focused on ensuring performance information remained meaningful and supported effective decision-making. Members welcomed the move towards a more integrated approach and recognised the benefits of considering quality, operational and strategic measures together.

016.4 IG highlighted the importance of maintaining oversight of maternity and neonatal services, particularly in light of recent national reports and reviews. Members agreed that performance reporting should continue to support improvement discussions as well as assurance.

016.5 The Board received assurance regarding organisational performance and welcomed continued refinement of performance reporting arrangements.

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

Minute No. ICB-25-06-017 – 'Triple A' Board Committee Highlights Reports

017.1 **Finance Committee**

ML presented the report. The Board received assurance regarding financial performance and delivery of agreed financial plans. Members noted that financial performance remained on track and that attention continued to focus on delivery of savings programmes whilst maintaining effective partnership working across the system.

017.2 **Transition Committee**

PEJ presented the report. Members noted that three risks remained under close review relating to workforce capacity and organisational resilience, uncertainty surrounding the national merger programme and the ongoing embedding of CSU changes. Assurance was provided that all three risks were reducing, with the remaining significant risk relating to business intelligence arrangements. The Committee would review the transition risk register further at its next meeting.

IG noted that consideration had been given to the future role of the Transition Committee and when responsibilities might transfer into business-as-usual governance arrangements. Members agreed that it was premature to conclude the work of the Committee at this stage and that the position should remain under review.

017.3 **Audit Committee**

RD presented the report. Members were advised that the Committee had reviewed the reports of both the external auditors, Grant Thornton, and the internal auditors, Mersey Internal Audit Agency, in relation to the 2025/26 Annual Report and Accounts.

The Committee had noted a number of learning points arising from the audit process, but no significant concerns were identified. Having considered the assurance provided by both internal and external auditors, the Committee recommended approval of the

Annual Report and Accounts, which were subsequently approved through the agreed governance process.

017.4 **Remuneration Committee**
SL presented the report. The Board noted the report and assurance provided regarding remuneration matters.

017.5 **Strategic Commissioning and Transformation Committee**
TM presented the report. Members noted progress relating to strategic commissioning arrangements, neighbourhood health development and transformation programmes. The Committee had reviewed future proposals relating to neighbourhood health centres and wider service transformation activity. Workforce capacity, organisational resilience and transition-related risks continued to be monitored closely.

RESOLVE: **The NHS Shropshire, Telford and Wrekin and NHS Staffordshire, Stoke-on-Trent Cluster Integrated Care Board RATIFIED the Terms of Reference for the Strategic Commissioning and Transformation Committee.**

017.6 **Quality and Performance Committee**
CE and VW presented the report. The Board received assurance regarding quality and performance oversight. Members noted progress relating to cardiovascular disease prevention, continued reductions in mental health out-of-area placements and improving infant mortality performance across parts of the system. The Committee remained focused on maintaining oversight of key quality indicators and areas requiring further improvement.

Members also noted discussions regarding maternity and neonatal services, including ongoing assurance activity in relation to recommendations arising from the Ockenden Review and associated improvement programmes.

017.7 **People, Culture and Inclusion Committee**
MI presented the report. Members noted oversight of equality, inclusion and workforce priorities, including consideration of the Equality Objectives and Working with People and Communities Strategy. The Committee confirmed that no matters required escalation to Board.

017.8 **Shropshire Place Partnership Committee**
The Board received the report and were assured regarding Place Partnership activity and progress against local priorities.

017.9 **Telford and Wrekin Place Partnership Committee**
DS presented the report. Members noted progress relating to neighbourhood development and the Committee's request for accelerated delegation arrangements to support implementation of neighbourhood health initiatives. Assurance was provided regarding ongoing partnership working across the Place.

017.10 **Staffordshire and Stoke-on-Trent Health and Care Senate**

RG presented the report and highlighted the approvals made through the Integrated Medicines Optimisation Group (IMOG). Members were advised of changes to prescribing arrangements, enabling General Practitioners to prescribe in line with the updated Corfield recommendations, thereby supporting improved access to treatment for patients.

Members also noted the approval of the Hybrid Closed Loop Policy for diabetes services. Assurance was provided that implementation of the programme was progressing successfully, with rollout taking place over a five-year period using a clinically prioritised approach to ensure patients with the greatest need benefit first.

017.11 Members also noted ongoing work in response to the national review of Child Sexual Exploitation, including significant information requests being coordinated across partner organisations. The Boards acknowledged the scale of the exercise and the requirement to work closely with local authority partners.

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

- **NOTED the reports and verbal updates received from the Board Committees and Place Partnership Committees;**
- **Received ASSURANCE regarding the effectiveness of the governance, performance, quality, finance and transition arrangements in place across the Cluster; and**
- **APPROVED and RATIFIED the recommendations presented by the Committees, as set out in the reports submitted.**

Minute No. ICB-25-06-018 – Any Other Business

018.1 Members noted receipt of a petition concerning the future of Leek Minor Injuries Unit, which had been managed in accordance with established procedures.

018.2 No further items of business were raised.

Minute No. ICB-25-06-019 – Review of New or Amended Risks Following Discussions During the Meeting

019.1 The Boards reviewed matters arising during the meeting and considered whether any new strategic risks had been identified.

019.2 No new risks or amendments to existing strategic risks were proposed.

Minute No. ICB-25-06-020 – Meeting Effectiveness

020.1 Members reflected on the effectiveness of the meeting and discussed opportunities to maximise time available for discussion and challenge. Several Members noted the value of paper-based discussions and agreed that future agendas should focus on strategic debate and assurance rather than presentation-led items wherever possible.

020.2 The Boards reflected positively on the resident experience presentation and the value of hearing directly from people using services.

RESOLVED: The Boards noted the reflections and learning identified.

16:10 – Meeting Closed

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

Enclosure No: 03

Board in Common Action Log

Minute ICB 29-01.008 – Residents/Community Story: End of Life Care
Meeting: 29 January 2026
Action: Provide an update on end of life care and neighbourhood development at a future public Board meeting.
Responsible officer: Simon Whitehouse, Chief Executive Officer
Due: Complete
Update: An update is included within the Delivery Review paper on the agenda.

Minute ICB-26-04-015 – 'Triple A' Board Committee Highlights Reports
Meeting: 30 April 2026
Action: Finalise and publish a joint leadership statement on anti-racism, anti-Semitism and Islamophobia, with co-signature from system leadership.
Responsible officer: Mish Irvine, Chief of Staff
Due: November 2026
Update: Work is ongoing through the Cluster EDI Group, comprising EDI Leads and supported by the Chief People Officers. Both organisations have anti-racist statements in place, alongside local actions to support belonging and inclusion. Following the change in the role of the ICB, Chief People Officers are leading work to support continued collaborative working on inclusion for both the workforce and citizens. Current areas of focus include race, religion, sexual safety and gender. The group will agree areas for system collaboration on joint programmes, building on the system-led anti-racism programme, with a further update to be provided later in the year.

Minute ICB-25-06-003 – Minutes from Previous Meetings
Meeting: 25 June 2026
Action: Amend the April minutes to reflect SC's status as an NHS Partner Member.
Responsible officer: Meeting Administrator
Due: Complete
Update: Previous minutes have been amended.

Minute ICB-25-06-012 – The Involvement Strategy (Working with People and Communities)
Meeting: 26 June 2026
Action: Provide a progress update on delivery of the Working with People and Communities Strategy at a future Board meeting.
Responsible officer: Mish Irvine, Chief of Staff
Due: January 2027
Update: The update will be provided in line with the timeline for completion of the ICB commissioning intentions and strategic plans, ensuring that the focus is on areas of highest need.

It will also be linked to the PSED-focused commissioning intentions being developed by the Cluster.

Minute ICB-25-06-013 – PSED Reports for the Population Across the Cluster
Meeting: 27 June 2026
Action: Bring an update back to the September Board meeting.
Responsible officer: Mish Irvine, Chief of Staff
Due: September 2026 (due date to be amended to January 2027)
Update: An update has been provided in the September 2026 CEO Board Report. A further update will be provided to the January Board, with the work directly linked to delivery of the commissioning intentions and ICB strategic plans.

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

Enclosure No: 04

Report to:	Integrated Care Boards in Common
Date:	24 September 2026
Title:	Resident's Experience - Digitalisation of Diabetes Care
Presenting Officer:	Lorna Clarson, Chief Officer - Strategy and Improving Outcomes
Author(s):	Imogen Hyde

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

Appendices:	None

Purpose of the Paper:

To provide background information about MyHealthKits ahead of the video presentation at the Board meeting.

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

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

MyHealthKits is a low-cost, home-based self-care intervention developed with patients and clinicians across Staffordshire and Stoke-on-Trent, to strengthen diabetes care in the community. The Diabetic Wellness Kit combines assistive products, education, and digital support to help people check, protect, and care for their feet at home. This presentation to the Board will highlight the positive impact these kits have had to diabetic patients in Staffordshire and Stoke-on-Trent.

Recommendations:

☐ The report is presented to Board for **DISCUSSION.**

Impact Assessments:					
	Completed?			If N - N/A, Rationale	If Y, Outcome / Date Reported & Signed off
Data Protection Impact Assessment (DPIA)	Yes	No	N/A	Click or tap here to enter text.	*Reported to IG Committee:* Click or tap to enter a date.
	☐	☐	☒		
Integrated Impact Assessment (IIA)	Yes	No	N/A	Click or tap here to enter text.	*Outcome and date of completion:* Click or tap here to enter text.
	☐	☐	☒		

Is the decision within Scheme of Financial Delegation (SOFD) powers & limits	Yes	☒	No	☐
Any potential / actual Conflict of Interest?	Yes	☐	No	☒
N/A	*N/A*			

Integration with Commissioning Board Assurance Framework (CBAF)			
CBAF1	☐	CBAF4	☐
CBAF2	☐	CBAF5	☐
CBAF3	☐	CBAF6	☐

Resident's Experience - Digitalisation of Diabetes Care

1. Introduction

1.1. MyHealthKits are practical wellness kits designed to help people manage their health with more confidence at home. Over the past five years, the company have worked with patients, clinicians, researchers, nurses and physiotherapists in Staffordshire and Stoke-on-Trent to create kits that fit real life. Each kit brings together simple tools, trusted health information, clear video support and easy to use resources. The aim of MyHealthKits is simple: to help people take small, manageable steps that support their health, independence and everyday wellbeing.

2. The story

2.1. In this video, local residents from Hanley share their experiences of using the kits and the difference they have made to their lives:
https://youtu.be/nVAOLtegUeo?si=SxCiNXeQD3FwF-L5

2.2. MyHealthKits was created to address a familiar NHS problem with costly consequences: people with long term conditions are expected to self-manage at home, yet many do not have the practical tools, confidence, or accessible guidance to do this well. In Staffordshire and Stoke-on-Trent, the need was particularly clear for type 2 diabetes. Only 14% of newly diagnosed patients attended structured diabetes education in 2021. Annual foot checks had fallen to 46% during recovery from the pandemic and were still only 78% in 2022 to 2023. Completion of all eight NICE care processes was 55.7%. At the same time, 150 diabetes related lower limb amputations between 2017 and 2023 cost the system more than £2.4 million, alongside major consequences for patients' independence, emotional wellbeing, and quality of life.

2.3. MyHealthKits shifts part of diabetes prevention and foot surveillance from clinic dependence to supported self-care at home through structured patient facing intervention that combines practical assistive products, clear education, and digital support.

2.4. The model was co-created with patients and clinical practitioners, then tested in socio-economically deprived community settings in Stoke-on-Trent and Newcastle under Lyme, where 617 kits were distributed through 22 community events and general practice routes. This early work showed high regular use, strong confidence gains, and clear qualitative evidence that the kits improved independence and motivation. The diabetic kit was then refined and taken into a formal Integrated Care System service evaluation funded through the Health Technology Adoption and Acceleration Fund. It was implemented across 13 general practices in three Primary Care Networks. In short, this moved from community proof of concept to structured system evaluation while staying focused on the same aim: practical community care that prevents harm before people reach hospital.

3. Collaboration

3.1. Patients, service users, carers, and communities were not passive recipients. Their involvement was integral to both design and delivery. In the early phase, kits were distributed

through 22 local community events in collaboration with community leads, primary care networks, and support services. People were able to select the kit that best matched their needs, with additional guidance from healthcare professionals when they had multiple conditions. The published research showed that this mattered: self-selection promoted autonomy, personalised use, and stronger engagement, while analysis identified four consistent themes across users' experiences: personalised use, greater self-efficacy, honest identification of barriers, and wider health promotion through community networks and households.

3.2. Delivery depended on contributions from staff across various stakeholders and system leadership. This project involved Staffordshire and Stoke-on-Trent ICS, 13 general practices across three primary care networks, community nursing and long-term conditions teams, and Health Innovation West Midlands. Earlier deployment also involved Wavemaker CIC, Stoke-on-Trent City Council through the Community Renewal Fund and social prescribers within general practice teams. This included flexible delivery routes for vulnerable groups, where clinical or support teams distributed kits directly to service users when that was more appropriate and equitable than expecting attendance at an event.

3.3. Working across organisational boundaries achieved reach and credibility that no single service could have delivered alone. Community and voluntary sector partners helped engage people across the local population, including older adults, people with disabilities, and people less likely to access traditional health support. Primary care networks helped identify and reach eligible patients through practice held diabetes registers, posters in surgeries, and direct text message outreach. Community teams linked the intervention to real care pathways. Academic partners ensured robust evaluation. Together, these partners turned a set of simple products into a scalable neighbourhood care model that was evidence-based, practical, and acceptable to patients in real NHS settings.

4. Impact

4.1. MyHealthKits' impact is strongest in three areas: better outcomes for patients, clear value for the NHS, and a practical model that reduces avoidable demand outside hospital settings. In this project, 782 diabetic wellness kits were distributed. Of these, 128 participants completed baseline and 12-week follow-up questionnaires and formed the matched analysis cohort. Mean EQ 5D utility scores, a measure of health-related quality of life, improved from 0.61 at baseline to 0.70 at 12 weeks, a change of 0.09 which the evaluation describes as clinically meaningful. Sixty five percent of matched respondents improved over the follow up period.

4.2. These results mattered because they reflected more than a score. Participants described being better able to inspect their feet, establish daily foot care routines, improve comfort, and act earlier when something changed. Qualitative findings showed that the kit supported confidence, independence, and motivation, with people integrating checks and care into daily life. Earlier published work also showed high use of diabetic foot care items, with moisturising cream used by 95% of respondents, magnifying glass by 82%, diabetic socks by 78%, and 92.5% saying they felt more confident managing their health at home. Recipients reported checking their feet more often, softening hard skin, improving comfort when walking, and being better able to inspect areas they could not previously see.

4.3. Self-reported healthcare use fell across all measured categories in the matched cohort. Face-to-face GP appointments fell from 194 to 139, GP telephone or online contacts from 110 to 76,

face-to-face nurse or podiatry contacts from 194 to 96, outpatient appointments from 115 to 67, A&E visits from 33 to 22, and inpatient episodes from 9 to 3. Using published NHS unit costs, the evaluation estimated a total cost reduction of £36,863 over 12 weeks, equal to £288 per patient. Even when inpatient episodes were excluded, the adjusted saving was £23,789, or £186 per patient. For a low-cost home-based intervention, this is a substantial finding for NHS services under pressure.

5. Scale

5.1. The model was first deployed in deprived communities in Stoke-on-Trent and Newcastle-under-Lyme, where 617 kits were distributed through 22 community events and general practice channels. It then progressed to a formal Staffordshire and Stoke-on-Trent ICS evaluation of the Diabetic Wellness Kit, implemented across 13 general practices, with 782 kits distributed.

5.2. Learning has been shared through multiple routes. Firstly, the model has been described in peer reviewed outputs. The 2023 Journal of Integrated Care paper reported positive feedback from 100 recipients across four kit types and showed that simple assistive products can improve self-care and independence. The 2025 Preventive Medicine paper analysed 617 kit distributions and 223 follow up interviews, showing that over 90% of users reported regular use and improved confidence, and identifying the behavioural mechanisms that supported self-management. Second, the ICS evaluation produced a formal implementation and evaluation report for NHS stakeholders, setting out methods, outcomes, cost estimates, and recommendations for wider rollout.

6. Sustainability

6.1. MyHealthKits was designed for sustainability from the outset. It uses simple, readily available products rather than specialist technology, and it fits into existing primary and community care pathways rather than requiring a separate service. In this project, the kits were assembled centrally and delivered directly to patients' homes after identification through practice registers, posters, and text message recruitment. That gives the model a realistic route into business as usual because it can sit alongside routine diabetes care, foot surveillance, and long-term condition management rather than competing with them.

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

Enclosure No: 05

Report to:	Integrated Care Boards in Common
Date:	24 September 2026
Title:	Chair's Report
Presenting Officer:	Ian Green OBE, Chair
Author(s):	Imogen Hyde and Bethan Emberton

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

Appendices:	None

Purpose of the Paper:

This report provides the Board with a strategic overview of key developments, achievements, challenges and stakeholder engagement activity since the previous meeting.

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

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

This report highlights a series of engagement visits undertaken during the reporting period, providing insight into the delivery of community, diagnostic and mental health services across Staffordshire and Stoke-on-Trent.

Recommendations:

☑ To receive the report for **INFORMATION.**

Impact Assessments:					
	Completed?			If N - N/A, Rationale	If Y, Outcome / Date Reported & Signed off
Data Protection Impact Assessment (DPIA)	Yes	No	N/A	Click or tap here to enter text.	*Reported to IG Committee:* Click or tap to enter a date.
	☐	☐	☒		
Integrated Impact Assessment (IIA)	Yes	No	N/A	Click or tap here to enter text.	*Outcome and date of completion:* Click or tap here to enter text.
	☐	☐	☒		

Is the decision within Scheme of Financial Delegation (SOFD) powers & limits	Yes	☒	No	☐
Any potential / actual Conflict of Interest?	Yes	☐	No	☒
N/A	*N/A*			

Integration with Commissioning Board Assurance Framework (CBAF)			
CBAF1	☐	CBAF4	☐
CBAF2	☐	CBAF5	☐
CBAF3	☐	CBAF6	☐

Chair's Report

1. Haywood Hospital

1.1. A particular highlight during August was my visit to Haywood Hospital, which provided an excellent opportunity to see the breadth of community services supporting people across Staffordshire and Stoke-on-Trent.

1.2. Throughout the day, I toured outpatient departments and stroke and neurological rehabilitation services, and heard presentations showcasing developments in musculoskeletal care, integrated community services and sexual health provision.

1.3. The visit demonstrated how multidisciplinary teams are working together to deliver innovative, person-centred care closer to home, helping to improve outcomes while reducing reliance on acute services.

2. Community Diagnostic Centres (CDC) in Hanley

2.1. I was pleased to visit the Community Diagnostic Centre in Hanley to see how this significant investment is transforming access to diagnostic services for local people.

2.2. Accompanied by Deonne Lee, I toured the new facilities and learned more about the range of diagnostic tests now available within a modern, community-based setting.

2.3. It was particularly encouraging to see how the centre is helping to reduce waiting times, support earlier diagnosis and ensure patients can access essential tests more conveniently and efficiently.

3. Harplands Hospital

3.1. During a visit to Harplands Hospital, accompanied by Janet Dawson, Chair of North Staffordshire Combined Healthcare NHS Trust, and Buki Adeyemo, Chief Executive of North Staffordshire Combined Healthcare NHS Trust, I had the opportunity to gain greater insight into the vital mental health services provided across the site.

3.2. Discussions focused on the challenges and opportunities facing mental health services, as well as the ongoing work to enhance patient experience and support recovery.

3.3 What stood out most was the unwavering commitment of colleagues to delivering compassionate, high-quality care and improving the lives of some of the most vulnerable people within our communities.

Ian Green OBE,
Chair
September 2026

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

Enclosure No: 06

Report to:	Integrated Care Boards In Common
Date:	24 September 2026
Title:	Chief Executive Officer (CEO) Report
Presenting Officer:	Simon Whitehouse, Chief Executive Officer (CEO)
Author(s):	Imogen Hyde and Bethan Emberton

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

Appendices:	Appendix 1 – Letter from Professor Claire Fuller, NHS England. Appendix 2 – NHS Shropshire, Telford and Wrekin Annual Assessment Letter. Appendix 3 – NHS Staffordshire and Stoke-on-Trent Annual Assessment Letter.

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.

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

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

NHS England's annual assessments recognise our progress, alongside the benefits of the Cluster arrangements, while highlighting ongoing performance challenges that require continued focus. The report also highlights important developments in quality, workforce sustainability and prevention, alongside national recognition of innovation and good practice across our systems.

Recommendations:

☑ To receive the report for **INFORMATION.**

Impact Assessments:					
	Completed?			If N - N/A, Rationale	If Y, Outcome / Date Reported & Signed off
Data Protection Impact Assessment (DPIA)	Yes	No	N/A	Click or tap here to enter text.	*Reported to IG Committee:* Click or tap to enter a date.
	☐	☐	☒		
Integrated Impact Assessment (IIA)	Yes	No	N/A	Click or tap here to enter text.	*Outcome and date of completion:* Click or tap here to enter text.
	☐	☐	☒		

Is the decision within Scheme of Financial Delegation (SOFD) powers & limits	Yes	☒	No	☐
Any potential / actual Conflict of Interest?	Yes	☐	No	☒
N/A	*N/A*			

Integration with Commissioning Board Assurance Framework (CBAF)			
CBAF1	☐	CBAF4	☐
CBAF2	☐	CBAF5	☐
CBAF3	☐	CBAF6	☐

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

Chief Executive Officer Report

1. Introduction

1.1. As we move into the second half of 2026/27, both Integrated Care Boards (ICBs) continue to operate within a period of significant national reform and organisational change, while remaining focused on improving outcomes for the people and communities we serve. The report reflects the continued development of our cluster arrangements and the progress being made in strengthening strategic commissioning, partnership working and system leadership.

2. Annual Assessment Letters

2.1. NHS England has shared its annual assessments of both NHS Shropshire, Telford and Wrekin ICB and NHS Staffordshire and Stoke-on-Trent ICB, providing an overview of performance, achievements and organisational development during 2025/26 (Appendix 2 and 3).

2.2. The NHS England assessments recognise the significant progress made by both ICBs during a challenging period of system pressure and organisational change. The letters highlight strengths in strategic commissioning, partnership working, governance, financial management and several key operational priorities.

2.3. Both assessments acknowledged the benefits of the cluster arrangements in strengthening leadership, improving governance and supporting organisational resilience. While recognising ongoing challenges, particularly in urgent and emergency care and aspects of cancer and mental health performance, NHS England concluded that both organisations had continued to mature as strategic commissioners and demonstrated strong commitment to improving outcomes for local communities through partnership working and system leadership.

2.4. It is positive to receive this feedback and is testament to the approach and work that staff across both ICBs have led and delivered on during a period of significant change. I would like to take this opportunity to thank my executive and senior leadership team and to all ICB staff that have demonstrated their commitment to improving outcomes for the residents that we serve. At the same time, we are not complacent and we will be unremitting in our continued approach to tackle the health inequalities that exist, to work well with all our partners and to use our commissioning levers to improve outcomes and experience of health services locally.

3. Undertakings

3.1. NHS England has confirmed that the undertakings placed on NHS Staffordshire and Stoke-on-Trent Integrated Care Board in April 2024 have been lifted, recognising that the organisation has delivered the required improvements and met all conditions set out by NHS England.

3.2. This significant milestone follows the lifting of undertakings for NHS Shropshire, Telford and Wrekin last year and its exit from the national NHSE Recovery and Support Programme (the highest level of national oversight and scrutiny). This means that both organisations within

the cluster have demonstrated an improvement in governance, financial grip and control and have now successfully met NHS England's requirements.

3.3. While this achievement reflects the hard work and commitment of colleagues across the system, both ICBs remain focused on improving outcomes, reducing health inequalities and delivering high-quality care for local communities.

4. NHS National Reset Programme and the ICB Cluster Management of Change

4.1. As part of the ongoing organisational change programme across the cluster, NHS England has now completed its review of voluntary redundancy applications submitted by colleagues within both ICBs. Individual outcomes have been communicated, and support continues to be provided to those affected.

4.2. Throughout this process, our priority has been to support colleagues with openness, fairness and compassion, while retaining valuable skills and experience wherever possible. Decisions have been informed by the developing operating model and future workforce requirements, with a continued focus on supporting colleagues into suitable roles within the new structure.

4.3. I would like to thank colleagues for their professionalism, resilience and continued commitment during a period of significant organisational change. We remain focused on supporting our workforce through the next phase of transition while ensuring we continue to deliver our responsibilities to patients, partners and communities.

5. Health Service Journal (HSJ) Awards

5.1. Several teams and organisations serving communities across Shropshire, Telford and Wrekin and Staffordshire and Stoke-on-Trent have been shortlisted in the 2026 Health Service Journal (HSJ) Awards.

5.2. I would particularly like to congratulate colleagues from NHS Staffordshire and Stoke-on-Trent ICB, whose Opioid Stewardship Programme has been shortlisted in both the Medicines, Pharmacy and Prescribing Initiative of the Year and Patient Safety Award categories.

5.3. These shortlists recognise the innovation, dedication and expertise that exists across our systems and highlight the significant impact local organisations are having on improving outcomes and experiences for patients and communities.

5.4. These achievements are especially notable given the significant organisational change across the NHS and reflect the commitment, resilience and professionalism of colleagues across our health and care system.

5.5. I am also pleased to note that many of our partners from across the system have been nominated and shortlisted for awards across a range of categories. I would wish to highlight that the Shrewsbury and Telford Hospital NHS Trust (SaTH) has been shortlisted in three categories at the HSJ Awards 2026. Being shortlisted for the NHS Trust of the Year is recognition of the significant progress the Trust has made in improving performance, reducing waiting times and developing innovative diagnostic pathways, reflecting the

dedication and commitment of colleagues across the organisation to improving care and outcomes for local people.

5.6. These achievements are especially notable given the significant organisational change across the NHS and reflect the commitment, resilience and professionalism of colleagues across our health and care system.

6. National Recognition for Opioid Stewardship Programme

6.1. In addition to being shortlisted for two HSJ Awards, the Opioid Stewardship Programme has been recognised by PrescQIPP as an exemplar of best practice in addressing overprescribing and improving medication safety.

6.2. The programme has been shortlisted in the Patient Safety and Addressing Overprescribing category, recognising initiatives that reduce medicines-related harm through safer prescribing practices, structured medication reviews and deprescribing approaches.

6.3. This recognition highlights the strength of partnership working across Staffordshire and Stoke-on-Trent and demonstrates the impact of a system-wide approach to opioid stewardship in improving patient outcomes, reducing the risks associated with long-term opioid use and supporting national priorities for medicines safety.

7. Professor Claire Fuller Visit – Neighbourhood Working

7.1. In July, the Cluster ICBs hosted a visit from Professor Claire Fuller, NHS England Medical Director and National Programme Director for Neighbourhood Health. Supported by system partners, the visit provided an opportunity to demonstrate progress against the national neighbourhood health agenda.

7.2. The Board is asked to note the positive feedback received from NHS England following the visit and follow-up discussions (Appendix 1). The feedback provides external assurance that the Cluster is demonstrating important elements of the emerging strategic commissioning model, particularly through its outcome's framework, place-based approach, provider integration and examples of neighbourhood delivery. Partners and colleagues from across the cluster geography demonstrated their leadership and commitment to this agenda.

7.3. It also provides a clear indication of the scale of work required to move from the current foundations towards implementation at scale, with a particular focus on translating the Neighbourhood Health Framework into commissioning, contracting, provider and place arrangements across the Cluster.

7.4. Working with our Senior Leadership Team and system partners, we will ensure the identified priorities are incorporated into the Cluster's strategic commissioning and transition programme. This will be combined with the appropriate oversight, delivery milestones and Board assurance established as this work progresses.

8. Quality Strategy for NHS-funded care in England

8.1. In July 2026, the National Quality Board published the Quality Strategy for NHS-Funded Care in England, establishing quality as the organising principle for NHS-funded care over the next

decade. The strategy provides a single national framework to improve outcomes, reduce inequalities and enhance patient experience, aligning with the NHS 10-Year Health Plan and responding to recommendations from recent national reviews.

8.2. Over the coming months, the Boards in Common will focus on reviewing current quality governance arrangements, strengthening system-wide quality improvement capability, embedding quality measures within strategic planning and performance oversight, and continuing to prioritise patient safety, patient experience and equity of outcomes across all services.

8.3. A cluster approach to quality is currently being developed and will be presented to the Boards in Common in early 2027.

9. Amos and Ockenden Reviews

9.1. The Executive Team and Boards recognise and thank the women, birthing people, families and colleagues who contributed to the recent independent maternity and neonatal reviews. Their experiences and insights are vital in driving improvement across services.

9.2. The publication of the Amos and Ockenden reviews in June 2026 highlighted recurring national concerns relating to culture, leadership, workforce capacity, governance, safety and patient experience. Both reviews found that services must do more to listen to women and families, learn from concerns and adverse events, and ensure patient voices are central to service improvement.

9.3. A Board development session is planned for October 2026 to consider the implications of the reviews and further strengthen perinatal governance and assurance. A further update on maternity and neonatal services will be presented to the November ICB Board.

10. Public Sector Equality Duty (PSED)

10.1. As a cluster, we are strengthening our use of data, intelligence and community insight to better identify health inequalities, unmet need and variation in access, experience and outcomes across our population.

10.2. This work combines population health management, data analytics and engagement with local communities to improve our understanding of the barriers faced by different population groups and inform more targeted commissioning decisions. Initial analysis is focused on cardiovascular, renal and metabolic (CVRM) conditions, helping to identify disparities and shape improvements in prevention, diagnosis, treatment and ongoing care.

10.3. As this work develops, it will support the design of more equitable neighbourhood-based services and ensure that reducing inequalities and improving equity of access remain central to our strategic commissioning and population health priorities.

10.4. PSED reports covering the populations of both ICBs are being developed and will be brought to the Boards in January 2027, providing an opportunity for the Boards to consider the findings and the implications for strategic commissioning and the delivery of equitable access, experience and outcomes. The reports will also provide a baseline from which progress can be monitored over time.

11. Advanced Foundation Trust Status

11.1. Midlands Partnership University NHS Foundation Trust (MPFT) has been selected by NHS England to participate in the second wave of assessments for Advanced Foundation Trust (AFT) status, with the programme formally commencing in July.

11.2. AFT status is intended to recognise high-performing organisations that are delivering the NHS's strategic priorities, including reducing waiting times, improving population health and supporting the shift towards preventative and community-based care. The national ambition is for all NHS trusts and foundation trusts to achieve AFT status by 2035.

11.3. MPFT is currently preparing for assessment later this year and is working closely with the ICB to support readiness and alignment throughout the process. The ICB has been invited to provide a letter of support for the application.

11.4. Achievement of AFT status would represent an important milestone for MPFT and the wider system, providing greater local autonomy and accountability while supporting its role in delivering the strategic commissioning and neighbourhood health agenda. It is important that we continue to work with MPUFT to ensure that we maximise the potential that this brings, should they be successful through the assessment process.

11.5. A further update on progress and the assessment process will be presented to the Boards in Common later this year. It is likely that other partners will also look to progress through this process in future waves and it is important that we share any learning from this to help future applications.

12. West Mercia North Strategic Road Safety Partnership Board

12.1. Partnership working to improve road safety has been strengthened through the establishment of a new Strategic Road Safety Partnership Board covering the northern area of the West Mercia Police region. This includes Shropshire, Telford and Wrekin, Herefordshire and Worcestershire and the ICB is part of this Partnership Board. The inaugural meeting took place in July and was chaired by John Campion, Police and Crime Commissioner. The Road Safety Partnership Board will oversee the development and delivery of a new Road Safety Strategy, which the ICB is in full support of. This strategy will bring together key partners to support prevention activity and improve road safety outcomes across the region.

13. Burntwood Health Centre Project

13.1. Burntwood Health Centre in Staffordshire project has reached an important milestone with the submission of a planning application for a new purpose-built facility on land off Milestone Way. Developed in partnership between Staffordshire County Council and NHS Staffordshire and Stoke-on-Trent, the new centre will replace existing and temporary GP accommodation while providing space for community health services, supporting improved access to integrated care for local residents. The application will now be considered by Lichfield District Council.

14. Laptop Donation

14.1. Work to support digital inclusion across Staffordshire and Stoke-on-Trent has continued through the successful completion of the second wave of our charitable laptop donation programme. We have now donated a further 260 laptops to local charity partners, bringing the total donated by the ICB through this programme to over 400. The devices are supporting a range of initiatives, including employability programmes, educational support for children outside mainstream schooling, and community outreach activities.

15. Detect and Protect Screening Spotlight

15.1. Colleagues in Newcastle Central Primary Care Network have developed a series of professionally produced videos featuring local people sharing their experiences of breast, bowel and cervical cancer screening. The campaign aims to encourage greater participation in NHS screening programmes by addressing common concerns, challenging misconceptions and highlighting the benefits of early detection through authentic patient stories.

15.2. The videos also help people understand what to expect from screening appointments, providing reassurance for those who may be anxious about attending. The response to the campaign has been highly positive, and it is hoped that these real-life experiences will help improve screening uptake across our communities.

15.3. To maximise reach and impact, the video series will also be showcased on the big screen in Newcastle town centre, supporting wider public awareness of this important prevention and early diagnosis message. The full series is available to view on the Newcastle Central PCN YouTube channel.

16. Strengthening the Primary Care Workforce and Future Leadership

16.1. Supporting, retaining and developing the primary care workforce remains a key priority across Shropshire, Telford and Wrekin. 18 newly qualified GPs are currently participating in the GP Development Programme, alongside targeted support for International Medical Graduates. A refreshed First 5 GP Network is also being launched, providing education, networking and pastoral support for GPs in the early stages of their careers.

16.2. To strengthen future training capacity, a further nine newly qualified GPs are being supported to become GP Trainers, helping to build the pipeline of future GPs and support the sustainability of the workforce.

16.3. Alongside this, more than 20 salaried GPs are participating in a Partnership Development Programme designed to encourage and support future GP Partners and address the ongoing decline in partnership numbers. This is complemented by a quarterly GP newsletter and new promotional video to raise the profile of general practice, showcase career opportunities and support recruitment across the system.

17. Conclusion

17.1. This report demonstrates the breadth of activity taking place across our cluster and the continued commitment of colleagues and partners to improving health outcomes, reducing inequalities and providing high-quality care for our population.

17.2. I would like to thank all colleagues, ICB staff, providers, local authority partners, primary care teams, voluntary sector organisations and community representatives for their continued dedication and effort during a period of considerable change.

Simon Whitehouse
Chief Executive Officer
September 2026

ICB Chief Executive
ICB Chair

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

9 September 2026

Dear Ian and Simon

Neighbourhood Health – Shropshire, Telford and Wrekin and Staffordshire and Stoke-on-Trent

Thank you to you and your team for meeting with us to discuss progress following the recent Neighbourhood Health Readiness Visit.

We appreciated the continued openness and constructive engagement from you and your colleagues. The follow – up discussion provided an opportunity to further review progress and consider the system's trajectory as neighbourhood health continues to develop.

The visit to the SSOT/STW cluster provided me with some clear examples of the Neighbourhood Health Framework in action and the impact of this is evident in the results that you showed and your self-assessed score. Of particular note:

- The Cluster outcomes framework you have developed is a strong example of strategic commissioning in partnership. The use of public health data to apply a weighted value to this framework only strengthens what you can equitably achieve for each of your places and neighbourhoods. This was one of a few examples of proportionate universalism being practically applied that I have seen and should be shared widely.
- Across SSOT and STW, I saw that the community trusts act as the integrator across the places to deliver this outcomes framework, and that the intention is to cover 1% of your population with this model across the cluster. Each place board determines how the outcomes are met and the integrator retains oversight with escalation to the ICB cluster. Again, this is a strong example of how the ICB as strategic commissioners, and an integrator model, covering providers across health and care, can deliver outcomes agreed for each place.
- In Telford and Wrekin, your focus on early detection and prevention was clear, with the Calm Café and Healthy hearts programme proactively reaching into your local communities. Recent data suggests 24% of people being screened have a high CVD risk.
- Strong GP leadership was also evidenced across SSOT and STW, with a clear determination for further growth in service delivery and this should be encouraged. Your

pathway transformation projects around oral nutritional supplements showed the potential of GP-led service redesign, reinvesting savings into general practice.

Taking together the visit and follow-up process, alongside the subsequent system and Place level self – assessments, the accompanying single page summary provides an agreed reflection of the system's current position.

We would encourage you to share the agreed single page summary with your Board and system partners to support local oversight of neighbourhood health priorities, agreed next steps and future delivery.

As discussed, the key areas of focus over the coming months are:

1. Development of Strategic Commissioning plan and embedded contracting frameworks for Neighbourhood Health for proactive, rising risk and reactive care cohorts at scale across the whole cluster footprint, and for new models of planned care.
2. Agree the spend plan for the £9.8m investment fund for 2627 and 2728
3. Develop provider infrastructure to respond to strategic commissioning framework, including lead provider arrangements
4. Finalise Place-based Neighbourhood Health Plans (aligned to learning from NNHIP and self-assessments)
5. Undertake a review of the BCF approach across your Places to agree single approach for 2027/28 across the Cluster, enabling more local ownership and responsibility for BCF.
6. Development of a priority plan to deliver the actions in the Red Tape Challenge to improve primary and secondary care interface
7. Develop estates strategy (based on clinical strategy), establishing neighbourhood Health centres within 26/27 plan
8. Develop appropriate data-sharing and reporting arrangements to support robust patient identification and evaluation within a neighbourhood dashboard
9. Create a mechanism to support Spread of Learning, best practice and evidence across programmes of work including reporting to Board

Thank you again for the time and commitment shown by you and your teams throughout both the visit and follow-up process. We look forward to continuing to work with you as neighbourhood health develops across the cluster footprint.

Yours sincerely

Professor Claire Fuller MRCGP DRCOG MBBS
National Priority Programme Director – Neighbourhood Health

Annex:

Single slide summary

NHS Shropshire, Telford and Wrekin + NHS Staffordshire and Stoke-on-Trent (cluster)

4 September 2026

ICB at a glance

ICB CEO	Simon Whitehouse (cluster CEO, single CEO from Sept 2025)
ICB Chair	Ian Green OBE (cluster Chair, in post from Nov 2025)
Registered population	1.8 million (STW 0.55m; SSOT 1.25m)
Places	4 (all co-terminous with the four HWBs)
Footprint	Midlands; rural Shropshire and the Staffordshire and Stoke conurbation

Local authorities	4 upper-tier: Shropshire and Telford and Wrekin unitary; Stoke-on-Trent unitary; Staffordshire two-tier, LGR outcome confirms two unitary authorities for North and South Staffordshire. STW to remain two unitary authorities on the same footprint: Telford and Wrekin and Shropshire.
Providers	Acute: SaTH, UHNM, UHDB, RJAH, RWT. Community/MH: Shropshire Community Health, MPFT, North Staffordshire Combined Healthcare. Ambulance: WMAS.
2024/25 position	9.8m NbH fund identified (6.8m SSOT, 2.9m STW), 80/20 population and targeted, not yet deployed.
NNHIP / NHC Wave 1	NNHIP 1 of 4 Places (Shropshire, wave 1). NHC pipeline submitted 27 May 2026; Wave 1 designation to confirm

Places

Place	Shropshire Place score - 38	Telford and Wrekin Place score - 39	Staffordshire Place score - 41	Stoke-on-Trent Place score - 42
Population	316,371	217,618	879,863	324,334
HWB sign-off	Delegated 13 May 2026; to HWB 9 Jul 2026	Delegated 14 May 2026	Joint Comm Board 14 May 2026	HWB 18 Jun 2026; shadow Place board 16 Jul 2026
NbH footprints / PCNs	5 footprints / 5 PCNs	4 footprints / 4 PCNs	9 proposed / 17 PCNs	4 footprints / 8 PCNs
HLE (M / F)	63.0 / 62.4	56.7 / 55.4	63.0 / 62.5	55.1 / 53.5
GP federation	Under development	Under development	Partial coverage North Staffs GP Fed (part) Stafford and Surrounds GP Alliance East and Mercian	North Staffordshire GP Fed
MNP / integrator	Shropshire Community Health: integrator and anchor	Shropshire Community Health: integrator and anchor	MPFT: integrator and anchor	MPFT: integrator and anchor

Examples of best practice surfaced across Places

- Shropshire and Telford and Wrekin: Dementia INT (DINT) across 2 PCNs and 163,000 population; 40 patients in six months; net system saving 158,285.76 pounds on a modelled 50% admission reduction.
- Staffordshire and Stoke-on-Trent: PCARM palliative crisis response and SPCT front door; 1,207 high-risk-of-delay patients reviewed and 918 supported by virtual specialist advice.
- Telford and Wrekin: Calm Cafe (social work plus 2 VCSE partners) and Healthy Hearts PCN nurse outreach; 283 NHS Health Checks with 24% found at high CVD risk..
- Cluster: oral nutritional supplements value programme led by the interim Chief Medical Officer, overseen by the Clinical Senate as a board subcommittee. Reduced ONS spend recycled to fund GP time and reprioritise dietetics.

Five Goals (RAG vs England; see Annex B for scores)

G1 Health outcomes	G2 GP access and experience	G3 Planned care	G4 Urgent and emergency care	G5 Patient and staff satisfaction

STW and SSOT ICBs present different performance challenges. STW's relative strength lies in planned care delivery, while workforce experience represents its main area for improvement. Conversely, SSOT demonstrates strong staff experience but faces substantial challenges in urgent and emergency care The most notable shared issues across both systems are poor A&E four-hour performance and high levels of end-of-life emergency admissions and poor outcomes for Diabetes, suggesting potential opportunities for joint learning and system-wide improvement in urgent care pathways and end-of-life care

Enablers (Section 4)

Enabler	Key point (fill = rating)
Data	Shared care record roadmap in development; CCIO named. FDP and S251 not evidenced. Single data source agreed as a CF ask.
Workforce	Staff experience differs (Shropshire G5 1.5; Staffordshire 4.0). No GP federation in STW.
Finance	9.8m NbH funding identified, not yet deployed. Out of licence breach and RSP. Payment reform (J10) not evidenced.
Digital	Shared care record to confirm; NHS App front door not evidenced. Current risk stratification/linked data models differ across cluster
Estates	STW 2 surgical hubs, 1 CDC, 8 Family Hubs; SSOT 4, 3, 7. HTP 312 million pounds is the STW anchor.

Framework readiness: Stage 1 (foundations) and Stage 2 (NbH Plan)

Ref	Stage 1 minimum requirement (2026/27): text colour shows rating	SCORE
S1	Agree an initial plan to reduce non-elective admissions and bed days via urgent, rehabilitation and reablement capacity	**4**
S2	Agree a plan for unwarranted variation and GP access, meeting GMS core hours and new urgent access requirements	**8**
S3	Agree neighbourhood footprints around natural communities for the future development of INTs	**2**
S4	Agree plans to establish INTs focused on high priority cohorts, including how devolving care budgets could work	**5**
S5	Start to plan a new neighbourhood approach for elective pathways, RTT contribution and devolved outpatient budget	**1**
S6	Confirm plans to meet 18-week community waits and eliminate 52-week waits	**5**
S7	Confirm how ICBs and LAs intend to use pooled funding under the Better Care Fund	**6**
S8	Continue to improve the primary and secondary care interface in line with the red tape challenge	**2**
S9	Confirm organisational ownership of planned deliverables	**5**
S10	Confirm plans for appropriate data-sharing arrangements for patient identification and evaluation	**2**
ICB SCORE	(Average of total place scores)	**40**

Stage 2 NbH Plan: seven-step readiness (overall EARLY STAGE)

1	**National objectives via the three reform agendas**
2	**Support wider local goals and public service reform**
3	**Local objectives informed by JSNA**
4	**Confirm final geographies**
5	**Confirm organisational delivery responsibilities**
6	**Confirm governance and operational arrangements**
7	**Align other initiatives (Family Hubs, Pride in Place, MH hubs, employment)**

Forward look - Key actions over next 6 months:

1. Development of Strategic Commissioning plan and embedded contracting frameworks for Neighbourhood Health for proactive, rising risk and reactive care cohorts at scale across footprint, and for new models of planned care.
2. Agree the spend plan for the £9.8m investment fund for 2627 and 2728
3. Develop provider infrastructure to respond to strategic commissioning framework, including lead provider arrangements
4. Finalise Place-based Neighbourhood Health Plans (aligned to learning from NNHIP and self-assessments)
5. Undertake review of BCF approach across the 4 Places to agree single approach for 2027/28 across the Cluster, enabling more local ownership and responsibility for BCF.
6. Development of a priority plan to deliver the actions in the Red Tape Challenge to improve primary and secondary care interface
7. Develop estates strategy (based on clinical strategy), establishing neighbourhood Health centres within 26/27 plan
8. Develop appropriate data-sharing and reporting arrangements to support robust patient identification and evaluation within a neighbourhood dashboard
9. Create mechanism to support Spread of Learning, best practice and evidence across programmes of work including reporting to Board

Forward look – Key actions over next 18 months

1. Host, anchor or integrator arrangements agreed for each place and reflected in commissioning and delivery arrangements.
2. Commissioning intentions translated into contracts, specifications or delivery agreements that support INT development, proactive care, interface improvement and neighbourhood outcomes, inc. for UEC & elective care
3. Data-sharing arrangements operational across statutory partners, with progressive inclusion of VCFSE, community pharmacy, optometry and dental partners.
4. BCF and wider pooled investment clearly aligned to neighbourhood priorities, with scheme-level inequalities measures, public HWB reporting and funding decisions feeding the next planning cycle.
5. Interface reform embedded across priority providers, with red tape challenge actions implemented, a clinical leadership development programme active, and neighbourhood-facing specialist input reflected in workforce or job planning where appropriate.

NHS England Midlands

Rebecca Farmer
Director of System Co-ordination and Oversight
Wellington House
133-155 Waterloo Road
London
SE1 8UG

E: Rebecca.farmer14@nhs.net

W: www.england.nhs.uk

Sent via email

Ian Green OBE
Chair of Shropshire,
Telford and Wrekin
Integrated Care Board

14 August 2026

Dear Ian,

Annual assessment of Shropshire, Telford and Wrekin (STW) Integrated Care Board's performance in 2025/26

I am writing under section 14Z59 of the NHS Act 2006, as amended by the Health and Care Act 2022, which requires NHS England to conduct an annual performance assessment of each Integrated Care Board (ICB).

This has been a particularly challenging year for ICBs, marked by significant system-wide pressures and continued organisational change. In parallel, ICBs have been required to adapt to an evolving operating model, while maintaining a clear focus on statutory duties, system leadership and delivery for local populations.

Against this backdrop, we recognise the complexity of the task facing your organisation and the sustained effort required to balance immediate operational pressures with longer-term strategic priorities. We also acknowledge the additional burden created by structural changes, and the need to maintain stability and continuity across systems during a period of transition.

In reaching this assessment, we have considered evidence from the ICB's annual report and accounts, available performance and assurance data, feedback from partners and stakeholders, and the discussions we have held with ICB colleagues over the course of the year.

While this annual assessment is a statutory requirement, we have sought to ensure that it is balanced and proportionate, recognising both the need to assess performance against statutory responsibilities and the realities of the organisational change that has taken place during the year.

We remain committed to working constructively with you, building on learning from the year, and supporting ICBs as roles, responsibilities and arrangements continue to evolve.

We would like to thank you, your Board and your wider team for your leadership and continued commitment during a demanding period of change. We look forward to continuing to work with you in the year ahead.

Yours sincerely

Rebecca Farmer
Director of System Co-ordination and Oversight, NHS England, Midlands

Cc. Dale Bywater, Regional Director Midlands, NHS England
Simon Whitehouse, ICB Chief Executive, STW ICB
Katrina Boffey, Deputy Director of System Co-ordination and Oversight, Midlands, NHS England

Section 1: ICB performance assessment

The ICB and partners delivered many 2025/26 Operational Plan commitments, with notable strengths in elective recovery, diagnostics, cancer faster diagnosis, financial grip and system governance. Progress was also made in primary care access, community alternatives to hospital care, neighbourhood working and targeted population health priorities.

The 2025/26 NHS National Oversight Framework (NOF) metrics show a mixed but improving picture. In Q4 (Quarter 4), the ICB was in the highest-performing quartile for Finance and Workforce, with above-average performance for Experience, Safety and Population Health. Cancer 62-day standard delivery remained more challenged, although elective performance improved strongly: 18-week RTT (Referral to Treatment) achieved 69.5%, up from 50.7%, above the national target, with the overall waiting list and long waits reduced. Diagnostic performance also improved, supported by increased community diagnostic capacity.

Urgent and emergency care (UEC) remained the most significant concern. A&E four-hour performance was 61.5%, this was below the national target and there was continued pressure in emergency departments, ambulance handover delays and 12-hour waits. The ICB maintained system-wide oversight through improvement work on out-of-hospital pathways, virtual wards, urgent community response, discharge and additional bed capacity, however these actions have not yet delivered the sustained improvement required.

Cancer performance improved. The ICB achieved the Faster Diagnosis Standard at 85.8% and delivered 62-day performance of 76.2%, which remained below the 85% ambition but reflected recovery work across pathways. Risks remain in some tumour sites, workforce, diagnostic capacity and pathway complexity, requiring continued focus in 2026/27.

Primary, community and diagnostic services progressed through Pharmacy First, urgent dental provision, improved digital access to general practice, integrated neighbourhood approaches and community-based alternatives to hospital care. The Telford Community Diagnostic Centre also provided substantial additional diagnostic capacity.

Mental health and neurodevelopmental services also improved, including increased investment, expanded Mental Health Support Teams, an all-age 24/7 Crisis Text Service, inpatient quality transformation and further development of dementia, learning disability and autism pathways. However, demand and capacity pressures remained material, particularly in children and young people's mental health, neurodiversity assessment and NHS Talking Therapies access.

Performance for people with a learning disability and autistic people improved in some areas. Annual health checks for people on GP learning disability registers rose from 12.07% in Q1 to 80.63% in Q4, and governance was strengthened to inform autism and ADHD (attention deficit hyperactivity disorder) pathway redesign from 2026/27. However, autistic and learning disability inpatient numbers increased, and neurodiversity assessment demand continued to exceed capacity, requiring sustained focus on access, waits, discharge and admission avoidance.

The ICB demonstrated strong financial management, delivering a £2.1 million favourable outturn against a planned £2.0 million deficit and £41.4 million of efficiencies, most of which were recurrent, supported by £90 million in deficit support funding. The ICB remained close to plan, with a year end variance of 0.13% and implied productivity growth of 5.6%. This reflects stronger grip and control, although the system remained dependent on deficit support and continued to face cost pressures in elective care, continuing healthcare and mental health services.

The ICB progressed wider statutory duties on population health, inequalities and sustainability. NOF metrics show improved bowel and breast screening coverage, strong Q4 delivery of learning disability annual health checks and good performance against the Greener NHS programme judgement. However, SMI (serious mental illness) physical health checks remained below target at 58% and deteriorated from 2024/25, while some inequalities metrics remained variable, requiring clearer evidence of impact for disadvantaged communities.

The evidence shows reasonable engagement with statutory SEND (special educational needs and disabilities) responsibilities, including collaboration with local authorities, education partners, voluntary and community organisations and providers, and upstream interventions such as vaccination campaigns and Asthma Friendly Schools. In 2026/27, SEND priorities, delivery risks and evidence of impact should be more consistently visible through Board and committee assurance.

Safeguarding arrangements were maintained through established partnership and governance routes, with risks and quality issues escalated through wider quality arrangements. NHS England is satisfied that the duty was discharged in 2025/26, but safeguarding themes, risks and learning should remain clearly reflected in Board-level assurance.

Complaints oversight was considered through broader quality governance, drawing on complaints, patient experience, provider intelligence and safety data, alongside resident experience items, public questions and committee reporting. However, the evidence base remains largely narrative, and in 2026/27 the ICB should strengthen reporting on complaints themes, learning, actions and impact.

Section 2: ICB capability assessment

The ICB entered formal joint leadership arrangements with Staffordshire and Stoke on Trent ICB, which allowed executives to pool resources, standardise risk management and make faster executive decisions regarding provider performance, such as holding joint interventions over West Midlands Ambulance Service delays, while successfully reducing corporate overheads in line with national administrative efficiency mandates. The ICB Board and Executive Team ensured that additional measures were put in place to support staff through the organisational change process in 2025/26, including the provision of a counselling service, increased access to professional coaching and the formation of staff and leadership networks.

The ICB further strengthened its maturity as a strategic commissioner during 2025/26, delivering tangible improvements in financial recovery, elective and diagnostic performance, cancer pathways, and the development of integrated neighbourhood and community-based models of care. Throughout the year, the Board maintained

strong oversight of key system priorities, including winter resilience, UEC improvement, quality, finance, risk, transformation, and the evolving system accountability and performance framework.

The ICB successfully recommissioned the GP Out of Hours service through a rigorous, transparent and well-governed procurement process. An independent panel review provided full assurance and a comprehensive endorsement of the commissioning approach, confirming that it was fair, robust and fully compliant with statutory and NHS requirements. The review highlighted strong governance, effective stakeholder engagement and clear decision-making, identifying no material concerns. It concluded that the awarded contract appropriately balanced quality, safety, patient experience and value for money, providing assurance and confidence in both the integrity of the process and the resulting service model.

Governance, risk management and internal control arrangements were generally robust, with Board and committee reporting covering performance, finance, quality and transformation. The ICB also strengthened system leadership through joint working with Staffordshire and Stoke-on-Trent ICB as part of wider clustering arrangements, while managing significant organisational change.

The ICB discharged its duties to have due regard to the wider effects of decisions, including the Triple Aim, and to obtain appropriate advice. Board consideration of the Neighbourhood Approach, Healthy Ageing Strategy, Neighbourhood Implementation Programme, System Winter Plan, Infrastructure Strategy, System Green Plan, Integrated Performance Report and Recovery Support Programme transition showed that decisions considered population health, inequalities, care quality, operational resilience, financial sustainability and environmental impact.

Feedback from local Health and Wellbeing Board (HWBB) partners reported that ICB engagement was very good. The ICB continues to strengthen system collaboration and Place-based governance by aligning the HWBB strategy with wider system priorities, supported by joint development sessions. The HWBB recognised a range of examples where more systematic joint work is delivering improved outcomes including developing and delivering a neighbourhood approach, developing a STW prevention framework and addressing inequalities, including Core20PLUS5.

The ICB demonstrated a strong commitment to the health and work agenda, using its role as an anchor institution to support local employment, skills development and inclusion. Initiatives during 2025/26 included work experience and employment opportunities for disadvantaged groups, alongside programmes designed to improve both economic participation and long-term health outcomes.

Overall, the ICB showed strengths in partnership working, system governance, finance and targeted improvement programmes. The ICB also demonstrated strengths in coordinating system partners through a challenging winter period. Further work is required to ensure there are consistent and sustainable system responses to persistent operational pressures, particularly UEC, ambulance handovers and some mental health access standards, there was also variation in engagement and delivery at place level.

In summary, the ICB has become more effective as a strategic commissioner, with stronger governance, improved financial control and clearer system coordination. Further development is required to translate strategic intent into consistent delivery across all places and services, and to ensure that scrutiny, local government and community partners are engaged earlier and more transparently in significant decisions.

Section 3: Support and intervention

The ICB commenced 2025/26 in the NHS England Recovery Support Programme, reflecting the level of national oversight required at the start of the year in relation to finance, governance and performance. The ICB also remained subject to undertakings and associated improvement requirements.

During the year, the ICB demonstrated sufficient improvement to exit the Recovery Support Programme in September 2025. This followed demonstrable progress in governance, financial management and operational performance, including elective and cancer recovery and some improvements in UEC metrics. Undertakings were also lifted, and the ICB has since operated with increased autonomy.

The ICB responded to these interventions through a structured improvement approach, working closely with NHS England and system partners to address the agreed requirements. This included strengthening governance arrangements, delivering financial recovery plans, improving operational performance and enhancing system leadership capability.

The system continued to receive targeted oversight and support in areas where delivery risks remained material. SaTH (Shrewsbury and Telford Hospital NHS Trust) was subject to tiered oversight for UEC, elective and cancer performance, and RJAH (Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust) was subject to tiered oversight for elective and cancer performance, with the ICB participating in the relevant meetings and improvement arrangements.

Overall, the support and intervention provided to the ICB contributed to a marked improvement in organisational maturity, strengthened governance arrangements, and a more sustainable financial position. This progress is evidenced by the successful delivery of key improvement programmes, the strengthening of assurance and oversight processes, and the organisation's exit from the Recovery Support Programme with the associated removal of NHS England undertakings.

Through sustained leadership, effective governance, strategic direction and partnership working, the ICB played a key role in driving the improvements required, embedding a culture of accountability and delivering the conditions necessary to secure exit from the Recovery Support Programme and the removal of undertakings. The collective leadership supported the organisation's recovery trajectory, providing a stronger platform for future improvement and strategic commissioning. Continued focus will be required in 2026/27 to embed these improvements and address the remaining challenges in UEC, ambulance handovers, mental health access, neurodiversity pathways, learning disability and autism inpatient reduction, and local authority scrutiny engagement.

Conclusion

In forming this assessment, we have sought to take a balanced and proportionate view of your performance, recognising both what has been delivered and the complexity of the operating environment in which ICBs continue to function. We are encouraged by progress towards a more mature system of integrated care, with decision-making increasingly informed by, and responsive to, the needs of local people and communities.

We recognise that, for some systems, this assessment relates to an ICB that has since merged or transitioned into a new organisational form. This letter therefore reflects performance for the statutory body in place during the period assessed. NHS England acknowledges the pace of change across systems and is committed to working with you in your current configuration, supporting continuity, learning from predecessor organisations, and continued improvement as the new ICB develops and embeds its responsibilities.

I ask that you share this assessment with your board and senior leadership team and consider publishing it alongside your annual report at a public meeting. In line with our statutory responsibilities, NHS England will also publish a summary of the outcomes of all ICB annual performance assessments.

Rebecca Farmer
Director of System Co-ordination and Oversight
Wellington House
133-155 Waterloo Road
London
SE1 8UG

E: Rebecca.farmer14@nhs.net
W: www.england.nhs.uk

Sent via email

3 August 2026

Ian Green OBE
Chair of Staffordshire and Stoke on Trent ICB

Dear Ian,

Annual assessment of NHS Staffordshire and Stoke on Trent (SSoT) Integrated Care Board's performance in 2025/26

I am writing under section 14Z59 of the NHS Act 2006, as amended by the Health and Care Act 2022, which requires NHS England to conduct an annual performance assessment of each Integrated Care Board (ICB).

This has been a particularly challenging year for ICBs, marked by significant system wide pressures and continued organisational change. In parallel, ICBs have been required to adapt to an evolving operating model, while maintaining a clear focus on statutory duties, system leadership and delivery for local populations.

Against this backdrop, we recognise the complexity of the task facing your organisation and the sustained effort required to balance immediate operational pressures with longer-term strategic priorities. We also acknowledge the additional burden created by structural changes, and the need to maintain stability and continuity across systems during a period of transition.

In reaching this assessment, we have considered evidence from the ICB's annual report and accounts, available performance and assurance data, feedback from partners and stakeholders, and discussions held with ICB colleagues over the course of the year.

While this annual assessment is a statutory requirement, we have sought to ensure that it is balanced and proportionate, recognising both the need to assess performance against statutory responsibilities and the realities of the organisational change that has taken place during the year.

We remain committed to working constructively with you, building on learning from the year, and supporting ICBs as roles, responsibilities and arrangements continue to evolve.

We would like to thank you, your Board and your wider team for your leadership and continued commitment during a demanding period of change. We look forward to continuing to work with you in the year ahead.

Yours sincerely

Rebecca Farmer
Director of System Co-ordination and Oversight, NHS England, Midlands

Cc. Dale Bywater, Regional Director Midlands, NHS England
Simon Whitehouse, Chief Executive Officer, SSoT ICB
Katrina Boffey, Deputy Director of System Co-ordination and Oversight, Midlands, NHS England

Section 1: ICB performance assessment

The ICB and its partners successfully delivered some of the commitments contained within the 2025/26 Operational Plan. Notable areas of positive performance included primary care, where the ICB ensured good progress in relation to digital improvements so that all GP practices were offering online consultations, participating in the You and Your GP initiative and providing clinical advice and guidance. The ICB was also above the national average for the 'Health Insights Survey'.

The ICB delivered 107% of its planned activity for children and young people's mental health services and 121% of its planned perinatal mental health activity. The ICB and wider system delivered improvements in overall population health, with an NHS England trend analysis showing that the percentages of patients receiving LLT treatment for cholesterol and hypertension have consistently increased since 2023, as has the percentage of patients with Severe Mental Illness receiving all six physical health checks. NHS England has acknowledged the SSoT system as an exemplar in the use of digitally enabled care for mental health.

There were several areas in which performance remained below the levels expected by NHS England. Urgent and Emergency Care (UEC) was the area of most significant concern, with the system unable to deliver its plan to ensure that 73.7% of patients attending A&E were seen within four hours; it achieved 66.4%. It also experienced some of the most significant ambulance handover delays in the country, with an average handover time of 76.8 minutes in 2025/26, compared with the England average of 31.3 minutes, and remained beyond the 45-minute maximum waiting time ambition.

NHS England recognises the efforts made by the ICB and its partners to coordinate the system response to UEC pressures during 2025/26; however, these actions have not yet delivered the level of sustained performance improvement required, and UEC remains the system's most significant area of concern heading into 2026/27.

The ICB was in receipt of regional cancer recovery funding and additional Cancer Alliance support in 2025/26 to improve the cancer performance, however this did not result in the delivery of the 62 day national standard, with 69.8% achieved against the 75% national ambition. The Faster Diagnosis Standard was slightly below the 80% target, with performance of 79.4% delivered. Further opportunities to improve the position will need to be identified and delivered.

The ICB over-performed against its plans for 18-week Referral to Treatment Times (RTT) and elective waiting list reductions, supported by progress through the Improvement Plans and the impact of the Q4 elective sprint. This was reflected in 18-week performance improving from 62.9% in February 2026 to 66.0% in March 2026, the largest month-on-month increase seen during the year. The ICB also strengthened controls over independent sector activity, which supported wider financial grip and control during the year. This demonstrates positive progress in elective recovery, however, the system did not reduce the number of patients waiting over 52 weeks to less than 1% by year-end, achieving an average of 1.5%, and long waits were not eliminated, with 96 patients waiting for 65 weeks or more at the end of the financial year.

The SSoT system was unable to eliminate out-of-area placements for mental health, as required by the NHS Operational Planning Guidance, and did not achieve its planned reductions in inpatient episodes for adult patients with learning disabilities and autism. The ICB ended the year with 34 inpatients against a plan of 19.

SSoT ICB was in the highest-performing quartile nationally for metrics linked to access, experience and population health. This was due to relatively strong performance in areas such as 18-week RTT (access), reduction in the number of general and acute (G&A) bed spells and the percentage of Continuing Healthcare (CHC) referrals completed within 28 days (experience), along with substantial increases in the percentages of patients being referred to weight management services and those on the disability register being referred for physical health checks. The ICB also scored comparatively highly in the performance metrics for 18-week RTT, as noted above, and improvements in patient-reported satisfaction with their GP practice.

The ICB achieved a comparatively poor level of performance against the national metrics for finance and productivity. This was due to the relative size of the system deficit as a proportion of its overall funding allocation and a low rate of implied productivity growth, which at 0.6% was significantly below the regional average of 2.4%. However, the ICB made significant progress towards restoring the financial stability of the SSoT system last year. The ICB delivered a surplus of £0.7m against an agreed deficit plan of £95m in 2025/26 and made some difficult decisions to achieve its efficiency plans, including taking steps to bring CHC expenditure under control and implementing the mandatory running cost reduction. This progress reflected sustained leadership and oversight from the ICB Board and Executive Team, which strengthened financial governance and delivery throughout the year.

The ICB continued to deliver the commitments made in its five-year strategy to reduce health inequalities in 2025/26. The ICB carried out work to reduce health inequalities, including a cancer awareness campaign that led to a 12% reduction in the cervical screening inequality gap. It ring-fenced funding to support the delivery of neighbourhood projects aligned to its Core20PLUS priorities and achieved comparatively high scores against metrics for reducing the deprivation gaps for MI and stroke admissions, weight management and physical health checks for people with disabilities.

The ICB has strong and effective arrangements in place to oversee improvements in the quality and safety of the services it commissions and to safeguard children and vulnerable adults. In May 2025, the ICB invited NHS England to independently review its Quality Impact Assessment (QIA) processes. The review concluded that strong governance, leadership, training and reporting arrangements were in place to effectively manage risks within the strategic commissioning process. This included arrangements to ensure that patient complaints, Patient Advice and Liaison Service (PALS) contacts and MP enquiries were used to inform the oversight of ICB-commissioned services and strategic commissioning decisions. For example, during the winter 2025/26 meetings, ICB Board papers explicitly tracked the rise in complaints regarding “corridor care” and overcrowding, using that data to encourage University

Hospitals of North Midlands (UHNM) to adopt the “Release to Respond” initiative in January 2026 to protect patient safety.

The ICB published a refreshed five-year strategy setting out its commitment to innovation, research and learning in April 2026. This included the adoption of a standardised scoring system, which the ICB Clinical Policy Advisory Group (CPAG) used to critically evaluate peer-reviewed clinical research and health economics data. This framework ensured that the ICB only directed its highly restricted funding towards interventions proven to be clinically effective and evidence-based, preventing spending on outdated or unproven procedures.

The ICB continued to deliver its Green Plan 2025-28, fully implementing its net zero supplier roadmap policies in 2025/26. Although monthly inhaler emissions were 38% lower than in 2019/20, this level of reduction placed the ICB in the bottom quartile nationally. Monthly nitrous oxide emissions were 35% lower than in 2019/20, placing the ICB within the middle 50% of reductions achieved by ICBs nationally.

The ICB actively aligned its commissioning and partnership frameworks with the government’s health and work ambitions. Partnering with Midlands Partnership University NHS Foundation Trust and North Staffordshire Combined Healthcare NHS Trust, the ICB expanded integrated Individual Placement and Support and NHS Talking Therapies employment advisory frameworks. It also supported its partner organisations to expand the Stoke Attrition Project and specialised recruitment pathways for disadvantaged or vulnerable demographics, including veterans and neurodivergent individuals.

Section 2: ICB Capability assessment

SSoT ICB entered formal joint leadership arrangements with Shropshire, Telford and Wrekin ICB, which allowed executives to pool resources, standardise risk management and make faster executive decisions regarding provider performance, such as holding joint interventions over West Midlands Ambulance Service delays, while successfully reducing corporate overheads in line with national administrative efficiency mandates. The steps that the ICB took to bring CHC expenditure under control and de-escalate the outsourcing of activity to the independent sector were evidence of the effectiveness of these changes, as well as the wider ICB governance structures that were in place during 2025/26. The ICB Board and Executive Team also ensured that additional measures were put in place to support staff through the organisational change process in 2025/26, including the provision of a counselling service, increased access to professional coaching and the formation of staff and leadership networks.

The ICB’s effectiveness as a strategic commissioner of health and care services was primarily demonstrated through the delivery of its financial recovery plan in 2025/26, while maintaining strong oversight of quality and patient safety.

The ICB demonstrated strengths in coordinating system partners through a challenging winter period. The SSOT ICB led a review of Discharge to Assess which improved length of stay and flow out of the acute sector and which impacted positively during the winter period. The SSOT SCC was benchmarked as an exemplar across

the Midlands and the ICB invested in the Incident Coordination Centre (ICC), this resulted in increased activity by more than 33% to support patients/professionals with access to alternatives, and the ICC deflected on average 55% away from ED/999. Further work is required to ensure there are consistent and sustainable improvements in UEC.

The ICB discharged its duty to have due regard to the wider effects of decisions (the "Triple Aim") and its duty to obtain appropriate advice. For example, in September 2025, the ICB's Medicines Optimisation and Respiratory Clinical Networks presented a data-driven case to the Board showing a marked and inequitable increase in emergency winter admissions for severe asthma and chronic obstructive pulmonary disease (COPD) in areas of high deprivation. The clinical advice highlighted that existing access routes were not consistently identifying and supporting these patients before escalation to crisis care. The Board acted on this advice by allocating protected funding to expand the Community Pharmacy Independent Prescribing Framework ahead of winter. This enabled titration and urgent steroid and inhaler access to be provided through community pharmacies in areas of greatest need, in line with the recommendations of the relevant clinical networks.

The ICB maintained its commitment to involving the public in decisions about the services it commissions. During 2025/26, it transitioned from broad public consultations to a "targeted insight" model, ensuring that those most affected by financial recovery decisions had a voice. Other initiatives included the establishment of a digital "People's Panel" to test the impact of proposed service changes, Community Conversations to help ensure that the withdrawal of "non-legitimate healthcare expenditure" did not inadvertently undermine community-led support groups relied upon by local people, and engagement with Healthwatch Staffordshire and local disability advocates to co-produce the communication materials sent to families explaining proposed changes to CHC.

Feedback from the ICB's local government partners confirmed that the ICB maintained effective engagement with its partners in local government during 2025/26. SSoT ICB showed a strong commitment to inclusive practice, multi-agency collaboration and continuous improvement. However, one partner indicated that its members felt the ICB had not fully represented service user and voluntary, community and social enterprise (VCSE) feedback.

During 2025/26, the SSoT Local Area Partnerships (LAPs) demonstrated clear strengths in strategic alignment, inclusive clinical practice, innovative use of digital technology and growing multi-agency engagement with children, young people and their families. However, significant weaknesses remained in the system's ability to meet its core statutory Special Educational Needs and Disabilities (SEND) responsibilities, and both local areas remained subject to formal statutory intervention by the Department for Education and NHS England. In Staffordshire, delays in Education, Health and Care Plan assessments and weaknesses in co-production led to the introduction of an Accelerated Progress Plan. By May 2026, additional targeted resources were beginning to improve monthly review activity. However, significant backlog pressures remained, particularly in Tamworth and East Staffordshire. Stoke-on-Trent LAP received an "Outcome 2" inspection rating due to inconsistent experiences and outcomes in relation to alternative provision quality, unmet clinical

needs and slow progress on multi-agency collaboration. Supported by an enhanced, NHS England-mandated regional governance structure and a debt-relief package that absorbed 90% of local high-needs overspends accumulated up to April 2026, the ICB must now mobilise its “Experts at Hand” and newly redrawn SEND reform plans to drive sustained operational improvements into 2026/27.

Section 3: Support and intervention

The undertakings that NHS England sought from SSoT ICB in April 2024 remained in place throughout 2025/26. These undertakings required the ICB to implement a financial recovery regime and eliminate its underlying financial deficit by the end of the year. The ICB also remained within NHS England’s Investigation and Intervention programme and continued to receive support from external recovery partners who were working with it and other organisations in the system.

The ICB put a range of additional financial “grip and control” arrangements in place in response to NHS England’s undertakings, many of which achieved a full-year effect during 2025/26. Formal governance, dashboards and portfolio assurance arrangements created clear accountability, improved efficiency, reduced financial risk and supported a balanced medium-term financial plan. Regular reporting to the Board, Finance and Performance Committee and NHS England evidenced strengthened grip and control, improved efficiency delivery and a reduction in the underlying deficit within the system. The ICB delivered its efficiency plans for 2025/26, taking action to reduce CHC expenditure, reduce the system’s reliance on temporary staffing and reduce independent sector acute provision.

These system-wide recovery actions delivered a balanced 2025/26 position, reduced the underlying deficit from £240m to £77.4m and established a credible route to sustainable breakeven by 2031/32 for the ICB and partner system organisations. NHS England carried out a review of the ICB’s performance against the undertakings during Q1 2026/27 and was pleased to issue a compliance certificate in July 2026.

The ICB participated in the National (Tier 1) and Regional (Tier 2) oversight arrangements that NHS England put in place to ensure that UHNM and the wider SSoT system deliver the required improvements in UEC, elective and cancer services respectively.

Conclusion

In forming this assessment, we have sought to take a balanced and proportionate view of your performance, recognising both what has been delivered and the complexity of the operating environment in which ICBs continue to function. We are encouraged by progress towards a more mature system of integrated care, with decision-making increasingly informed by, and responsive to, the needs of local people and communities.

We recognise that, for some systems, this assessment relates to an ICB that has since merged or transitioned into a new organisational form. This letter therefore reflects performance for the statutory body in place during the period assessed. NHS England acknowledges the pace of change across systems and is committed to working with

you in your current configuration, supporting continuity, learning from predecessor organisations, and continued improvement as the new ICB develops and embeds its responsibilities.

I ask that you share this assessment with your board and senior leadership team and consider publishing it alongside your annual report at a public meeting. In line with our statutory responsibilities, NHS England will also publish a summary of the outcomes of all ICB annual performance assessments.

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

Enclosure No: 07

Report to:	Integrated Care Boards in Common
Date:	24 September 2026
Title:	Commissioning Board Assurance Framework and Corporate Risk Register Report
Presenting Officer:	Mish Irvine, Chief of Staff
Author(s):	Paul Winter, Associate Director of Corporate Governance (using all ICB Exec Strategic Objective and Risk Owners' updates)

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

Appendices:	Appendix – Commissioning Board Assurance Framework (CBAF)

Purpose of the Paper:

The new style integrated Commissioning Board Assurance Framework (CBAF) and Corporate Risk Register (CRR) report is presented for the first time as a live "snapshot" update to the Board.

History of the paper, incl. date & whether for A / D / S / I (as above):	Date
Executive Team Meeting and Board Development Session	July 2026

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

The CBAF and CRR updates are presented for Board approval and assurance, as based on updates made to the new Integrated Care Board (ICB) systems on or by 4th September 2026. Any updates made after this point will not be reflected in the report and require on-the-day verbal updates from the Lead Executive where different to the reported positions in the following pages.

The CRR section of the report is modelled on the NHS England June 2026 Public Board national risk register report. Updates have been provided by Lead Executives and Risk Owners.

Reports will have by the time of the Board meeting have gone to the individual Board Assurance Committees, covering their local lead areas on CBAF or CRR areas. These are not captured in the report; however, may be available where a "Triple A" Escalation report has been received from the Non-Executive Member (NEM) chair of the committee.

Recommendations:
☐ To **ASK** both BOARDS for *formal sign-off* of the Executive Team approved CBAF containing the newly-agreed 2026/27 Strategic Objectives for the ICBs; ☐ To **ASSURE** both BOARDS of the latest position with our approved CBAF and Assurance Statements for each of the newly-agreed 2026/27 Strategic Objectives for the ICBs ☐ To **ASK** both BOARDS *to approve the recommendation* made in sub-section 3.2(c) about undertaking a "deep dive" on the current highest scoring risk on the CRR. ☐ To **ASK** both Boards *to approve the layout of this report* – if so, to be applied to all future ones (any amendments will be made in time for the next iteration, where requested).

Impact Assessments:					
	Completed?			If N - N/A, Rationale	If Y, Outcome / Date Reported & Signed off
Data Protection Impact Assessment (DPIA)	Yes	No	N/A	Click or tap here to enter text.	*Reported to IG Committee:* Click or tap to enter a date.
	☐	☐	☒		
Integrated Impact Assessment (IIA)	Yes	No	N/A	Click or tap here to enter text.	*Outcome and date of completion:* Click or tap here to enter text.
	☐	☐	☒		

Is the decision within Scheme of Financial Delegation (SOFD) powers & limits	**Yes**	☒	**No**	☐
Any potential / actual Conflict of Interest?	**Yes**	☐	**No**	☒
N/A	N/A			

Integration with Commissioning Board Assurance Framework (CBAF)					
CBAF1		☒	**CBAF4**		☒
CBAF2		☒	**CBAF5**		☒
CBAF3		☒	**CBAF6**		☒

Q2 Board Overview Report - Corporate Risk Register and Commissioning Board Assurance Framework (CBAF)

1. Introduction

1.1. This report summarises the latest Quarter 2 (half-year) positions for the:

- ***Cluster ICBs Commissioning Board Assurance Framework*** – or CBAF, further to the six 2026/27 Strategic Objectives being confirmed at two Board Development Sessions over the summer period and completion by the Executive Leadership of the aligned Controls & Assurances; and
- ***Cluster ICBs Corporate Risk Register*** – or CRR, further to successful completion of the migration work moving from our legacy / predecessor, single ICB systems over to the new joint Cluster system (using the Corestream risk module) and approval of the Cluster Risk Strategy at April Board / Audit Committees in Common.

2. Executive Summaries

2.1. Several CBAF Strategic Risks present with high-risk scores, which is to be expected, although demonstrating that there are further business activities needing to be undertaken by ICB Functions over the remainder of the financial year to bring the current Delivery Status into higher degrees of assurance about their delivery. The underlying Risk Controls and Assurances for each Objective are in a positive baseline position and there are no major or insurmountable gaps reported, which is of good-to-reasonable assurance to Cluster Board that we are progressing well, with underlying issues being managed.

2.2. The overall ICB Risk Profile also presents a number of high-scoring risks; although each of clear mitigations in place and our lead Board Assurance Committees are working on local assurances improvement activities pertinent to their Terms of Reference and Business Cycles. This is also reflective of our corporate Risk Owners' changing perceptions of clearer strategic direction for ICB Cluster Risk Management (as presented by the shift in emphasis in our new Risk Strategy and Cluster Risk Appetite Statements). Which denote overall stronger governance emerging and a shift from planning into delivery of the Strategic Objectives set out in our Operating Model and 5-Year Commissioning Plans.

3. Commissioning Board Assurance Framework (CBAF) Summary Report to Board

3.1. The full CBAF – as also having been presented to Board Assurance Committees this month – is provided as Appendix One. (The Board is being presented with this full version today, to serve as the "baseline" assessment view for Board awareness. Future iterations will look different to this, without as much detail and a more summarised / overview style adopted).

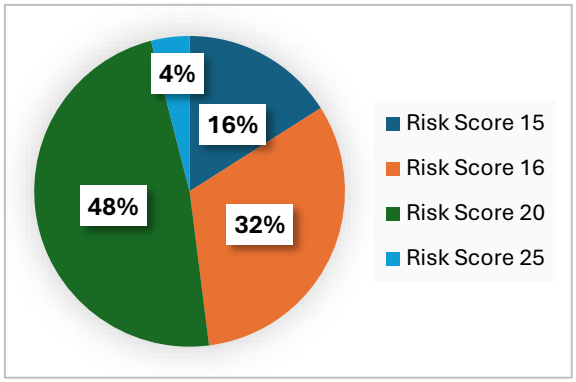
3.2. **All** six Board-agreed Strategic Objectives currently show "Partial Assurance" with Medium Risk Profile and Improving Delivery Trends, per the opening statements' provided by each Lead Executive Objective Owner. CBAF 6 ICB Cluster Organisational Capability To improve Strategic Commissioner Self-Assessments year-on-year against NHSE 'KLOEs' is showing slight improvement in its aligned "top Three" risks profile currently.

4. Corporate Risk Register Summary Report to Board

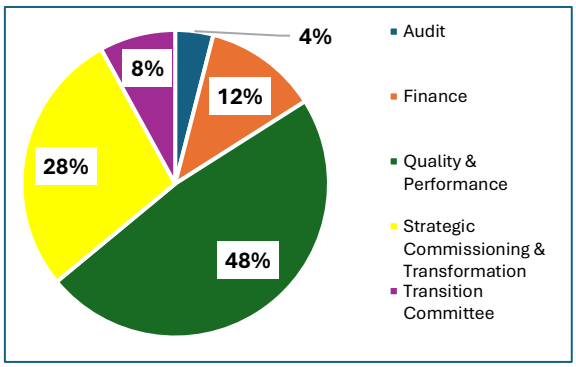
4.1. A summary of our current operational risks with a current score of 15 or above – per Cluster Risk Strategy – is presented in Table One below:

TABLE ONE

Inherent Risk Score	No.
15	4
16	8
20	12
25	1
TOTAL	**25**



Lead Committee	No.
Audit	1
Finance	3
Quality & Performance	12
Strategic Commissioning & Transformation	7
Transition Committee	2
TOTAL	**25**



5. Risk Profile and 'Heatmap'

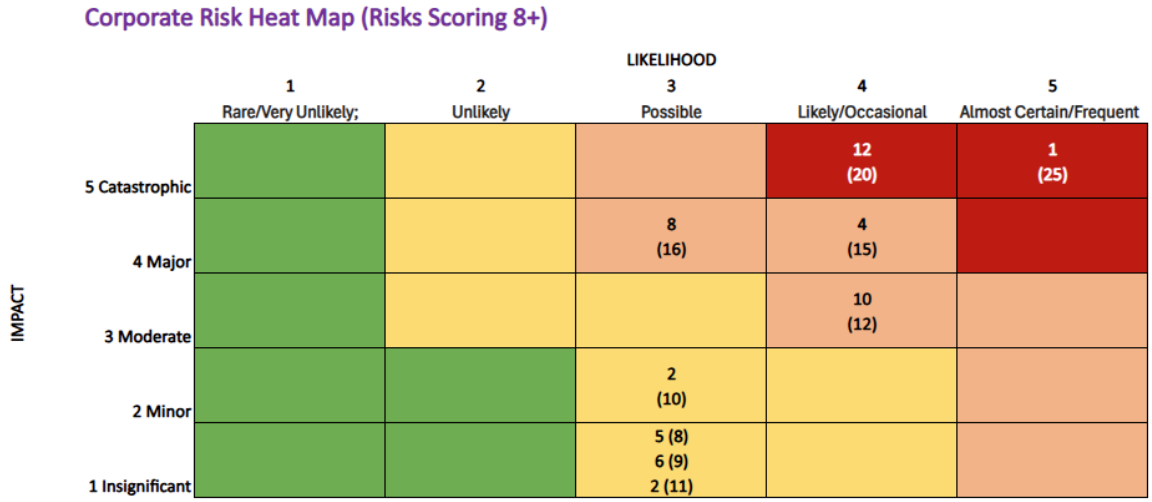
5.1. Currently, our Risk Profile shows there are a total of **50** open risks on the Corporate Risk Register; **25** scoring 15 or more. This is a significantly high-scoring Risk Profile. However this may be deemed acceptable per existing Risk Appetite levels and where we are in our new organisational lifecycle. Our Risk Profile remains concentrated in the higher-risk categories, with **35** risks scoring 12+ and 13 risks rated Very High.

5.2. The most significant area of exposure is the cohort of 12 risks scoring 20, while one risk remains at the maximum score of 25, requiring continued Board oversight and assurance. The Board is also asked to endorse a continued focus on mitigation and assurance for these highest-rated risks as a priority; through targeted Executive action and Board / Audit Committee scrutiny to reduce exposure within Cluster Risk Appetite Statements.

5.3. The most significant operational risks, with Inherent Risk Scores of 20+ are as follows:

- Digital Cyber Security **(Risk Ref. #2) – 20**
- Inadequate provision of Epilepsy Nurse Specialists for children **(Risk Ref. #3) – 20**
- Infant & Neonatal Mortality **(Risk Ref. #23) – 20**
- Delays in Urgent and Emergency Care: STW **(Risk Ref. #29) – 20**
- Diabetes Management: STW **(Risk Ref. #30) – 20**
- Financial Sustainability: STW & SSOT System **(Risk Ref. #31) – 20**
- Financial Sustainability: STW & SSOT ICB **(Risk Ref. #54) – 20**

- Looked After Children Initial / Review Health Assessment **(Risk Ref. #46) – 20**
- UHNM Electronic Patient Record **(Risk Ref. #77) – 20**
- ND & Autism Pathway Commissioning for Children **(Risk Ref. #82) – 20**
- Revenue & Capital Financial Plan Delivery 26/27: STW & SSOT **(Risk Ref. #83) – 20**
- Designated Clinical Officer vacancy **(Risk Ref. #85) – 20**
- Ambulance Handover Delays **(Risk Ref. #26) – 25**



6. Future Reporting and Assurance

6.1. Future reports, once a trend is noticeable in terms of period-on-period change (technically all risks are New in this report, so none exists), themes trends, risk closures or additions will be included. Including a summarised, principal mitigation plans overview, where possible.

6.2. Board discussion and increased / enhanced Board Assurance Committee oversight of the current Risk Profile is required. As while there is no legally mandated or official standard average for organisations, across UK Corporate Governance as a whole, the Good Governance Institute would suggest that an average UK Corporate Risk Register typically contains between 10-30 strategic risks at any given time.

6.3. With our Cluster currently at the upper end of that spectrum, due to the current number of our high-scoring risks alone, it is recommended the Board task the Audit Committees in Common with exploring how we could seek to descale this current Risk Profile and avoid "risk fatigue" setting in among Board & Committee members

7. Deep Dives on Outlier Risks

7.1. **CRR#26** (Ambulance Handover Delays: Lead Committee / Lead Exec = Quality & Performance / Phil Smith).

7.2. Descriptor = IF Ambulance Handover delays and average handover times sustain, do not reduce and achieve our operational planning commitments; THEN patient delays awaiting to handover at Acutes will occur; RESULTING IN reduced available capacity for ambulances to respond in the community and impacts upon patient outcomes, patient safety, quality of care and risks of patient harm.

7.3. None of our (preliminary) Risk Appetite Statements agreed by Board in April 2026 would expect any Compliance / Performance & Delivery risks to be scored at 25. The proposed target score of 9 is also very ambitious given the risk has been on Cluster and predecessor ICB registers for over 12 months, without any movement towards Target Risk Score.

7.4. The latest update notes – "*Risk is reviewed and supported at UEC Board to remain static. Although the ambulance service have reduced their internal risk across the West Midlands, this is due to improvements across their whole footprint, where our system remains continually challenged. Although there was some incremental improvements previously in Ambulance handover times at UHNM, these have been consistently above the national requirement. Recent operational pressures have impacted operational performance, with a critical incident being declared at the end of June across UHNM*."

7.5. The Board is asked to whether it would like to commission an in-depth review (to be undertaken by the relevant lead Board Assurance Committee, with potential redefinition of new mitigating actions per acceptable Risk Appetite Statement[1] for the 'Performance & Delivery' category) for this current, highest-possible scoring risk.

8. Conclusion

8.1. The deployment of the new Risk Register for the Cluster has been undertaken well, including via a recent "spring clean" of the register post-migration to the new system, Risk Owners responding in the main proactively and positively in line with the new ICB Cluster Risk Strategy. The current Risk Profile however continues to warrant enhanced oversight and assurance at Lead Board Assurance Committees to explore how this can be reduced in line with the new Risk Strategy.

8.2. The development of the new Cluster CBAF has also been satisfactorily undertaken, with the harmonisation of two different legacy approaches / systems and a set of robust Strategic Commissioner facing new CBAF Strategic Objectives agreed and robust Controls & Assurances developed for each. Given the high Risk Profile, the Board Assurance Committees need to ensure their Business Cycles align with agendas and papers discussed at future meetings to ensure the focus is maintained on all areas of delivery and hopefully, improved positions in terms of CBAF Assurance Statements and reduced risk scores

[1] Performance & Delivery Risk Appetite Statement = "*We have an open risk appetite – e.g. we want to move away from orthodox ways of managing service provision towards outcome-based indicators of performance. We are willing to take measured risks to improve services / outcomes over time… We have low tolerance for unmanaged or repeated underperformance, especially where it affects safety, equity, or key NHS standards*." Maximum Risk Scores = 15.

Appendix - Commissioning Board Assurance Framework

1. The Context for and Purpose of our CBAF

1.1. The Commissioning Board Assurance Framework (CBAF) is the principal way through which we hold ourselves to account for the delivery of our Board-established Strategic Objectives.

1.2. It is, as confirmed by the Good Governance Institute, a: *Structured governance tool that helps an organisation's Executive Leadership and Board of Directors monitor Strategic Objectives and manage critical risks. It maps out the primary goals, identifies what could threaten them, and provides evidence that sufficient controls are actively working to support their delivery.*

2. Strategic Contexts for Assurance

2.1. The Cluster's CBAF translates complex operational data into clear, high-level dashboards and answers four essential questions for Board Members:

- What are our Key Objectives?
- What are the Principal Strategic Risks that could prevent their being achieved? [1]
- Are our Assurance Controls working? [2]
- What is the evidence? [3]

2.2. Assurance requires whole Unitary Board collective accountability and responsibility to discuss, challenge and confirm that the Action Plans implemented to deliver our ICB Strategic Objectives are appropriate. Or whether those need redefining, where successful delivery is threatened. The Monitoring & Reporting information informs the ongoing, ever-changing confidence levels of the Board regarding achievement of our Strategic Objectives but cannot be captured within a single document (the CBAF). The rest of the Meeting Agenda + Papers should equally inform the Board's / the Committees' "live" decision-making about relative assurance levels.

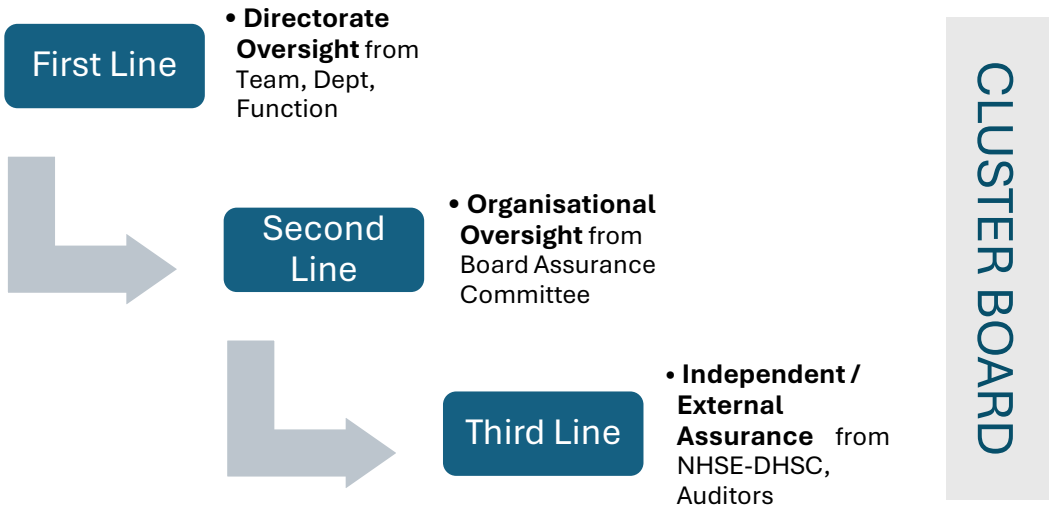
3. CBAF Assurance

3.1. Assurance will be secured through application of the *"Three Lines of Assurance Model"*:

[1] Strategic Focus: It focuses exclusively on the top risks to the Strategic Objectives (annual goals) not operational risks

[2] Policies, Systems, Procedures that mitigate those risks, mapped to show where assurance comes from (internal or external) to confirm controls are effective, rather than just stating they exist

[3] Any Data, Reports, Audits that give Board and/or Committees assurance that our Controls are effective



4. CBAF Strategic Objectives

4.1. These have been derived from Cluster ICBs Five-Year Strategic Commissioning Plans, to support achievement of our primary purpose / mission and mirroring our 2026/27 - 2028/29 'Strategic Intents' to:

- To shift care systematically from hospital to community / neighbourhood settings;
- To reduce avoidable demand and unwarranted variation through proactive population-based models;
- To improve access, flow and patient experience across UEC & elective pathways; and
- To stabilise, then improve system financial sustainability.

4.2. Each Objective has then been translated into tangible, "SMART" success measures which define the endpoint (outcome), rather than the process of trying to get there. In this way, they permit in- and end-year assessment as to whether an Objective has been achieved; making Assurance easily understood by all Board Members.

5. CBAF Dashboard Structure

Strategic Objective: What we are trying to achieve [4]
Principal Risks: The threats to achieving that objective
Risk Owner(s): The Lead Exec(s) responsible for managing the risk
Key Controls: The measures put in place to manage the risk
Sources of Assurance: The reports or audits confirming that Controls are working
Gaps in Assurance: Areas where additional oversight or action is required

6. The Key for CBAF Dashboard Assurance Statements

Statement	Review / Rationale

[4] Any company should have 3 to 5 Strategic Objectives at any given time, to ensure teams & resources aren't spread too thinly, and allowing the necessary time to deliver 'mission critical' priorities effectively. These may be subdivided into c. 15 Strategic Goals, providing these are mapped in the context of a Strategic Framework (e.g. CBAF), as a comfortable number of subset priorities

Fully Assured	**Reasonable Assurance / High Confidence Level:** the Strategic Objective Owner (Lead Exec) has actively verified the Controls & Data and is confident these are free from errors. Taking account of the issues identified, the Board can take strong assurance that the Controls upon which the ICB relies to manage this risk are suitably designed, consistently applied and effective.
Partially Assured	**Qualified Conclusion / Moderate Confidence Level:** the Objective Owner has verified that procedures follow reasonable assurance standards but has identified specific areas where insufficient evidence or certain metrics show conditional matters - the data is generally reliable, with exceptions that require caution.
Limited Assurance	**Qualified Conclusion / Moderate to Low Confidence Level:** the Objective Owner has verified that procedures primarily consist of local analytical reviews + management inquiries rather than deeper, third-party verification - the data meets basic preconditions, with the Lead confirming there are no obvious "red flags".
Not Assured	**Limited Conclusion / Low Confidence Level:** the Objective Owner has identified Disclaimer or Adverse statements that represent the lowest confidence in delivery, or insufficient evidence exists to form a positive opinion or conclusion is – the data is flawed and misleading and there are "red flags".

Strategic Objective / Strategic Risk Summary

CBAF – 01: Targeting Resources & Reshaping Models of Care To deliver the 5 Key System Shifts through our Commissioning Intentions: **TREATMENT to PREVENTION** – rollout of 26/27's jointly agreed Key Priorities	**Strategic Link**	*Five-Year Commissioning Plans (Five Big Changes)*	
	Assurance Leads	**Lead (Support) Execs =**	**Lead Committee =**
		CMO (DS&O)	***Senate/SCTC***

Controls Assurance Statements

Control	Gaps in Control	Sources of Assurance
Board-approved 5-Year Strategic Commissioning Plan + Annual Commissioning Intentions aligned to the Five Big Changes / NHS 10 Year Health Plan. **Primary Care Commissioning** ☑ Primary Care Strategy (focus on transformation via Integrated Neighbourhoods, maximised contribution of Community-based Primary Care, strengthened commissioning, contracting, transformation support); ☑ 2 GP Federations able to deliver at scale + fully embedded PCNs; ☑ PCN OD programme supports strategic direction & developing maturity of General Practice to deliver Neighbourhood Agenda; ☑ SSOT Local Implementers (primary, secondary, community, voluntary providers) to test care models. **Medicines Optimisation** ☑ Development of a Cost Improvement Plan; ☑ Commissioning Community Pharmacy, General Practice + other providers (focus on safety, quality, efficiency to support prevention, LTC management, acute care); ☑ Ensuring medicines use is considered as part of pathway redesign / new models of care; ☑ Developing local capacity and capability.	☒ Variable Place & Neighbourhood models; ☒ Differing levels of maturity of Primary Care across Neighbourhoods; ☒ Collective Action may impact on implementation / pace; ☒ Unified PHM approach.	***First Line (Owner)*** – *Commissioning Teams* *PHM Team* *Programme Management Office* *Clinical Leads Place Teams* *Benefits Realisation Reports* *Quarterly Programme Highlight Reports* ***Second Line (Committee)*** - *SCTC* *Health & Care Senate* *Q & P Committee* *Integrated Performance Reports* *Health & Wellbeing Board reports* ***Third Line (External)*** – *NHSE Assurance Meetings* *Office for Health Improvement & Disparities +* *National Population Health benchmarking* *External Audit* *Regional Prevention Programme reviews*

Controls Assurance Statements

Control	Gaps in Control	Sources of Assurance
Health & Care Senate ☑ Robust clinical governance approvals of clinical pathway / policy; ☑ Internal advisory panel on commissioning specifications in place. **Primary Care** ☑ Effective leadership, governance, oversight of quality & performance of Primary Care / PODs; ☑ Primary Care Forum; ☑ SCTC Committees' Reports incl. Business Cases; ☑ PMO oversight of all 26/27 priority programmes; ☑ Benefits Realisation & Exception Reports; ☑ Five-Year Strategic Commissioning Plan + 26/27 Commissioning Intentions; ☑ PMO governance (all strategic priority programmes); ☑ Health & Care Senate providing oversight of commissioning priorities / pathway redesign; ☑ PHM methodology adopted across major commissioning programmes; ☑ Prevention priorities aligned with Core20PLUS5 + local population health intelligence; ☑ Neighbourhood implementation progressing across Places with governance arrangements established; ☑ Benefits realisation reporting developed for priority transformation programmes.	☒ Variable Place & Neighbourhood models; ☒ Differing levels of maturity of Primary Care across Neighbourhoods; ☒ Collective Action may impact on implementation / pace; ☒ Unified PHM approach.	***First Line (Owner)*** *–* *Commissioning Teams* *PHM Team* *Programme Management Office* *Clinical Leads Place Teams* *Benefits Realisation Reports* *Quarterly Programme Highlight Reports* ***Second Line (Committee)*** *-* *SCTC* *Health & Care Senate* *Q & P Committee* *Integrated Performance Reports* *Health & Wellbeing Board reports* ***Third Line (External)*** *–* *NHSE Assurance Meetings* *Office for Health Improvement & Disparities +* *National Population Health benchmarking* *External Audit* *Regional Prevention Programme reviews*

Controls Assurance Statements

Gaps in Assurance	Mitigations (Progress made/target dates)	Progress Made
☒ Independent assurance that prevention programmes are reducing avoidable demand; ☒ Assurance that Population Health Management is consistently driving commissioning decisions; ☒ Assurance regarding measurable return on investment from prevention initiatives; ☒ Assurance that neighbourhood delivery models are consistently implemented across both ICBs; ☒ Independent validation that prevention programmes are reducing health inequalities.	☑ Complete implementation of the Cluster Prevention Framework by Q3 26/27; ☑ Embed Population Health Management within all major commissioning programmes; ☑ Introduce a common Prevention Outcomes Framework across SSOT and STW; ☑ Strengthen Benefits Realisation reporting through PMO and SCTC; ☑ Develop consistent neighbourhood implementation standards; ☑ Introduce quarterly reporting on prevention outcomes, inequalities and return on investment.	☑ Five-Year Strategic Commissioning Plan + 26/27 Commissioning Intentions approved; ☑ PMO governance established for all strategic priority programmes; ☑ Health & Care Senate providing oversight of commissioning priorities and pathway redesign; ☑ PHM methodology adopted across major commissioning programmes; ☑ Prevention priorities aligned with Core20PLUS5 & local population health intelligence; ☑ Neighbourhood implementation progressing across Places with governance arrangements established; ☑ Benefits realisation reporting developed for priority transformation programmes.

Top Three Aligned Corporate Risks re. the Strategic Objective

Risk Ref.	Descriptor	Trend	Score
79	General Practice Collective Action	**New**	**9**
76	Risk to Accessible High Quality and Sustainable Primary Care Services	çè	**16**
43	Continuing Risk Associated with Shared Care Prescribing - STW System	**New**	**16**

Overall Assurance Summary

Current / Latest...		
Delivery Status & Rationale		**PARTIALLY ASSURED**
Risk Assessment & Rationale	**Medium**	
Trend & Explanation	ì	**IMPROVING** (Q4 25-26 to Q1 26-27)

Strategic Objective / Strategic Risk Summary

CBAF – 02: Developing System Architecture & Governance, Targeting Resources Towards Implementation of New Delivery Approaches / Models of Care To deliver the 5 Key System Shifts through our Commissioning Intentions: **HOSPITAL to COMMUNITY** – rollout of neighbourhoods, integrated care, place-based population health approaches	**Strategic Link**	*Five-Year Commissioning Plans (Five Big Changes)*	
	Assurance Leads	**Lead (Support) Execs =**	**Lead Committee =**
		CO SD&I (CO S&IO)	***SCTC***

Controls Assurance Statements

Control	Gaps in Control	Sources of Assurance
☑ Approved Strategic Commissioning Plan; ☑ ICB Cluster Operating Model; ☑ Board approval of System Architecture & Governance approach for Neighbourhood delivery – e.g. Place established as Board (sub)committees; ☑ Programme Governance through SCTC & Board; ☑ Outcomes Framework - Investment approach aligned to neighbourhood priorities; ☑ Provider development / route maps (e.g. Group, AFT)	☒ Aligned H&WB Board approaches; ☒ Consistent adoption of Place & Neighbourhood governance, prioritisation, implementation models; ☒ Neighbourhood delivery at scale; ☒ Populated Place & Neighbourbood teams; ☒ Route map for system architecture aligned to 10 Year Plan delivery.	***First Line (Owner)*** – *Place & Commissioning Teams* ***Second Line (Committee)*** - SCTC - outputs & update reports ***Third Line (External)*** - DHSC-LGA Assurance Meetings (Q1 outputs)

Gaps in Assurance	Mitigations (Progress/Target dates)	Progress Made
		SCTC assured that plan is now 50% complete

Top Three Aligned Corporate Risks re. the Strategic Objective

Risk Ref.	Descriptor	Trend	Score
38	System Digital Operating Model: STW	çè	9
73	Impact of Government Reform and Transition	çè	16
79	GP Collective Action	**New**	9

Overall Assurance Summary

Current / Latest...		
Delivery Status & Rationale		**PARTIALLY ASSURED**
Risk Assessment & Rationale	**Medium**	
Trend & Explanation	ì	**IMPROVING** (Q4 25-26 to Q1 26-27)

Strategic Objective / Strategic Risk Summary			
CBAF – 03: Targeting Resources & Reshaping Models of Care To deliver the 5 Key System Shifts through our Commissioning Intentions: **ANALOGUE to DIGITAL** – delivering a unified digital, data & population intelligence capability to support strategic commissioning / system transformation	**Strategic Link**	*Five-Year Commissioning Plans (Five Big Changes)*	
	Assurance Leads	**Lead (Support) Execs =**	**Lead Committee =**
		CO S&IO (CFO / SIRO)	***SCTC***

Controls Assurance Statements

Control	Gaps in Control	Sources of Assurance
Digital, Data & Intelligence Strategy ☑ Board-approved Digital, Data & Intelligence Strategies for both ICBs; ☑ IG, Cyber Security & Data Protection arrangements; ☑ SIRO oversight arrangements; ☑ Caldicott arrangements. **Population Health Management & Intelligence** ☑ Board-approved 5 Year Commissioning & Population Health Improvement Plans; ☑ Strategic Commissioning Framework; ☑ Strategic analytics, segmentation & risk strat capability; ☑ Health inequalities strategy, intelligence & targeted intervention methodology. **Digital Transformation** ☑ Shared Care Record & interoperability programmes; ☑ Federated Data Platform & national digital programme adoption; ☑ Data architecture & information management standards; ☑ Digital programmes governed through Transformation & Digital Group;	☒ Digital maturity & capability remain variable across partner organisations; ☒ Interoperability / data-sharing arrangements are not yet fully developed across all systems; ☒ PHM tools & intelligence are not consistently embedded in decision-making / transformation programmes; ☒ Digital workforce, analytical capacity & specialist skills remain constrained; ☒ Benefits Realisation from digital investments is at varying levels of maturity; ☒ Dependence upon national programmes & delivery timescales for key enabling platforms.	***First Line (Owner)*** – *Chief Officer Strategy & Improving Outcomes Digital, Data & Analytics Teams* ***Second Line (Committee)*** - SCTC - outputs & update reports Transformation & Digital group Audit Committee (IG, cyber) ***Third Line (External)*** - *PHM Assurance from CAG (Q1 outputs)* *NHSE Digital & Technology Assurance* *External Audit reviews* *DSPT/CAF compliance assessment* *Cyber security assurance reviews* *Regional/National Digital Governance & Shared Care Record assurance processes* *Audit Committee (digital, IG & cyber)* *DSPT / CAF submission* *NHSE oversight*

Controls Assurance Statements		
Control	**Gaps in Control**	**Sources of Assurance**
Digital Transformation (continued) ☑ Benefits Realisation Framework for digital transformation investments. **System Leadership & Collaboration** ☑ Data & Digital Collaborative Forum; ☑ Analytics, Intelligence & Data Network; ☑ CIO Forum; ☑ Provider + Local Authority engagement on data-sharing & interoperability; ☑ Regional / National digital governance participation.	☒ Digital maturity & capability remain variable across partner organisations; ☒ Interoperability / data-sharing arrangements are not yet fully developed across all systems; ☒ PHM tools & intelligence are not consistently embedded in decision-making / transformation programmes; ☒ Digital workforce, analytical capacity & specialist skills remain constrained; ☒ Benefits Realisation from digital investments is at varying levels of maturity; ☒ Dependence upon national programmes & delivery timescales for key enabling platforms.	
Gaps in Assurance	**Mitigations (Progress/ Target dates)**	**Progress Made**
☒ Assurance regarding system-wide interoperability & information-sharing maturity; ☒ Assurance that PHM capability is consistently driving service redesign / commissioning decisions; ☒ Assurance regarding realisation of quantified benefits from digital investments; ☒ Assurance regarding long-term analytical / digital workforce capacity; ☒ Independent validation of population intelligence methodologies and outcomes.	☑ Digital maturity: implement Cluster-wide Digital, Data & Intelligence Strategy / maturity assessment framework; ☑ Adopt / embed PHM requirements within all major commissioning & transformation programmes; ☑ Interoperability: deliver agreed roadmap for Shared Care Record, data-sharing & system integration; ☑ Digital workforce: develop Digital, Analytics & Intelligence Workforce Plan; ☑ Benefits Realisation: establish formal digital framework & quarterly assurance reporting; ☑ Governance: finalise & implement Cluster Digital Governance Framework / reporting architecture.	

Top Three Aligned Corporate Risks re. the Strategic Objective			
Risk Ref.	**Descriptor**	**Trend**	**Score**
41	Lack of System Capacity and Funding to Support Digital Clinical Risk	çè	11
N/A – yet to be added	Insufficient analytical, digital & PHM capability / capacity to support strategic commissioning	çè	9
N/A – yet to be added	Inadequate interoperability, information-sharing & data quality limiting population insight / transformation delivery	çè	9

Overall Assurance Summary		
Current / Latest...		
Delivery Status & Rationale		**PARTIALLY ASSURED**
Risk Assessment & Rationale	**Medium**	
Trend & Explanation	ì	**IMPROVING** (Q4 25-26 to Q1 26-27)

Strategic Objective / Strategic Risk Summary

CBAF – 04: Productivity, Efficiency & Financial Sustainability To achieve our **Joint Financial Vision** through our Commissioning Intentions: rollout of 26/27's Financial Strategy / 10 Year Plan + MTFP priority deliverables and strong financial management / grip and control	**Strategic Link**	*Five-Year Commissioning Plans (Key Enablers)*	
	Assurance Leads	**Lead (Support) Execs =**	**Lead Committee =**
		CFO (CO D&I)	***Fin Co***

Controls Assurance Statements

Control	Gaps in Control	Sources of Assurance
Financial Planning & Governance ☑ Board-approved Financial Strategy; ☑ Board-approved MTFP; ☑ System Collaborative Financial Management Agreement. **Financial Management & Control** ☑ SFIs, Scheme of Delegation & Finance Policies; ☑ Budget setting & budget holder accountability; ☑ Monthly financial reporting and forecasting. **Efficiency & Transformation**	☒ Multi-year efficiency plans & Benefits Realisation arrangements remain at varying levels of maturity; ☒ Financial sustainability remains reliant on delivery of system operational recovery & productivity improvements; ☒ Strategic Commissioner / Payor capability continues to develop across the Cluster; ☒ Financial exposure to external demand, inflation & national policy changes remains significant;	***First Line (Owner)*** – *All functions have a part to play in delivering productivity, efficiency, financial sustainability* ***Second Line (Committee)*** - *Finance Committee Finance Reports* *Finance Strategy* *SCTC Efficiency & Transformation Oversight* *Audit Committee Internal Audit Grip & Control* *Integrated Performance Report to Board* ***Third Line (External)*** -

☑ Efficiency Oversight Group; ☑ Efficiency Programme Governance Framework; ☑ Benefits Realisation Framework. **Independent Oversight** ☑ Internal Audit Programme; ☑ Audit Committee; ☑ NHSE Financial Oversight.	☒ Financial incentives & accountability arrangements across system partners are not yet fully aligned.	*External Audit Value for Money Report* *NHSE CRM Assurance Meeting*

Controls Assurance Statements		
Gaps in Assurance	**Mitigations (Progress/Target dates)**	**Progress Made**
☒ Assurance regarding delivery of recurrent financial sustainability beyond 26/27; ☒ Assurance that all efficiency opportunities are fully quantified, deliverable & measurable; ☒ Assurance regarding the long-term affordability of operational recovery trajectories; ☒ Assurance over the impact of inflationary, policy & demand-driven pressures; ☒ Independent validation of Benefits Realisation across transformation programmes.	☑ Efficiency maturity - implement a Cluster-wide Benefits Realisation Framework + assurance process. Develop multi-year efficiency plan; ☑ MTFP assumptions - complete review & alignment of Cluster financial assumptions / MTFP trajectories; ☑ Financial recovery - Deliver Recovery plan milestones & achieve financial plan forecast; ☑ Strategic Commissioner role - develop & implement Strategic Commissioner / Payor Development Plan; ☑ Collaborative management - finalise & implement SSOT-STW System Collaborative Financial Management Agreement.	☑ Multi-Year efficiency, productivity & transformation opportunities identified. Efficiency Oversight Group in place. Multi-Year Efficiency Plan development workshops (Jul-26). Multi-Year PIDs in progress: on track for 31.8.26; ☑ Cluster ICB & Providers session to review Finance Strategy/MTFP planning, efficiency/productivity + transformation assumptions - to incorporate Benefits Realisation update; ☑ 26/27 Recovery Plan Actions – updates provided to Leadership Team, Finance Committee Jul-26 & Deep Dive review into AACC/CHC Jul-26; ☑ Strategic Commissioning Value review programme fully developed as part of Efficiency Programme by 31.08.26; ☑ System Collaborative Financial Management Agreement 1st draft shared with SSOT for agreement in Q3 26/27.

Top Three Aligned Corporate Risks re. the Strategic Objective				**Overall Assurance Summary**
Risk Ref.	**Descriptor**	**Trend**	**Score**	**Current / Latest...**

83	Revenue & Capital Financial Plan Delivery 26/27: STW-SSOT	çè	20	**Delivery Status & Rationale**		**PARTIALLY ASSURED**
54	ICB Financial Sustainability	çè	20	**Risk Assessment & Rationale**	Medium	• YTD/FOT & Efficiency on plan, recovery plan in place to manage key risks • Multi-Year efficiency programme in development • Financial Governance established • MTFP/Financial Strategy & Strategic Transformation Programme Interdependencies in development/discussion
31	Financial Sustainability – System Interdependencies	çè	20	**Trend & Explanation**	ì	**IMPROVING** (Q4 25-26 to Q1 26-27)

Strategic Objective / Strategic Risk Summary

CBAF – 05: Quality, Safety, Access & Experience To achieve our **High Quality, Safe Care Vision as a Strategic Commissioner**: focus on prevention, high outcomes, reducing avoidable harm, enhancing patient experience, minimising variation and timely access of care.	**Strategic Link**	*Five-Year Commissioning Plans (Key Enablers) Quality Strategy: NHS-funded care in England (2026)*	
	Assurance Leads	**Lead (Support) Execs =**	**Lead Committee =**
		CNO (CMO)	***QPC***

Controls Assurance Statements

Control	Gaps in Control	Sources of Assurance
Clinical Governance ☑ Established Cluster-wide Health & Care Senate in place for SSOT. **Primary Care** ☑ Effective leadership, governance, oversight of quality & performance of Primary Care / PODs; ☑ Primary Care Forum (SCTC subcommittee). **Value Based Healthcare** ☑ Senate clinical value embedded in commissioning to improve outcomes / use of resources **Quality Governance oversight & assurance**	☒ Cluster quality priorities not identified; ☒ Cluster Quality Strategy/Framework clearly identifying roles responsibilities & escalations; ☒ Health & Care Senate model, Cluster-wide; ☒ Neighbourhood & INT implementation; ☒ Cluster-wide Primary Care Quality Data Set; ☒ Clinical leadership consistent throughout commissioning cycle; ☒ Full quality intelligence via revised system oversight / data arrangements leading to	***First Line (Owner)*** - *CNO / CMO* ***Second Line (Committee)*** - *QPC / Clinical & Care Senate (Approval) - outputs & update reports Commissioning Teams* ***Third Line (External)*** -

☑ Cluster-wide Perinatal Governance in place; ☑ NHS Quality Strategy 2026 + National Escalation Framework (NQB 2022) + Host / Home Commissioner guidance embedded; ☑ Impact Assessment processes for service change & transformation programmes; ☑ Patient Safety Incident Response Framework (PSIRF) implementation & learning reviews from incidents, complaints, claims, inquests; ☑ Continuous Quality Improvement methodologies embedded across the system;	intelligence triangulation, to strengthen proactive risk I.D. & decision-making; ☒ Clinical governance processes remain dependent upon provider reporting, limiting direct ICB oversight of some quality risks; ☒ STW & SSOT QIA processes unaligned; ☒ Learning from incidents, complaints / patient feedback not yet consistently translated into measurable commissioning improvements across all services; ☒ Independent advocacy for serious maternal & perinatal events (from Sep-26).	*HWWBs + HOSCs scrutiny;* *NHSE Assurance & Oversight Meeting + NOF;* *External Audit findings;* *Independent external reviews & peer reviews* *CQC assessments & inspection outcomes*

Controls Assurance Statements

Control	Gaps in Control	Sources of Assurance
Quality Governance oversight & assurance (contd.) ☑ Safeguarding partnership governance; ☑ Complaints, Patient Experience & Healthwatch intelligence including MNVP; ☑ Child Death processes Cluster-wide incl. surveillance; ☑ SEND & Neurodevelopmental Programme reporting; ☑ Transformation & Efficiency Programme surveillance; ☑ Corporate / Directorate Risk Registers; ☑ Strategic Commissioner responsibilities & values based principles allocate resources effectively & oversee quality of Primary Care / Neighbourhood health; **Strategic Oversight** ☑ Contract quality schedules + strategic meetings provide ongoing monitoring of provider compliance with quality standards & improvement requirements; ☑ Regional Quality, Perinatal, Mortality groups + safety forum / LeDeR.		
Gaps in Assurance	**Remedial Actions (Progress/ Target Dates)**	**Progress Made**

☒ Assurance re. delivery of the AACC efficiency programme 26/27; ☒ Infant & Neonatal Mortality oversight due to increased concern re. lack of reduction in Stoke rate of death / increasing in Telford & Wrekin; ☒ ND, ASD & CAMHS waiting list reductions; ☒ Co-ordinated oversight of quality.	☑ Weekly AACC efficiency meetings check progress vs. Efficiency Plan, mitigating when plan is off trajectory; ☑ PHM approach used to understand infant and child death: led by CNO & DPHs; ☑ Working Group's strategic commissioning focus pan-Cluster due to variation; ☑ Cluster Quality Strategy Quality Strategy to be developed (Jan 27).	☑ When AACC plans are not delivering, mitigations are agreed and put in place with expected recovery trajectories; ☑ Efficiency Oversight Group governance in place; ☑ Workshop in Oct-26 for SSOT for infant mortality; ☑ Commenced engagement with strategy development.

Top Three Aligned Corporate Risks re. the Strategic Objective

Risk Ref.	Descriptor	Trend	Score
23	Infant & Neonatal Mortality	çè	20
52	Paediatric End of Life Care	çè	16
42&82	Adult / Child ADHD & Autism waiting lists and commissioning	çè	16

Overall Assurance Summary

Current / Latest...		
Delivery Status & Rationale		PARTIALLY ASSURED
Risk Assessment & Rationale	Medium	
Trend & Explanation	ì	IMPROVING (Q4 25-26 to Q1 26-27)

Strategic Objective / Strategic Risk Summary

CBAF – 06: ICB Cluster Organisational Capability To improve our Strategic Commissioner Self-Assessments year-on-year against NHSE 'KLOEs' (e.g. moving from "Starting" to "Maturing") to help underpin our Transformation & Delivery

Strategic Link	*Five-Year Commissioning Plans (Key Enablers)*	
Assurance Leads	**Lead (Support) Execs =**	**Lead Committee =**
	COS (All Execs/SLT)	***PCI***

Controls Assurance Statements

Control	Gaps in Control	Sources of Assurance
ICB OD	☒ All Place Boards set up;	***First Line (Owner)*** –

☑ NHSE-PACE Exec / Board Development programmes; ☑ SLT Development programme; ☑ EDI Board Development programme; ☑ Inclusion development & recruitment actions for ICB workforce linked to internal PSED data; ☑ ICB OD Plan encompassing Leadership / Values / Staff Survey / Wellbeing; ☑ Internal Operating Model clarifying roles / responsibilities at team level; ☑ Training Plan linked to Strategic Commissioning Capability Assessment; ☑ PCI (Part A) Committee Oversight + Reports; ☑ Audit Committee oversight of appropriate HR outcomes & governance. **Inclusion, Workforce/OD, Comms & Involvement** ☑ ICB Involvement Strategy & delivery; ☑ Workwell / Widening Access Demonstrator programme group (into PCI); ☑ Targeted OD work at PLACE level to support development of System architecture (e.g. PCNs OD);	☒ Governance linked to devolution of funding to Anchor Institutes & clarity of contracting methodology for workforce, engagement, inclusion metrics; ☒ Clarity from NHSE on assurance route of Primary Care Workforce Plans; ☒ Overview of System workforce plans & liaison with Education Providers on upcoming trends / demand for training places – now an NHSE function – unclear on process at Region (likely to be undertaken by PCI Part B)	*CoS however all functions have their part to play in a high performing organisation. The work will be carried out in partnership with the wider Exec Team + SLT* ***Second Line (Committee)*** - *Joint Cluster ICB PCI: outputs & reports Audit Committee* ***Third Line (External)*** - *NHSE Assurance Meeting (Q1 outputs)*

Controls Assurance Statements

Control	Gaps in Control	Sources of Assurance
Inclusion, Workforce/OD, Comms & Involvement ☑ Strategic Workforce Plans overview from Anchor Institutions & HEIs liaison re. future requirements; ☑ Delivery of the Clustered ICB Involvement Strategy in line with Neighbourhood working; ☑ Clarity of input & good relationships with each Place HOSC, HWWB, MPs / Place OD; ☑ PCI Part B assurance: inclusion KPIs linked to commissioning intentions (PSED data), workforce	☒ All Place Boards set up; ☒ Governance linked to devolution of funding to Anchor Institutes & clarity of contracting methodology for workforce, engagement, inclusion metrics; ☒ Clarity from NHSE on assurance route of Primary Care Workforce Plans; ☒ Overview of System workforce plans & liaison with Education Providers on upcoming trends / demand	***First Line (Owner)*** – *CoS however all functions have their part to play in a high performing organisation. The work will be carried out in partnership with the wider Exec Team + SLT* ***Second Line (Committee)*** -

implications of commissioning & patient/population voice (outcomes linked involvement, satisfaction),. **Governance** ☑ Clear ICB decision making / governance structure; ☑ CBAF & Risk Registers for Board & Committees; ☑ Place Board development with clear governance into the ICB Board (in line with timing of new NHS Bill).	for training places – now an NHSE function – unclear on process at Region (likely to be undertaken by PCI Part B).	*Joint Cluster ICB PCI: outputs & reports Audit Committee* ***Third Line (External)*** **-** *NHSE Assurance Meeting (Q1 outputs)*
Gaps in Assurance	**Mitigations (Progress/Target Dates)**	**Progress Made**
☒ Commissioning outcomes linked to inclusion data; ☒ Training plan linked to Strategic Commissioning capability; ☒ Refreshed PCI committee ToR Part A & B; ☒ OD plan and internal Operating Plan in development with SLT colleagues; ☒ Place Boards in development in line with Modernisation Bill	☑ Training plan in development linked to Strategic Commissioning capability of ICB workforce; ☑ ICB OD plan in place but iterating & Operating Model in development – further SLT time Sep26; ☑ Development of inclusion, workforce & engagement/involvement metrics linked to commissioning intentions – to Board Nov26; ☑ PCI Part A by Sep26, followed by Part B by Oct26; ☑ Good Place relationships – 3 Boards formed & development day to support Staffs Place Board development Autumn 26 (CDIO).	

Top Three Aligned Corporate Risks re. the Strategic Objective

Risk Ref.	Descriptor	Trend	Score
87	Risk of lack of capacity (stress/burnout) of ICB colleagues to undertake OD/training to deliver a high performing organisation	↓	8
88	Risk of lack of clarity of roles/responsibilities between ICB-Providers-NHSE in delivery & assurance of Neighbourhood care (metrics / assurance & performance management)	↓	8

Overall Assurance Summary

Current / Latest...		
Delivery Status & Rationale		**PARTIALLY ASSURED**
Risk Assessment & Rationale	Medium	Risk scores decreasing (initially logged as 9s, now 8s)

89	Risk of development & delivery (via assurance / appropriate governance routes) of metrics associated with workforce-OD, involvement / engagement + inclusion linked to delivery of Neighbourhood care by Anchor Institutions	↓	8	**Trend & Explanation**	-	**NEW**

7. Appendix 1 – Glossary of Terms

Glossary of Terms

Assurance
Confirmation that the evidence provided by the report / the data etc, has created sufficient confidence in the reader that what is being reported to them provides them with the highest levels of certainty that the statements being made are trustworthy. “Being Assured” means:-

- ☑ Full clarity about the authenticity of a Strategic Objective success statement;
- ☑ Knowledge the right Controls are in place to help ICB achieve the Objective & desired outcomes;
- ☑ Assurance those are being properly implemented & outputs / actions adhered to;
- ☑ Performance information stating current achievements are “SMART”;
- ☑ Assurance that risks are being graded correctly / consistently for each Strategic Objective;
- ☑ Assurance that the identified actions (mitigations) fully address the root cause of the risk;

Reassurance
Confirmation or re-iteration that a thing is true, with the intention of restoring or reconfirming confidence.

Board
The group of individuals with authority to vote on matters of significance to the organisation.

Framework
A conceptual structure that provides as a guide for something, comprising the systems, processes, behaviours and hierarchies within which certain tasks are done.

Governance
The systems and processes established to systematically support the achievement of purpose and objectives. Performance management and risk management are both integral parts of governance, as both are concerned with ensuring the achievement of objectives.

Risk Appetite
The decision about the level of risk an organisation is prepared to accept in relation to a situation, after balancing potential opportunities and threats it presents. It represents a balance between the potential benefits of innovation and the threats that change can bring.

Risk Tolerance
The predetermined upper level of risk that an objective can be exposed to. This might be an maximum risk score or might relate to an upper Consequence or Likelihood rating which if reached must be mitigated at all cost.

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

Enclosure No: 08

Report to:	Integrated Care Boards in Common
Date:	24 September 2026
Title:	NHS Shropshire, Telford and Wrekin ICB Annual Report and Accounts
Presenting Officer:	Ian Green OBE, Chair
Author(s):	Imogen Hyde and Bethan Emberton

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

Appendices:	Appendix 1 - NHS Shropshire, Telford and Wrekin ICB Annual Report and Accounts Appendix 2 - Summary of the NHS Shropshire, Telford and Wrekin ICB Annual Report and Accounts.

Purpose of the Paper:

The purpose of this report is to submit the Annual Report and Accounts to a Public Board Meeting which will provide assurance to the Board that the Integrated Care Board (ICB) has met its statutory requirements.

History of the paper, incl. date & whether for A / D / S / I (as above):	Date
Board Approved the Annual Report and Accounts	June 2026

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

NHS England has confirmed there is no requirement for Integrated Care Boards (ICBs) to hold an Annual General Meeting (AGM) and by submitting an annual report and accounts to a Public Board Meeting, it meets statutory requirements.

Recommendations:

☑ To **ASSURE** the Board that the ICB has met the Annual Report and Accounts statutory requirements.

Impact Assessments:					
	Completed?			**If N - N/A, Rationale**	**If Y, Outcome / Date Reported & Signed off**
Data Protection Impact Assessment (DPIA)	**Yes** ☐	**No** ☐	**N/A** ☒	Click or tap here to enter text.	*Reported to IG Committee:* Click or tap to enter a date.
Integrated Impact Assessment (IIA)	**Yes** ☐	**No** ☐	**N/A** ☒	Click or tap here to enter text.	*Outcome and date of completion:* Click or tap here to enter text.

Is the decision within Scheme of Financial Delegation (SOFD) powers & limits	**Yes**	☒	**No**	☐
Any potential / actual Conflict of Interest?	**Yes**	☐	**No**	☒
N/A	*N/A*			

Integration with Commissioning Board Assurance Framework (CBAF)			
CBAF1	☐	**CBAF4**	☐
CBAF2	☐	**CBAF5**	☐
CBAF3	☐	**CBAF6**	☐

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

Enclosure No: 09

Report to:	Integrated Care Boards in Common
Date:	24 September 2026
Title:	NHS Staffordshire and Stoke-on-Trent ICB Annual Report and Accounts
Presenting Officer:	Ian Green OBE, Chair
Author(s):	Imogen Hyde and Bethan Emberton

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

Appendices:	Appendix 1 - Staffordshire and Stoke-on-Trent Annual Report and Accounts Appendix 2 - Summary of the Staffordshire and Stoke-on-Trent Annual Report and Accounts.

Purpose of the Paper:

The purpose of this report is to submit the Annual Report and Accounts to a Public Board Meeting which will provide assurance to the Board that the Integrated Care Board (ICB) has met its statutory requirements.

History of the paper, incl. date & whether for A / D / S / I (as above):	Date
Board Approved the Annual Report and Accounts	June 2026

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

NHS England has confirmed there is no requirement for Integrated Care Boards (ICBs) to hold an Annual General Meeting (AGM) and by submitting an annual report and accounts to a Public Board Meeting, it meets statutory requirements.

Recommendations:

☑ To **ASSURE** the Board that the ICB has met the Annual Report and Accounts statutory requirements.

Impact Assessments:

	Completed?			If N - N/A, Rationale	If Y, Outcome / Date Reported & Signed off
Data Protection Impact Assessment (DPIA)	**Yes**	**No**	**N/A**	Click or tap here to enter text.	*Reported to IG Committee:* Click or tap to enter a date.
	☐	☐	☒		
Integrated Impact Assessment (IIA)	**Yes**	**No**	**N/A**	Click or tap here to enter text.	*Outcome and date of completion:* Click or tap here to enter text.
	☐	☐	☒		

Is the decision within Scheme of Financial Delegation (SOFD) powers & limits	**Yes**	☒	**No**	☐
Any potential / actual Conflict of Interest?	**Yes**	☐	**No**	☒
N/A	*N/A*			

Integration with Commissioning Board Assurance Framework (CBAF)			
CBAF1	☐	**CBAF4**	☐
CBAF2	☐	**CBAF5**	☐
CBAF3	☐	**CBAF6**	☐

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

Enclosure No: 10

Report to:	Integrated Care Boards in Common
Date:	24 September 2026
Title:	5 Year Strategic Commissioning Plan – H1 review
Presenting Officer:	Dr Lorna Clarson, Chief Officer: Strategy and Improving Outcomes
Author:	Gemma Smith, Director of Strategy and Commissioning

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

Is the decision within Scheme of Financial Delegation?	**Yes**	☒	**No**	☐
Any potential / actual Conflict of Interest?	**Yes**	☐	**No**	☒

N/A

Appendices:	None.

Purpose of the Paper:

This report provides the Board in Common with a six-month update on progress against the Cluster's Five-Year Strategic Commissioning Plans. It highlights key achievements, areas of progress, challenges and risks, and sets out priorities for the remainder of 2026/27, providing assurance on the Cluster's continued development as a strategic commissioner focused on improving outcomes, reducing health inequalities and delivering more integrated, neighbourhood-based care.

The report is specifically focused on delivery of the priorities and commitments set out in the Strategic Commissioning Plans and does not provide a comprehensive update on all ICB programmes, operational activity or performance areas. Updates are limited to programmes and initiatives that directly contribute to the delivery of the strategic commissioning and transformation ambitions within the plans.

Executive Summary:

The first half of 2026/27 has seen strong progress in delivering the Five-Year Strategic Commissioning Plans despite significant organisational change. Key achievements include approval of the Cluster Operating Model, completion of the Strategic Commissioning Diagnostic Self-Assessment, development of the Strategic Commissioning Framework for Neighbourhood Health, and continued strengthening of Place, neighbourhood and Integrated Neighbourhood Team arrangements.

Progress has also been made across a range of strategic priorities, including community alternatives to hospital care, primary care access, prevention and health inequalities, delegated specialised commissioning, productivity and efficiency, and transformation of mental health, CYP, neurodevelopmental and SEND services. Enabling infrastructure for workforce, digital, governance and commissioning has also continued to develop.

The focus for the second half of the year will be on implementation and delivery, including operationalising the Strategic Commissioning Framework, improving outcomes for frailty and CVRM populations, strengthening community-based care and further embedding the Cluster Operating Model. Priorities also include reducing health inequalities, improving productivity and progressing key transformation programmes.

While progress has been positive, challenges remain, including pressures across urgent and emergency care, diagnostics, elective recovery, mental health out-of-area placements, neurodevelopmental demand and workforce capacity. Overall, the report demonstrates that the foundations for strategic commissioning are now in place, with the next phase focused on delivering measurable improvements in outcomes, access, experience, productivity and health inequalities.

Recommendations:

- ☑ Note for **INFORMATION** the progress made during the first half of 2026-27 in delivering the Five-Year Strategic Commissioning Plans.
- ☑ Note for **INFORMATION** the priorities for delivery during the second half of 2026-27.
- ☑ Note for **INFORMATION** the key risks and challenges identified within the report and the actions underway to mitigate these.
- ☑ Receive **ASSURANCE** that progress continues to be made towards the development of a mature strategic commissioning organisation across the Cluster

History of the paper	Date
Shared with all Executive leads	7-9-2026

Impact Assessments:

	Completed?			If N - N/A, Rationale	If Y, Outcome / Date Reported & Signed off
	Yes	No	N/A		
DPIA	☐	☐	☒	Will be completed for individual programmes if required.	
Integrated Impact Assessment (IIA)	Yes	No	N/A	IIAs will be completed on individual programmes	
	☐	☒	☐		
	☐	☒	☐		

Integration with Commissioning Board Assurance Framework (CBAF)			
CBAF1	☒	CBAF5	☒
CBAF2	☒	CBAF6	☒
CBAF3	☒	CBAF7	☒

5 Year Strategic Commissioning Plan – H1 review

1. Introduction

1.1. The Five-Year Strategic Commissioning Plans set out the Cluster's ambition to improve population health outcomes, reduce inequalities, maximise value from resources, and support a shift towards prevention, neighbourhood health, and integrated care. Central to this is the development of a mature strategic commissioning approach aligned to population need and long-term outcomes.

1.2. This report provides a mid-year review of progress during the first six months of 2026/27. It highlights key achievements, including implementation of the Cluster Operating Model, development of the Strategic Commissioning Framework for Neighbourhood Health, strengthened Place and Integrated Neighbourhood Team arrangements, and continued delivery of transformation programmes focused on prevention, outcomes and inequalities.

1.3. Progress has been delivered amid significant organisational change, including management of change processes, voluntary redundancies, and the development of cluster-wide arrangements across two statutory organisations. Despite these challenges, momentum has been maintained across strategic priorities and the foundations for long-term delivery have been strengthened.

1.4. Priorities for the second half of 2026/27 will focus on implementation and measurable impact, including embedding the strategic commissioning operating model, delivering the Strategic Commissioning Framework through Place partnerships and Integrated Neighbourhood Teams, improving outcomes for priority populations, reducing inequalities, and enhancing the sustainability of health and care services.

1.5. While challenges remain, the report demonstrates continued progress towards becoming a mature, outcomes-focused strategic commissioner and delivering the ambitions set out in the Five-Year Strategic Commissioning Plans.

2. Operating Model and Strategic Commissioning Development

2.1 The first half of 2026/27 has been a significant milestone in the Cluster's journey towards becoming a mature strategic commissioner, with approval of the Cluster ICB Operating Model providing a clear framework for the organisation's future role and direction.

2.2 The Operating Model sets out a transition from operational oversight and transactional commissioning towards strategic leadership, population health improvement, system stewardship and effective resource allocation. At its core is a commissioning cycle that brings together population health intelligence, strategic planning, commissioning, payer functions and evaluation to support better prioritisation, investment decisions and outcomes. It also provides greater clarity on the respective roles of the ICB, Place partnerships, providers and

neighbourhoods, helping to align priorities, commissioning intentions and delivery across the system.

2.3 Alongside implementation of the Operating Model, the Cluster completed its first Strategic Commissioning Diagnostic Self-Assessment, establishing a baseline of organisational maturity and a shared understanding of effective strategic commissioning. The assessment identified strengths in population health intelligence, integrated needs assessment and strategic planning, while also highlighting opportunities to further strengthen market shaping, strategic purchasing, evaluation, value-based commissioning, return on investment methodologies and joint commissioning arrangements.

2.4 This progress has been achieved during a period of significant organisational change, including management of change processes, voluntary redundancies and the development of cluster-wide arrangements across two statutory organisations. Despite these challenges, strong foundations have been established for a more outcomes-focused approach to commissioning, supported by increased collaboration across STW and SSOT and the commitment and resilience of staff.

2.5 During the remainder of 2026/27, the focus will shift from design and assessment to implementation and demonstrable impact. Priorities include embedding the Operating Model in practice, developing a clear set of commissioning intentions across the Cluster, strengthening the ICB's role as a strategic commissioner and intelligent payer, and ensuring commissioning decisions are informed by population need, health inequalities, quality, outcomes and value. Further work will strengthen neighbourhood commissioning, population health management, prioritisation and resource allocation, evaluation and benefits realisation, while building the leadership capability and strategic commissioning skills required to support the Cluster's long-term ambitions.

2.6 While significant progress has been made, the organisation continues to navigate a period of major change. Embedding a new operating model alongside workforce restructuring, statutory responsibilities and ambitious transformation programmes remains challenging.

2.7 There is also a risk that capacity continues to be diverted towards activities that are not aligned to the future strategic commissioning model and may be more appropriately led by providers or NHS England. As organisational capacity has reduced, continuing historical approaches to activities risks limiting the organisation's ability to focus on its core strategic commissioning responsibilities. Combined with the loss of experienced staff through voluntary redundancies, these pressures could affect delivery pace, organisational resilience and the successful transition to the future operating model.

3. Merger Readiness

3.1 During the first half of 2026/27, the Cluster continued to strengthen joint working across the two ICBs. A joint recommendation on the future organisational footprint has been submitted to NHS England and the Secretary of State, with a decision expected later in 2026. In parallel, both organisations have worked collaboratively to maintain leadership, commissioning responsibilities and delivery of key transformation programmes.

3.2 Progress has focused on strengthening joint planning, governance and decision-making arrangements, while continuing to develop shared approaches to strategic commissioning and service transformation.

3.3 The focus will be on maintaining organisational stability while preparing for potential future national decisions. This includes strengthening cluster-wide ways of working, progressing due diligence activity and ensuring governance arrangements are in place to support any future organisational change.

3.4 A key priority will be balancing merger readiness with business-as-usual responsibilities and delivery of strategic transformation programmes.

3.5 The national policy landscape continues to evolve, creating uncertainty about the future organisational arrangements within which ICBs will operate. The Cluster will therefore need to remain flexible and responsive to emerging national guidance while continuing to plan for a range of potential scenarios.

4. Workforce Development and Support

4.1 The first half of 2026/27 has been a period of significant organisational change, with staff adapting to new structures while supporting the development of a more mature strategic commissioning organisation. As management of change processes have progressed, capacity has increasingly been released to focus on strategic priorities, while maintaining organisational stability and continuity of leadership.

4.2 Progress has also been made in strengthening workforce governance, engagement and organisational capability. Key developments include the establishment of the Cluster Staff Voice Forum, use of People Pulse surveys to inform organisational development, enhanced workforce assurance through the People, Involvement and Inclusion Committee, the introduction of in-house recruitment services, refreshed learning and development programmes, and approval of new Public Sector Equality Duty objectives supported by Inclusive Recruitment Training.

4.3 The focus will be on embedding new structures, strengthening leadership capability and delivering the organisational development programme. Priorities include developing strategic commissioning, population health management and system leadership skills, improving staff experience through Staff Voice arrangements, NHS Staff Survey feedback and wellbeing initiatives, and continuing to advance equality, diversity and inclusion objectives.

4.4 Strategic workforce programmes will also continue, including the launch of WorkWell and ongoing delivery of the Journey to Work programme in SSOT.

4.5 Workforce remains a critical enabler of the Cluster's ambitions. The organisation continues to manage the impact of organisational change and voluntary redundancies while maintaining delivery of core responsibilities and transformation programmes. Retaining organisational knowledge, supporting staff wellbeing and sustaining engagement remain key priorities.

4.6 Further development is also needed in specialist areas such as strategic commissioning, population health management, analytics and system leadership to ensure the workforce is equipped to support the Cluster's long-term objectives.

5. Place, Neighbourhoods and Integrated Neighbourhood Teams

5.1 During the first half of 2026/27, variable progress has been made in developing Place and Neighbourhood Health across the Cluster. A Neighbourhood Health programme has been established, initially focusing on frailty and cardiovascular, renal and metabolic disease (CVRM), creating a shared framework that aligns strategic commissioning priorities, population need and local delivery underpinned by recurrent investment of £2.9m in STW and £6.8m in SSoT.

5.2 Place governance has continued to strengthen, including the introduction of the Stoke-on-Trent Place Board in shadow form. Progress in Staffordshire has not advanced at the pace originally envisaged, with further work required to agree and embed Place governance arrangements. Partners remain committed to progressing this agenda and establishing the conditions necessary for effective place-based working, but it is important for the Board to note that progress has been much slower than we would have liked.

5.3 In STW, SHIPP and TWIPP continue to develop as highly valued place based partnerships, providing strong CEO leadership and an important forum for collective leadership and collaboration across health, care, local authority and VCSE partners. However, there is further work required for both partnerships to fully mature and realise their potential aligned with the wider national direction of travel towards more devolved, partnership-led models of care, with SHIPP and TWIPP providing a strong foundation on which to build.

5.4 Whilst the development of the Strategic Commissioning Framework represents a positive step forward and provides greater clarity on the future direction of Integrated Neighbourhood Teams, there remains considerable work to further develop, embed and implement the model across the cluster. Progress to date has not been as rapid as intended, and an increased pace of delivery will be required to realise the anticipated benefits. Our Providers will play the lead role in driving this agenda forward during the second half of the year, with a clear expectation that they demonstrate strong partnership working, collective ownership and system leadership in the design and delivery of INT's.

5.5 The focus will shift from mobilisation to implementation and measurable delivery. Priorities include strengthening Place governance and partnerships, achieving full neighbourhood coverage through established INTs, and delivering improved outcomes for frailty and CVRM populations while preparing for future work on mental health and children and young people.

5.6 Further emphasis will be placed on demonstrating the impact of neighbourhood working through improved outcomes, reduced inequalities and variation, and reduced pressure on acute services. Work will also address priorities identified through the Neighbourhood Health Self-Assessment, including outcomes measurement, population health management, financial frameworks and neighbourhood maturity.

5.7 The pace of neighbourhood transformation remains variable across the Cluster due to differences in local maturity, workforce capacity and supporting infrastructure. Continued

leadership, partnership working and targeted support will be required, particularly as Place arrangements in Staffordshire continue to develop.

5.8 Successful delivery will also depend on workforce capacity and the ongoing development of enabling infrastructure, including estates, digital capability, analytics and information sharing. As neighbourhood models mature, demonstrating measurable improvements in outcomes will take time, although strong foundations are now in place for Place partnerships and INTs to become the primary mechanism for improving outcomes, reducing inequalities and supporting more sustainable community-based care.

6. Procurement

6.1 During the first half of 2026/27, significant progress was made in developing the proposed Midlands Procurement Service (MPS), which will provide a single specialist healthcare procurement function for Midlands ICBs and NHS England. Procurement activity across the region has been reviewed to inform a future operating model that supports strategic commissioning, market stewardship and consistent application of the Provider Selection Regime.

6.2 The MPS will be hosted by the Derbyshire, Nottinghamshire and Leicestershire ICB Cluster. Separately, goods and services procurement functions have been commissioned through the North Midlands and Black Country Procurement Group.

6.3 The focus will be on supporting implementation of the Midlands Procurement Service ahead of its planned launch in December 2026 and ensuring procurement arrangements support the Cluster's strategic commissioning ambitions.

6.4 Work will also strengthen strategic purchasing capability and closer alignment between commissioning, procurement, finance and contracting functions to support effective investment and market management.

6.5 The closure of CSUs created risks to procurement capacity and expertise, making successful implementation of the MPS critical. Key risks include workforce transition, recruitment of specialist staff and ensuring robust governance arrangements are in place. While the number of staff transferring into the service is lower than required, mitigations are in place and the expected impact on the Cluster is low.

7. Community Alternatives to Hospital

7.1 Community alternatives to hospital remain central to the Cluster's ambition to shift care closer to home and reduce pressure on urgent and emergency care services.

7.2 During the first half of 2026/27, both systems strengthened community-based services through investment into community services of £2.9m in STW and £6.8m in SSoT to deliver improvement in performance, growth in activity and to expand capacity in services such as Virtual Wards, Urgent Community Response, intermediate care and discharge pathways. In STW, around 300 patients per month are now redirected from emergency departments to community services, while improved Virtual Ward utilisation has increased capacity and

patient flow. In SSOT, service improvements and additional capacity have strengthened admission avoidance, care coordination and discharge arrangements.

7.3 These developments support the wider Neighbourhood Health agenda by providing our population with care closer to home as well as reducing avoidable admissions, improving patient flow and enabling more proactive management of frailty and CVRM cohorts.

7.4 The focus will be on increasing the utilisation and impact of Virtual Wards, Urgent Community Response, intermediate care and care coordination services. Strengthening links between neighbourhood teams, primary care, acute services and social care will be key to reducing days spent away from home by providing alternatives to admissions, improving discharge pathways and supporting people to remain independent at home.

7.5 Alongside this. in the second half of the year moving into 2027/28, we will commence work to develop an outcomes-based commissioning approach for community services, supporting greater consistency and standardisation across the system. This will help drive the transformation of traditional community service models, creating more integrated, responsive and proactive services that are better positioned to deliver the left shift towards prevention, early intervention and care closer to home, whilst supporting a sustainable shift from hospital-based to community-based care. This builds on the 2026/27 published commissioning intentions for community services and will require community providers to engage fully in the leadership challenge to transform and modernise community services. This transformation is required to ensure that there is maximum benefit gained from the significant investment made into community services across the Cluster in recent years.

7.6 Demand across urgent and emergency care services remains high, with hospital flow, admissions and access performance continuing to present challenges. Effective and sustainable community alternatives are a key part of ensuring timely access to urgent and emergency care for those who need it most.

7.7 Variation in referral patterns, awareness and utilisation also remains. Realising the full benefits of these services will require continued pathway redesign, clinical leadership and strong alignment between urgent care, neighbourhood health and strategic commissioning programmes. Demonstrating measurable reductions in admissions and bed utilisation will remain a key focus during the remainder of the year. The current service offer of multiple services layered on top of each other, is often difficult to navigate and can lack clarity re best use of the resource invested for the outcomes delivered. There is a clear commitment from all partners in relation to having entire population coverage of high quality, high performing community services that engage fully with GP colleagues and support the population to be cared for effectively in a community setting.

8. Elective Recovery and Planned Care

8.1 During the first half of 2026/27, progress has been made in improving planned care pathways, access and productivity across the Cluster. A key achievement has been the development of the first ten clinical pathways within each ICB to support implementation of a Single Point of Access (SPOA) model from October 2026, helping to streamline referrals and improve access to the most appropriate care.

8.2 Both systems have also strengthened elective care infrastructure through surgical hubs and initiatives to improve theatre utilisation and productivity, supporting more effective use of elective capacity.

8.3 The focus will be on implementing the SPOA model, improving referral quality, increasing the use of advice and guidance, and strengthening integration between primary and secondary care. Further priorities include expanding virtual and community outpatient models, increasing Patient Initiated Follow-Up (PIFU) and continuing to improve theatre and outpatient productivity.

8.4 Elective recovery continues to face challenges from rising demand and workforce pressures. Realising the benefits of SPOA, virtual pathways and PIFU will require consistent adoption across providers and clinicians.

8.5 There has been good progress made across several of our providers on the elective recovery work. However, it remains variable, and patients are still often waiting too long for their interventions. There will be an unremitting focus on this throughout the remained of 2026/27 in order to tackle the longest waiting lists and to move closer to delivering the NHS Constitutional Standards as a minimum in this area.

8.6 Reducing variation in access, productivity and pathway utilisation will remain a key priority to ensure improvements translate into shorter waits, better access and improved patient outcomes.

9. Cancer

9.1 Improving cancer outcomes through earlier diagnosis, increased screening and reducing inequalities has remained a key priority during the first half of 2026/27.

9.2 Progress has included implementation of FIT pathways, continued expansion of Lung Cancer Screening, targeted case-finding initiatives and cancer awareness campaigns, alongside work with Lingen Davies to develop a prostate cancer programme for high-risk groups. Across SSOT, screening and diagnostic pathways have been strengthened, while the Cancer Bus programme has helped target communities with lower screening uptake and poorer outcomes.

9.3 Clinical leadership has also been strengthened through the establishment of GP Cancer Leads across the Cluster and continued collaboration with the West Midlands Cancer Alliance to support earlier diagnosis and pathway improvement.

9.4 The focus will be on increasing screening uptake, improving early diagnosis and reducing inequalities in cancer outcomes. Priorities include expanding Lung Cancer Screening, embedding enhanced FIT pathways, delivering targeted awareness campaigns and using population health intelligence to focus resources on communities most at risk of poorer outcomes.

9.5 Further work will strengthen primary care cancer leadership, expand cancer champion programmes and support consistent implementation of improved pathways across the Cluster.

9.6 Improving cancer outcomes remains dependent on increasing participation in screening programmes and ensuring timely access to diagnostics and treatment. Variation in screening uptake, stage at diagnosis and outcomes persists, particularly among deprived and underserved communities.

9.7 Sustained improvement will require continued collaboration across primary care, community, acute, public health and voluntary sector partners and engagement with our population, alongside sufficient diagnostic and treatment capacity to meet growing demand.

10. Diagnostics

10.1 Improving diagnostic access and capacity remains a key priority for elective recovery and earlier diagnosis. During the first half of 2026/27, progress has been made in expanding Community Diagnostic Centre (CDC) provision and increasing access to community-based diagnostic pathways.

10.2 Key developments include the opening of the Hanley CDC in SSOT, development of a business case for a second CDC in Shrewsbury, and the expansion of community diagnostic pathways across areas such as breathlessness, asthma, paediatric phlebotomy, gynaecology and gastrointestinal services. Primary care audits have also supported pathway optimisation and better use of diagnostic capacity.

10.3 The focus will be on increasing utilisation of CDCs, expanding community diagnostic services and strengthening GP direct access pathways. In STW, securing approval and funding for a second CDC in Shrewsbury will be a key priority.

10.4 Further work will support integration of diagnostics across elective care, cancer, neighbourhood health and long-term condition pathways, alongside exploring AI-enabled reporting solutions to improve productivity and reporting capacity.

10.5 Diagnostics services continue to face challenges from rising demand, workforce pressures and reporting capacity constraints. Realising the full benefits of CDCs and community pathways will require sustained utilisation, effective pathway management and continued clinical engagement.

10.6 Ongoing investment in workforce development, digital innovation and service redesign will be essential to improve access, reduce waiting times and support wider elective recovery and early diagnosis ambitions.

11. General Practice

11.1 General Practice remains central to the Cluster's ambition to deliver proactive, neighbourhood-based care. During the first half of 2026/27, primary care maintained strong performance against key access and workforce measures despite rising demand and system pressures. Same-day access remains above the national average across STW and SSOT,

patient continuity remains strong, NHS App registrations continue to grow, and GP workforce numbers have increased across both systems.

11.2 General Practice and Primary Care Networks will continue to play a key role in delivering neighbourhood health, prevention and population health improvement. Priorities include maintaining access and continuity of care, supporting Integrated Neighbourhood Teams, improving long-term condition management, and identifying high-risk patients earlier to reduce avoidable hospital use.

11.3 Further focus will be placed on digital access, NHS App utilisation, workforce development and delivery of contractual requirements to improve patient experience and support sustainable service delivery.

11.4 General Practice continues to face rising demand, increasing patient complexity and ongoing workforce pressures, while playing a growing role in neighbourhood health and system transformation. Maintaining capacity, workforce resilience and service quality while delivering transformational change remains a key challenge.

11.5 Although workforce growth has been achieved, recruitment and retention remain important risks, particularly as neighbourhood health models require greater multidisciplinary working and clinical leadership. Whilst there has been strong clinical engagement and leadership from GP colleagues across the Cluster, the level of appetite and momentum for transforming general practice has been variable across the Cluster. The ICB's are committed to supporting and enabling this transformation and will continue to invest its effort and resources where there is clear local leadership, ambition and a willingness to drive change. There are some strong examples emerging of where GP colleagues are increasingly coordinated, aligned and working collectively to improve.

12. Dentistry

12.1 Improving access to NHS dentistry remains a key priority, with activity increasing across both STW and SSOT during the first half of 2026/27 for both adults and children. This reflects continued efforts by providers and commissioners to maximise available capacity despite ongoing pressures.

12.2 Increased access supports the wider prevention agenda by enabling earlier intervention, improving oral health and reducing inequalities, particularly for children and vulnerable groups.

12.3 The focus will be on sustaining and increasing NHS dental activity by maximising available capacity and working with providers to improve access. There will also be greater alignment between dentistry, prevention, community engagement and population health improvement initiatives.

12.4 Despite progress, access to NHS dentistry remains challenging. Workforce recruitment and retention continue to limit capacity and are the main barriers to further improvement.

12.5 Contractual and funding arrangements also influence the pace of change. Maintaining progress will require continued collaboration with providers and a sustained focus on workforce resilience and service sustainability.

13. Community Pharmacy

13.1 Community pharmacy continues to improve access to care, support prevention and reduce pressure on general practice. During the first half of 2026/27, Pharmacy First became embedded across pharmacies, providing timely assessment and treatment for common conditions, while contraception services offered accessible alternatives to GP appointments.

13.2 Pharmacies have made a strong contribution to prevention through the Hypertension Case Finding Service, supporting earlier identification of cardiovascular risk, and through the Discharge Medicines Service, which helps reduce medicines-related harm after hospital discharge. Progress has also been made in expanding clinical services, with independent prescribing pathfinder sites supporting anticoagulation and hypercholesterolaemia pathways, alongside delivery of vaccination programmes and preparations for autumn flu and COVID campaigns. A key milestone was the introduction of the first cohort of newly qualified independent prescribing pharmacists, supported by a Cluster-wide review of prescribing capacity.

13.3 Priorities for the remainder of 2026/27 include implementing the expanded Pharmacy First prescribing service and supporting community pharmacist prescribers to manage a wider range of conditions. Community pharmacy will also play a greater role in neighbourhood health and prevention programmes, including expanding cardiovascular disease case-finding, developing locally commissioned prevention services, and targeting support to communities with the greatest need using population health intelligence.

13.4 Further work will focus on increasing awareness and uptake of pharmacy services, strengthening links with urgent and emergency care pathways, and integrating pharmacy more fully within neighbourhood models of care.

13.5 The main challenge is the implementation and uptake of independent prescribing within community pharmacy. Early indications suggest that only a proportion of pharmacies may participate in the expanded national service, risking variation in access across the Cluster.

13.6 Financial sustainability also remains a concern, with funding arrangements for some nationally commissioned services potentially limiting wider uptake. Continued engagement with pharmacy partners will be essential to support workforce development, maximise participation and realise the benefits of expanded pharmacy services.

14. Community Optometry

14.1 Community eye care services have continued to expand during the first half of 2026/27, supporting the delivery of more care closer to home and reducing reliance on hospital outpatient services. Optometry First is now embedded across STW, providing an effective alternative to outpatient and urgent care pathways for a range of eye conditions. Community cataract, glaucoma, medical retina and paediatric orthoptic pathways have continued to develop, supported by closer collaboration between primary and secondary care and

increased use of accredited community providers. Similar arrangements are in place across SSOT under a different commissioning model.

14.2 Urgent Eye Care Services continue to provide timely assessment for acute eye conditions, helping to reduce demand on emergency departments and hospital services. Progress has also been made in implementing independent prescribing within community optometry, following formulary approval and the development of implementation plans. Work has additionally commenced on improving access for vulnerable groups through annual sight-testing provision within SEND settings.

14.3 The focus for the remainder of 2026/27 will be on consolidating progress and strengthening the contribution of community eye care services to access, prevention and care closer to home. A key priority will be a Cluster-wide review of optometry services to identify variation in service models, commissioning arrangements and outcomes, and to explore opportunities for greater alignment.

14.4 Work will also continue to expand independent prescribing, strengthen integration between community and secondary care services, and improve access for vulnerable and underserved populations.

14.5 Further integration between community and hospital services is needed to maximise the benefits of pathway redesign. Success will depend on consistent referral practices, effective clinical collaboration and seamless patient transitions between services.

14.6 Despite these challenges, community optometry remains a strong example of how specialist services can be delivered successfully through community-based models, improving access and patient experience while reducing pressure on hospital services.

15. Specialised Commissioning

15.1 The first half of 2026/27 has focused on embedding delegated specialised commissioning responsibilities across the Cluster, establishing governance and assurance arrangements, and working with the Office of Pan ICB Commissioning to develop new ways of working. A key area of focus has been the refresh of clinical networks across the Midlands to strengthen clinical leadership, support pathway transformation and reduce unwarranted variation.

15.2 Work has also begun to align specialised commissioning more closely with the wider strategic commissioning agenda, ensuring specialised services are considered as part of whole pathways of care and contribute to improved population health outcomes and integrated models of care.

15.3 The focus for the remainder of the year will be on embedding specialised commissioning within the Cluster's strategic commissioning and transformation programmes, ensuring commissioning decisions support improved outcomes across whole pathways. Work will also continue to strengthen governance, oversight, clinical engagement and accountability arrangements.

15.4 While delegation provides greater opportunity to influence outcomes and pathway integration, it also brings increased complexity and responsibility. Key challenges include

ensuring governance, commissioning capacity and clinical leadership arrangements continue to mature, and fully embedding specialised commissioning within local transformation, neighbourhood and population health programmes.

16. Vaccinations, Immunisations and Screening (Section 7a)

16.1 During the first half of 2026/27, the Cluster has supported national and regional preparations for the transfer of Vaccinations, Immunisations and Screening responsibilities from NHS England to ICBs. Through engagement in West Midlands governance and implementation forums, the Cluster has helped shape future arrangements while strengthening local readiness for transition.

16.2 Work has focused on understanding future responsibilities, developing governance arrangements and ensuring commissioning approaches support improved uptake, better outcomes and reduced health inequalities. This aligns with wider prevention and population health priorities, including Core20PLUS5, Population Health Improvement Plans and neighbourhood health development.

16.3 The focus for the remainder of the year will be on preparing for the transfer of responsibilities from April 2027 and finalising future commissioning arrangements. Work will also strengthen partnerships with public health teams, providers and system partners, while exploring opportunities to better align vaccination and screening programmes with population health intelligence, targeting approaches and neighbourhood health initiatives.

16.4 The transfer of responsibilities presents both opportunities and challenges. Key risks include maintaining sufficient commissioning capacity, expertise and governance arrangements to support a smooth transition.

16.5 It will also be important to retain the expertise and relationships developed across NHS England, public health and provider organisations, while ensuring delegated responsibilities are fully aligned with wider prevention and population health priorities.

17. Health and Justice

17.1 During the first half of 2026/27, the Cluster has continued to engage in regional and national programmes supporting the transfer of Health and Justice commissioning responsibilities from April 2027. This has included contributing to the development of future commissioning models and ensuring local priorities are reflected in emerging arrangements.

17.2 The focus for the remainder of the year will be on preparing for the transfer of responsibilities and embedding Health and Justice within the Cluster's strategic commissioning model. Work will continue through regional programmes to shape future arrangements and ensure organisational readiness.

17.3 A further priority will be aligning Health and Justice services with wider objectives on population health, prevention and reducing inequalities, while strengthening links with broader care pathways to support more coordinated care for vulnerable groups.

17.4 Successful transfer will depend on robust governance, sufficient commissioning capacity and strong partnership working. Maintaining specialist expertise and appropriate clinical and operational oversight will be essential to ensuring safe and effective delivery of these services.

18. Mental Health

18.1 Mental health transformation has continued across the Cluster during the first half of 2026/27, with a focus on prevention, early intervention, community-based support and reducing reliance on inpatient care. Across both systems, mental health has become increasingly integrated within neighbourhood health models, supported by stronger community services, improved crisis pathways and closer partnership working.

18.2 In STW, progress includes the transformation of CAMHS, expansion of Mental Health Support Teams in schools, development of community alternatives to admission, improvements in NHS Talking Therapies and work to reduce inappropriate out-of-area placements.

18.3 In SSOT, Mental Health Support Teams continue to expand, NHS 111 Mental Health Option 2 and the 24/7 Crisis Text Service are improving access to urgent support, and development of a neighbourhood-based 24/7 Mental Health Centre model is progressing. Investment in Mental Health Act digitisation has also supported service improvement.

18.4 Priorities include further strengthening community mental health services, expanding alternatives to inpatient admission and embedding mental health care within neighbourhood models of care. Reducing inappropriate out-of-area placements, improving discharge arrangements and increasing community-based support for people with complex needs will remain key areas of focus.

18.5 Work will also continue to strengthen prevention and early intervention, particularly for children and young people, through the expansion of Mental Health Support Teams, neighbourhood-based services and improved access to psychological therapies. Greater integration of mental health clinicians within Integrated Neighbourhood Teams will support population health, healthy ageing and long-term condition management.

18.6 Demand for mental health services continues to exceed capacity in several areas. Out-of-area placements remain a significant challenge, particularly within SSOT, while inpatient and PICU capacity pressures continue to affect operational performance and financial sustainability.

18.7 Workforce shortages present ongoing risks to service expansion and the development of community alternatives to admission.

18.8 In addition, further work is required to deliver intensive and assertive outreach services to support people with the most complex needs, prevent avoidable admissions and reduce recurrent crisis presentations. This is a key deliverable which will require significant investment.

19. Learning Disabilities and Neurodevelopmental Conditions

19.1 During the first half of 2026/27, work has focused on improving Learning Disability, Autism and Neurodevelopmental pathways in response to growing demand. Alongside efforts to reduce waiting times, there has been a strong emphasis on providing support while people await assessment.

19.2 Key developments include support worker models for children and young people on waiting lists, combined Autism and ADHD referral pathways, and Neurodevelopmental Pathway Navigator roles to help individuals and families access information and support. Further work has also been undertaken to strengthen early years pathways and improve coordination across SEND, CAMHS and community services.

19.3 Priorities include further strengthening neurodevelopmental pathways, improving coordination of support and ensuring people can access help based on need rather than diagnosis alone. Work will continue to develop more integrated approaches across Learning Disability, Autism, Neurodevelopmental and SEND services, with a greater focus on all-age pathways and reducing fragmentation.

19.4 Reducing waiting times and improving access to assessment and support will remain key priorities, supported through pathway redesign, workforce development and improved use of resources.

19.5 Demand for neurodevelopmental services continues to exceed capacity both locally and nationally, resulting in significant waiting list pressures and increasing costs associated with Right to Choose. While support for those waiting has improved, the gap between demand and capacity remains a major challenge.

19.6 Further service redesign is required to ensure long-term financial and operational sustainability. Greater consistency across the Cluster, including clearer pathways, stronger service integration and a shared strategic approach, will be critical to improving outcomes for individuals and families.

20. Children and Young People and SEND

20.1 Improving outcomes for children and young people remains a key Cluster priority. During the first half of 2026/27, progress has been made in strengthening SEND services, improving access to support and developing more integrated approaches across health, education and local authority partners, with an increasing focus on early intervention and coordinated support.

20.2 In STW, work has focused on reducing diagnostic waiting times, reviewing autism and ADHD pathways, and embedding needs-led approaches that provide support regardless of diagnosis. CAMHS transformation has continued, alongside improvements to speech and language therapy and pathways for long-term conditions such as asthma and epilepsy.

20.3 In SSOT, investment has expanded epilepsy specialist nursing and psychology support, while a new asthma diagnostic pathway has been developed through Community Diagnostic Centres. SEND reform activity has progressed, including maturity assessments,

implementation of the Expert at Hand model, and improvements in speech and language therapy, occupational therapy and local offers. Neighbourhood-based pilot models have also been introduced to provide earlier, coordinated support and meet the needs of children and young people and their families closer to home.

20.4 Priorities include delivering SEND reform plans, implementing the Joint System SEND Strategy and strengthening integrated approaches across health, education and local authorities. Work will continue to expand neighbourhood-based models, progress CAMHS transformation, and improve access to speech and language therapy, epilepsy services and asthma pathways.

20.5 Further focus will be placed on early intervention, reducing variation in services and improving local support to reduce reliance on specialist provision.

20.6 Rising complexity of need continues to place pressure on services and requires coordinated delivery across SEND reform, CAMHS transformation, neighbourhood development and pathway redesign programmes. Strong partnership working and sustained leadership will be essential.

20.7 Challenges also remain within neurodevelopmental pathways, including diagnostic waiting times, workforce capacity and the need for further service redesign to meet demand and deliver sustainable improvements in access and outcomes. This is a significant risk that requires a focused approach across the system and a need for our mental health providers to work collaboratively and in full partnership, more than they have done previously on this agenda.

21. Women's Health and Maternity

21.1 Improving experience and outcomes for women, birthing people and babies' remains a key priority across the Cluster. During the first half of 2026/27, access to Termination of Pregnancy services was expanded, increasing choice and accessibility across both systems. Progress has also continued across maternity and neonatal services, including work on perinatal health equity, perinatal mental health, bereavement support and digital transformation, supported by ongoing engagement through Maternity and Neonatal Voices Partnerships.

21.2 A key achievement has been the development of a Women's Health Needs Assessment, using population health management approaches to identify inequalities and inform future commissioning priorities. Improvements have also been made to gynaecology pathways, including community-based services and faster access to assessment for unscheduled bleeding.

21.3 The main focus will be delivery of the Women's Integrated Neighbourhood Service (WiNS), initially through menopause pathways before expanding into urogynaecology, complex contraception and heavy menstrual bleeding services.

21.4 The Women's Health Needs Assessment will be finalised to support future commissioning and action on inequalities. Work will also continue on the Preconception Care Education pilot and delivery of national maternity and neonatal improvement priorities.

21.5 A key risk is ensuring women's health and maternity priorities are fully embedded within neighbourhood health programmes and the differing needs of women at each stage of their lives are met by services which are accessible, high quality and integrated.

22. Digital

22.1 The first half of 2026/27 has focused on maintaining stable digital services and supporting the development of the Cluster as a strategic commissioning organisation. Following ICB clustering, a review of digital systems is underway to identify opportunities for greater alignment across infrastructure, tooling and IT support arrangements.

22.2 A key focus has been the transition of services following the closure of Commissioning Support Units, including migration of services to the Health Informatics Service and planning for future Microsoft 365 alignment. Progress has also continued in strengthening digital enablers, including Shared Care Records, implementation of the National Record Locator, and support for integrated care, information sharing and population health management. Preparations are also underway for the 2026/27 Digital Maturity Assessment, with continued emphasis on digital innovation and productivity.

22.3 Priorities include completing system migrations, strengthening Cluster-wide digital infrastructure and progressing Microsoft 365 alignment to support collaborative working. Further work will focus on maximising the use of Shared Care Records, supporting National Record Locator implementation and ensuring digital capabilities enable neighbourhood health, integrated care and strategic commissioning.

22.4 The Cluster will also continue to promote digital innovation, automation and technology-enabled care, using Digital Maturity Assessment findings to inform future investment and improvement priorities.

22.5 The transition of digital services following CSU closure remains a significant programme of work, requiring careful management to maintain service continuity and technical capacity.

22.6 There is also a need to ensure digital capabilities keep pace with wider organisational transformation, particularly around information sharing, productivity, interoperability and access to high-quality data to support neighbourhood health and integrated care.

23. Data and Analytics

23.1 During the first half of 2026/27, the Cluster focused on strengthening analytical capabilities to support strategic commissioning. Following the closure of CSUs, work has concentrated on securing future business intelligence and analytical support, with the Cluster helping to shape the emerging National Data Service model.

23.2 Significant progress has been made in developing data infrastructure to support neighbourhood health and population health management, including near-complete access to patient-level GP data across STW. Analytical capabilities have also been strengthened through the development of value intelligence and evaluation functions, alongside Cluster-

wide self-service reporting that provides consistent performance information for decision-makers.

23.3 Priorities include embedding data and analytics more fully within strategic commissioning, strengthening neighbourhood intelligence and expanding the use of population health management approaches. Further work will develop value intelligence and evaluation capabilities to better assess outcomes, inequalities and return on investment.

23.4 The Cluster will also continue to enhance self-service reporting and engage in the development of the National Data Service to ensure future analytical arrangements meet local needs.

23.5 National uncertainty around future analytical service arrangements and funding remains a key risk. Maintaining analytical capacity and expertise during this transition period will be critical.

23.6 Continued investment in data quality, linked datasets, evaluation capability and analytical skills will also be required to support neighbourhood health, population health management and evidence-based commissioning decisions.

24. Prevention and Health Inequalities

24.1 Reducing health inequalities and improving population health remain core priorities for the Cluster. During the first half of 2026/27, both STW and SSOT strengthened their use of population health intelligence to target interventions towards communities experiencing the poorest outcomes.

24.2 Key achievements include expansion of lung cancer screening, cancer awareness and screening initiatives, cardiovascular prevention and case-finding programmes, maternity inequalities work, and targeted community engagement. In SSOT, delivery of the Tackling Health Inequalities Strategy has included community pharmacy hypertension case-finding, accessible communications and outreach to underserved communities.

24.3 Reducing health inequalities is now a core part of commissioning decision-making, and is being embedded as part of service redesign and neighbourhood development. It has become the business of the whole organisation rather than a stand-alone programme.

24.4 The focus will be on utilising local intelligence to optimise prevention and inequality reduction through Population Health Improvement Plans and Integrated Neighbourhood Teams, ensuring resources are targeted towards communities with the greatest need.

24.5 Priorities include increasing cancer screening uptake and early diagnosis, accelerating delivery of the CVRM programme preventing avoidable heart attacks, strokes and other complications, reducing maternity inequalities, and strengthening partnership working with local authorities, public health and community organisations.

24.6 There will also be a greater focus on demonstrating measurable impact through engagement with our population, particularly those at risk of inequalities, to understand their experiences and challenges, which will supplement improved evaluation, population health metrics and evidence-based investment decisions in ensuring our commissioned services are as effective as they can be.

24.7 Health inequalities remain complex and are influenced by wider factors such as deprivation, housing, employment and education. Sustained improvement will require long-term partnership working across health, local government, VCSE organisations and communities.

24.8 While intelligence on inequalities continues to improve, translating insight into measurable and sustainable improvements in outcomes, access and experience remains a key challenge. Continued focus will be needed to optimise prevention and inequality reduction within neighbourhood health, strategic commissioning and wider system transformation.

25. Productivity and Efficiency

25.1 Improving productivity and value remains a key element of the Cluster's Medium-Term Financial Plan and strategic commissioning approach. During the first half of 2026/27, both ICBs made significant progress in reducing historically high levels of Continuing Healthcare (CHC) and prescribing expenditure through stronger assurance, prescribing optimisation and greater focus on value-based decision-making.

25.2 The focus will be on delivering larger-scale productivity opportunities across urgent and emergency care and planned care pathways. Working with providers, both ICBs will continue to identify opportunities to reduce unwarranted variation and improve value through transformation programmes and medium-term financial planning.

25.3 The Strategic Commissioning Framework for Neighbourhood Health will be a key enabler, supporting earlier intervention, proactive care and reduced reliance on hospital services to improve both outcomes and system productivity.

25.4 Many productivity opportunities depend on the successful delivery of wider transformation programmes and neighbourhood-based models of care. Achieving sustainable reductions in hospital demand will require continued investment in community services, pathway redesign and strong partnership working.

25.5 Further work is also needed to strengthen evaluation and benefits realisation, ensuring efficiency improvements deliver positive impacts on quality, patient outcomes and long-term financial sustainability.

26. Performance and Access

26.1 Improving performance and access remains a key priority across the Cluster. During the first half of 2026/27, performance was mixed, with progress in several areas alongside ongoing challenges linked to demand, workforce pressures, system flow and organisational change.

26.2 In STW, improvements were seen in elective recovery, cancer performance, community waiting times, children and young people's mental health access, and reductions in mental health inpatient stays for people with a learning disability or autism. In SSOT, progress was made in children and young people's mental health access and the 31-day cancer standard, although challenges remain in elective recovery, diagnostics, cancer waiting times, community waiting times and out-of-area placements.

26.3 The focus will be on sustaining improvements and accelerating recovery where performance remains below target. Priorities include elective recovery, diagnostics, cancer standards, community waiting times and mental health access, supported by provider recovery plans and ongoing performance oversight.

26.4 Reducing unwarranted variation and using population health intelligence to support more equitable access will also remain key areas of focus.

26.5 Performance recovery remains a significant challenge, particularly in diagnostics, urgent and emergency care, elective recovery and mental health pathways. Demand, workforce constraints and capacity pressures continue to affect the pace of improvement.

26.6 Out-of-area mental health placements, learning disability inpatient utilisation and elective recovery in SSOT remain areas of concern. Continued delivery of transformation programmes and community-based alternatives will be essential to improving access, reducing waiting times and achieving sustainable long-term performance improvements.

26.7 Ultimately our residents should, as a minimum, have services that meet their needs and meet the NHS Constitutional Standards. Our collective effort and focus must be on enabling timely access to high quality and sustainable services that best meet the needs of our residents. Patient experience of our services is a key measure of how we are performing as a health system.

27. Communications, Engagement and Public Sector Equality Duties

27.1 Effective involvement remains central to strategic commissioning and delivery of the Five-Year Plans. During the first half of 2026/27, a joint Working with People and Communities Strategy was developed with system partners, setting out how the ICBs will involve patients, communities and stakeholders in planning and commissioning services.

27.2 As part of the management of change process, communications and involvement functions were redesigned to align with the ICB Operating Model. This included the introduction of a Cluster-wide strategic lead for involvement and local Involvement and Insight Specialists to strengthen the use of lived experience and community insight in commissioning decisions.

27.3 New systems have been introduced to improve stakeholder management, engagement and consultation activity across the Cluster. Workforce engagement has also been strengthened through the Staff Voice Forum, while a Cluster-wide involvement framework and joint Equality and Involvement Committee are being established to strengthen governance and assurance.

27.4 The Cluster has also enhanced its use of population health intelligence and community insight to better understand inequalities in access, experience and outcomes, particularly within CVRM pathways and across protected characteristic groups.

27.5 The focus will be on implementing the Working with People and Communities Strategy, delivering involvement programmes aligned to commissioning priorities and Public Sector Equality Duty requirements, and strengthening opportunities for communities to influence decision-making.

27.6 Work will continue with VCSE partners, Healthwatch and wider stakeholders to shape future involvement arrangements and strengthen the role of that community insight plays in strategic commissioning decision-making.

27.7 Further priorities include embedding population health intelligence and equality analysis into commissioning decisions, neighbourhood health programmes and the refresh of the Five-Year Strategic Commissioning Plans, supported by regular reporting on inequalities and population outcomes.

27.8 The proposed transfer of Healthwatch functions to ICBs and local authorities creates uncertainty and will require ongoing collaboration with partners to develop future arrangements. The proposed amendments to the Health Bill that is currently going through parliament may impact on this and there will be a need to monitor this as the Bill progresses.

27.9 Further work is also needed to improve the quality of demographic and protected characteristic data and to strengthen the use of intelligence and community insight in commissioning, service redesign and reducing health inequalities.

28. Conclusion

28.1. The first half of 2026/27 has seen the Cluster make significant progress in establishing the foundations of a more mature strategic commissioning organisation, despite a period of considerable organisational change and uncertainty.

28.2. Strong progress has been made in developing the operating model, strengthening strategic commissioning capability, advancing our approach to commissioning for neighbourhood health, investing in community services and maintaining momentum across a wide range of transformation programmes.

28.3. However, progress has not been consistent across all areas, particularly in relation to the differing levels of maturity of Place arrangements, the pace of implementation of Integrated Neighbourhood Teams and the wider transformation required to shift care from hospital settings into communities.

28.4. The second half of the year must now focus on delivery, implementation and demonstrable impact. Alongside safely navigating winter pressures and maintaining a relentless focus on operational performance, the Cluster will need to strengthen financial grip and control through all available commissioning, contracting and transformation levers.

28.5. A key priority for the second half of the year will be the continued development and implementation of the Strategic Commissioning Framework for Neighbourhood Health, with outcomes-based commissioning increasingly used as the mechanism for driving transformation.

28.6. Through the development of a multi-year commissioning framework, with clear priority cohorts identified, we will provide greater clarity regarding the outcomes we are seeking to achieve and the changes required to deliver them. It will also require a continued focus on maturing Place arrangements across the Cluster, with stronger place-based leadership, governance and decision-making enabling services to be planned and delivered more effectively around the needs of local populations.

28.7. This represents a significant shift in approach, moving away from organisationally focused models towards greater shared accountability for outcomes across local populations. While the framework provides the strategic direction, successful delivery will require providers and partners to play a leading role in redesigning services, strengthening integration and aligning resources around the needs of communities.

28.8. Our commissioning intentions will establish a clear set of expectations, informing both 2027/28 planning and longer-term decisions on service development and investment. As resources are progressively redirected towards prevention, early intervention and neighbourhood-based models of care, organisations will need to align their strategies, delivery models and leadership approaches accordingly.

28.9. Achieving these ambitions will require a step change in how the system operates, with greater collective ownership of outcomes, stronger collaboration across organisational boundaries and a renewed focus on delivery.

28.10. The ICB cannot deliver this transformation through commissioning alone. Moving forward, we will increasingly look to providers to lead change in those areas where they are best placed to improve outcomes, reduce variation and redesign services. Delivering the left shift at the scale and pace required will depend on providers embracing this leadership role, working alongside system partners to transform how care is organised and delivered across the Cluster.

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

Enclosure No: 11

Report to:	Integrated Care Boards in Common
Date:	24 September 2026
Title:	Cluster Winter Plan 2026/27 and Board Assurance Statement
Presenting Officer:	Phil Smith, Chief Officer System Development & Integration
Author(s):	Gareth Wright, Director of System Improvement, Coordination & EPRR

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

Appendices:	Appendix 1 - 2026/27 Cluster Winter Plan. Appendix 2 – NHS England Winter Planning 2026/27 Board Assurance Statement.

Purpose of the Paper:

The purpose of this report is to update the Boards on the Cluster Winter Plan, recognising that the plan remains subject to ongoing refinement. The report also provides the basis for Board assurance to support the Chair and Chief Executive Officer (CEO) in approving the submission of the Board Assurance Statement to NHS England.

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

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

For the first time, winter planning is being undertaken on a Cluster basis, providing a single overarching plan and common approach, while retaining distinct arrangements for each county where required. This creates greater opportunity for consistency and coordination across the Cluster, including common command, control and communication arrangements. This must, however, be delivered with significantly reduced ICB staffing capacity and against a backdrop of two systems operating with limited resilience to sustained periods of high operational pressure.

At the time of writing, progress towards winter preparedness is well on track, including completion of NHS England-led confirmatory activities. There is a broad and sufficient evidence base to provide assurance on the Cluster's state of preparedness and support a recommendation that the Chair and Chief Executive approve submission of the Board Assurance Statement to NHS England by the required deadline of 7 October 2026.

Recommendations:

The Boards are asked to:

- ☑ **ASSURE** themselves of the Cluster's winter preparedness, noting the single Cluster Winter Plan, the common approach across the two ICBs and the distinct county-level arrangements where required;
- ☑ **APPROVE** the recommendation for the Chair and Chief Executive Officer to submit the relevant ICB Board Assurance Statement(s) to NHS England, confirming the Cluster's position on winter preparedness, by the required deadline of 7 October 2026.

Impact Assessments:

	Completed?			If N - N/A, Rationale	If Y, Outcome / Date Reported & Signed off
Data Protection Impact Assessment (DPIA)	**Yes**	**No**	**N/A**	Click or tap here to enter text.	*Reported to IG Committee:* Click or tap to enter a date.
	☐	☐	☒		
Integrated Impact Assessment (IIA)	**Yes**	**No**	**N/A**	Click or tap here to enter text.	*Outcome and date of completion:* For consideration by QPC on 23 September 2026
	☒	☐	☐		

Is the decision within Scheme of Financial Delegation (SOFD) powers & limits	**Yes**	☒	**No**	☐
Any potential / actual Conflict of Interest?	**Yes**	☐	**No**	☒

Integration with Commissioning Board Assurance Framework (CBAF)

CBAF1	☐	**CBAF4**	☐
CBAF2	☐	**CBAF5**	☒
CBAF3	☐	**CBAF6**	☐

Cluster Winter Plan 2026/27 and Board Assurance Statement

1. Introduction

1.1. Winter planning is being undertaken on a Cluster basis for the first time this year. There is a single overarching Cluster Winter Plan, with a common approach across the two Integrated Care Boards (ICBs) and distinct arrangements for each county where required. This provides greater opportunity for consistency and coordination, including common command, control and communication arrangements, while recognising the different local circumstances and provider positions across the Cluster.

1.2. NHS England requires ICBs to submit a Board Assurance Statement (BAS) by 7 October 2026. The purpose of this report is to update the Boards on the Cluster Winter Plan, recognising that it remains subject to ongoing refinement, and to provide the evidence and assurance required to support the Chair and Chief Executive in approving submission of the BAS to NHS England.

2. NHSE Direction for Winter 2026/27

2.1. National winter planning requirements were issued by NHS England on 17 July 2026 through Winter planning 2026/27, expectations and assurance. The requirements place a significant additional ask on ICBs and our operating model, compared with that set out in the Model ICB and Model Region Blueprints. The stated intention is for ICBs to be responsible for commissioning, providers responsible for delivery and regions responsible for performance oversight.

2.2. The requirements are broadly consistent with those of previous years, although more specific in a number of areas. A further communication issued on 4 September 2026 identified discharge as a national delivery priority, with a particular focus on addressing reporting anomalies and unwarranted delay. The national priority of 'Getting People Home Safely for Christmas' includes an expectation that acute bed occupancy should be approximately 80% by that point. This requirement has already been incorporated into the Cluster Winter Plan.

3. NHS England Midlands direction

3.1. NHS England Midlands issued its winter planning expectations on 16 July 2026, covering system winter plans, bed modelling and assurance. The requirements emphasise learning from 2025/26, mitigating risk during system change, clear executive leadership and accountability, and Board assurance.

3.2. A nationally directed winter preparedness exercise took place on 10 September 2026, attended on a Cluster basis by ICB and provider representatives from both acute hospitals, community trusts and local authorities. This was preceded by a Cluster pre-exercise on 18 August 2026, which tested command and control readiness and the response to rising operational pressures.

3.3. An NHS England Midlands assurance visit to SSOT is scheduled for 21 September 2026, focused on UHNM but coordinated by the ICB. No equivalent visit is planned for STW this year, reflecting the progress made.

3.4. The outcomes from these activities will inform any final refinements to the Winter Plan and the evidence underpinning the BAS. A verbal update on the SSoT visit will be provided at the Board meeting.

4. Our Cluster Approach to Winter

4.1. Learning from winter 2025/26 has been incorporated into this year's planning. Key themes include the need to recognise that operational pressure is not evenly distributed across the winter period, with different providers experiencing their greatest pressures at different points. The plan therefore places particular emphasis on:

- reducing hospital occupancy towards 80%, while maintaining sufficient outflow through the festive period and strengthening complex discharge pathways;
- ensuring that system and provider interventions are realistic, deliverable and focused on clear and impactful benefits;
- coordinating interventions across the Cluster where this provides additional resilience or benefit; and
- entering winter from as strong a position as possible and exiting winter in a way that supports a strong start to 2027/28, including making effective use of March as a reset month ahead of the early Easter period.

4.2. These lessons have informed both the design and phasing of the Cluster Winter Plan.

4.3. The Cluster approach provides several opportunities for winter planning and response, including a unified plan, common command, control and communication arrangements, and the ability to manage and balance risk across the Cluster where appropriate.

4.4. However, these arrangements are being delivered with significantly reduced ICB staffing capacity and against a backdrop of two systems with limited resilience to sustained periods of high operational pressure. It is therefore important that roles, responsibilities and expectations between NHS England, the ICBs and providers are clear.

4.5. Consistent with the national operating model, the emphasis is increasingly on system provider partners working collaboratively to coordinate delivery and manage operational pressures, with the ICB acting as a point of escalation where required. This approach was reinforced through a Cluster senior leadership briefing led by the ICB Chief Executive on 26 August 2026. This is a change in approach and one that requires provider colleagues to work even more closely together than in previous years.

4.6. The Cluster plan recognises the differences between Shropshire, Telford & Wrekin and Staffordshire & Stoke-on-Trent, including the different operating and resilience positions of providers. Consequently, the plan comprises a common Cluster approach with distinct county-level elements where required.

4.7. This enables the Cluster to retain local responsiveness while taking advantage of opportunities to coordinate planning, leadership and risk management at scale.

5. Cluster Winter Plan 2026/27

5.1. Winter resilience is dependent on delivery of the underlying provider and system improvement programmes, particularly where providers are not yet achieving their agreed operational plan trajectories. Alongside this improvement work, the Cluster will transition to a winter-ready position, manage rising pressure, sustain the response through the peak winter period and then exit winter in a controlled manner.

5.2. The Winter Plan also seeks to maximise the contribution of the Neighbourhood model, supported by targeted provider and ICB interventions where these are required to strengthen resilience and capacity.

5.3. The Cluster response will operate through five phases:

- Deliver our programmes – continuing provider and system improvement programmes to establish the strongest possible starting position for winter.
- Reduce rising pressure – implementing an intensive system-wide response as winter pressures increase, with the aim of offsetting demand and creating capacity resilience.
- Recovery – using the early New Year period to decompress capacity and rebuild operational reserve.
- Sustain our response – maintaining resilience through the remainder of winter and establishing the conditions for a strong March 2027.
- Transition from winter – tapering the winter response in a controlled manner and establishing a strong starting position for 2027/28.

5.4. Progress towards winter preparedness is on track. Draft plans were submitted to NHS England Midlands on 21 August 2026 (Appendix 1), and the national winter preparedness exercise has now taken place. The NHS England Midlands assurance visit to UHNM on 21 September 2026 will provide a further opportunity for external challenge and assurance.

5.5. The Cluster is continuing to refine its bed modelling to understand the capacity deficit that may need to be managed, particularly under scenarios involving high incidence of seasonal illness. ICB funding will be directed towards targeted interventions where there is evidence of clear and impactful benefit, including additional discharge transport, winter communications and targeted capacity.

5.6. Functional teams across the ICBs are continuing to undertake preparedness activity and assurance checks. The evidence available at the time of this report provides a broad basis for assurance, while recognising that some activity and final checks remain in progress.

5.7. The Plan will continue to be refined in response to ongoing work, NHS England feedback and the outcomes of assurance activity. The intention is to return the final Plan to the Boards in November 2026 for ratification, once the remaining work and adjustments have been completed.

6. Board Assurance Statement

6.1. The NHS England BAS provides the formal mechanism through which Boards assure themselves of winter preparedness. The requirements are more comprehensive this year, comprising 35 assurance points compared with 16 in 2025/26.

6.2. NHS England has indicated that the BAS should be used to shape winter planning rather than as a retrospective checklist. Provider BAS submissions, co-signed by Chairs and Chief Executive Officers, are required by 30 September 2026, with ICB submissions required by 7 October 2026.

6.3. The BAS is submitted through an Excel workbook. For ease of Board review, an extract of the BAS requirements and the supporting evidence is included at Appendix 2.

6.4. The evidence has been reviewed at Executive level, with relevant elements considered by the Executive Winter Director, Chief Nursing Officer and Medical Director arrangements. There is also concurrency with provider Boards' consideration of their own BAS submissions, with some assurance points dependent upon provider-level evidence.

6.5. The evidence available demonstrates substantial progress towards winter preparedness and provides a broad basis for Board assurance. The Boards are therefore asked to assure themselves of the Cluster's preparedness and approve submission of the BAS, subject to completion of any final checks and incorporation of relevant feedback arising from the remaining assurance activity ahead of the 7 October deadline.

7. Conclusion

7.1. Winter planning is being delivered through a new Cluster approach for 2026/27, bringing together a single overarching plan and common approach while retaining appropriate local arrangements. This provides opportunities for greater coordination, consistency and collective management of risk across the Cluster.

7.2. The approach is being implemented in the context of reduced staffing capacity and two systems with limited resilience to sustained operational pressure. The plan therefore places particular emphasis on early preparation, delivery of existing improvement programmes, effective discharge and capacity management, clear system responsibilities and targeted interventions.

7.3. Progress towards winter preparedness is well on track. While the Winter Plan remains subject to refinement, including consideration of the outcomes of ongoing NHS England assurance activity, there is a broad evidence base to support Board assurance at this stage.

7.4. The Boards are therefore asked to assure themselves of the Cluster's winter preparedness and approve the submission of the ICB Board Assurance Statement to NHS England by 7 October 2026, subject to final checks and any necessary updates arising from the remaining assurance activity.

Appendix 2 – Assessment of evidence status against the BAS requirements

NHSE Winter Planning 26/27 Section A: Board Assurance Statement (BAS)				ICB evidence for Assurance
Governance				
1	1.1	The Board has assured the ICB Winter Plan for 2026/27.		Board review on 24 Sep 26 ahead of submission by 30 Sep 26
	1.2	The Board is assured that a robust quality and equality impact assessment (QEIA) informed development of the ICB's plan and this has been reviewed by the Board.		Quality & Performance Committee in common will review key points of an Integrated Impact Assessment on 23 Sep 26, on behalf of Board
	1.3	The Board is assured that the ICB's plan was developed with active engagement and input of all system partners, including primary care, 111 providers, Community Health Service Providers (including NHS and non-NHS providers), acute and specialist trusts, mental health, ambulance services, local authorities and social care provider colleagues.		Winter planning has been conducted with oversight by our two system UEC Delivery Groups, of which all partners are members of and represented at an appropriate level.
	1.4	The Board has identified a named Executive Winter Sponsor with clear accountability for winter preparedness, delivery, escalation and system oversight.		Phil Smith is the accountable Executive Gareth Wright is responsible Winter Director
	1.5	The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.		This Exercise took place on 10 Sep 26, a strong team from across the cluster participated, including Local Authorities representation.
	1.6	The Board is assured that clear winter governance arrangements, escalation processes and operational leadership arrangements are in place across the system.		Our operational command & control including on-call out of hours has been consolidated on a cluster basis. There is a clear line of sight and accountability through to Executive level.

	1.7	The Board is assured that fit testing arrangements, PPE provision and other key infection prevention and control mitigations, as set out in the Health and Social Care Act 2008: code of practice on the prevention and control of infections are in place across the system and are supported by plans to scale rapidly in response to infectious disease surges, ensuring continuity of safe care and workforce protection.		Provider organisations have FFP3 fit testing programmes, trained fit testing capacity, stock management processes and contingency arrangements in place to respond to increased demand. Compliance monitored through workforce systems in line with NHSE requirements. Assurance regarding compliance will be sought through CRM and monthly IPC system group forums.
	1.8	The Board has received assurance that health protection governance, escalation processes, and provider response arrangements are effective and support timely management of infectious disease incidents and outbreaks, as set out in the ICB Commissioning Guidance - https://www.england.nhs.uk/long-read/clinical-response-outbreaks-of-infectious-disease-commissioning-guidance-icbs/		Providers have established outbreak management procedures, seven day IPC support, access to specialised microbiology advice and clear escalation processes to respond to seasonal infectious disease pressures. Winter preparedness activity includes refresher training, outbreak management guidance, routine assurance visits and daily operational oversight arrangements. 24/7 response to infectious disease in the community is confirmed within STW & SSOT via contractual arrangements with Health Hero and MPFT.

Section B: 26/27 Winter Plan checklist				**ICB evidence for Assurance**
Prevention and vulnerable cohorts				
1	1.1	The Board is assured that those eligible have access to priority vaccination programmes, including childhood vaccinations. This includes 1. RSV vaccination for pregnant women, older adults aged 75 years and over, and older adult care home residents; 2. pneumococcal vaccination for all adults aged 65 years and over and children and adults in a clinical risk group; 3. the annual winter flu and COVID-19 vaccination campaigns.		Seasonal influenza and COIVD-19 vaccination programmes are planned across the system supported by dedicated vaccination teams, peer vaccinators and targeted communications. Maternity services provide dedicated vaccination programmes for pertussis and RSV throughout the year. Targeted outreach initiatives are in place to improve uptake amongst underserved populations and reduce health inequalities. Uptake is monitored through ICB and public health oversight at Health Protection Assurance meetings and regular meetings held with providers to collectively address areas of poor uptake.

	1.2	The Board is assured that a risk-stratified approach is in place to identify individuals at increased risk of winter-related deterioration or admission, including those with co-morbidities that leave them susceptible to hospital admission as a result of winter viruses, younger people with significant co-morbidities, and other vulnerable cohorts. Targeted interventions are in place, including vaccination, pre-winter health checks, personalised care planning, access to antivirals where appropriate, and community-based support to reduce avoidable admissions and support continuing care in the community.		Both systems are introducing a consistent risk stratified approach as part of the Neighbourhood roll out to identify those at risk, particularly frailty. Targeted vaccination is in place as 1.1, and both systems have contracts in place for access to antivirals for flu in care homes to minimise outbreaks/harm. Continuing care is available in both systems to access community resources where admission is avoided, monitored through UEC performance data.
Flow, occupancy and discharge				
2	2.1	The Board is assured there are clear operational plans and daily processes to reduce avoidable bed occupancy and improve patient flow seven days a week, including pre-winter review of bed demand and capacity, delivery of model discharge pathway requirements, and executive oversight of required and actual daily discharges, patients with no criteria to reside by pathway, discharge performance and long discharge delays.		Daily processes are undertaken by our unified System Coordination Centre 7 days, 0800-1800. Winter demand & capacity model has been specified by NHSE and submitted by acute providers. Further system work will focus on mitigating the capacity deficit.
	2.2	The Board is assured that system partners have agreed and implemented measures to eliminate corridor care, with defined patient safety thresholds, supported by coordinated patient flow, discharge and escalation arrangements, with system level oversight and mitigation of risk during periods of increased demand.		Corridor care is explicit in the provider version of BAS. Our acute providers have affirmed absolute focus on eradication. System oversight will be provided within our escalation and Risk framework.
	2.3	The Board is assured that discharge planning is being undertaken jointly with local authorities and social care partners, with effective system discharge coordination arrangements, clear processes to identify, escalate and resolve discharge delays, and real-time visibility of demand and community capacity.		This is business as usual facilitated by our Care Transfer Hub (STW) and Integrated Discharge Hub (SSOT). The supplementary NHSE Discharge guidance issued 4 Sep 26 will be enacted.
	2.4	The Board is assured that providers have baselined current discharge arrangements against the model discharge pathway, identified gaps, and agreed improvement actions across acute, community and social care partners.		Model discharge pathway published by NHSE on 7 Jul 26. Baseline / gap assessments have been carried out and incorporated in our system Improvement programmes.
	2.5	The Board is assured that pre-Christmas and holiday-period occupancy reduction plans have been agreed and will be implemented.		Achieving this served both systems well last winter and is reprised in our Winter Plan aiming for 80% occupancy by Christmas Day. Target confirmed in the NHSE Discharge guidance issued 4 Sep 26.

Demand, capacity, and surge management				
3	3.1	The board is assured that whole system demand and capacity modelling has informed winter planning and that tested surge and extreme surge response arrangements are in place to support safe operational delivery during periods of increased demand.		As 2.1 above, Winter demand & capacity model has been specified by NHSE, including 'super surge' scenario.
	3.2	The Board is assured that workforce, NHS 111 and mutual aid arrangements are sufficient to respond safely to sustained periods of increased demand.		Workforce is in the provider BAS, so CEOs to provide assurance. NHS111 in section 4 below.
	3.3	The Board is assured that bed escalation capacity arrangements have been agreed and tested across system partners.		This was tested during our cluster pre-Exercise (18 Aug) ahead of the NHSE Midlands Exercise (10 Sep).
Primary Care, NHS 111 and admission avoidance				
4	4.1	The Board is assured that anticipated general practice demand has been assessed, and that: • sufficient capacity has been commissioned, including for surge periods (e.g. ARI hubs) • robust escalation process are in place • through the IUC Clinical Assessment Service (or equivalent), sufficient capacity will be commissioned for out of hours general practice, including weekends and bank holidays.		General practice demand has been assessed across both Staffordshire and Stoke-on-Trent (SSOT) and Shropshire, Telford and Wrekin (STW). Practices are currently delivering approximately 565,000 appointments per month in SSOT and 260,920 appointments per month in STW, demonstrating sustained high levels of demand and indicating a further anticipated increase during the winter period. To support winter resilience, SSOT has commissioned Same Day Urgent Access Hubs which will provide 46,154 additional urgent appointments between November 2026 and March 2027. Activity can be flexed in response to system pressures and includes dedicated capacity for hospital discharge follow up of moderately to severely frail patients to support admission avoidance and reduce readmissions. A similar Urgent Access Hub model is being developed within STW, supported through a winter business case. Robust monitoring and escalation arrangements will operate throughout the winter period through regular provider review meetings and integration with system winter governance arrangements.

				Out of hours primary care provision continues through commissioned IUC/CAS arrangements, including weekends and bank holidays, with capacity planning undertaken as part of winter preparedness arrangements. Community Pharmacy extended opening arrangements will further support access during Christmas, New Year and Easter periods.
	4.2	The Board is assured that practices are compliant with contractual requirements, including opening hours, use of online consultation, clinically urgent same day appointments (working towards 90% target) and practices making 1 appointment per 3,000 registered population available to NHS 111 for direct booking.		All GP practices provide contractual core opening hours from 08:00 to 18:30 Monday to Friday, with Enhanced Access available during evenings and weekends through Primary Care Networks. Online Consultation functionality is available across all 190 practices within SSOT and STW and is actively monitored through supplier data, NHS England reporting and local business intelligence tools. Practices receive targeted support where utilisation or compliance metrics fall below expected levels. The Winter Plan includes ongoing development of the Modern General Practice Model, including Cloud Based Telephony, Online Consultations, care navigation and NHS App promotion to improve access and manage demand appropriately. Same-day urgent appointment capacity will be enhanced through Urgent Access Hubs allowing practices to continue delivering clinically urgent appointments while maintaining continuity of care for vulnerable and frail patients. All practices have the ability to make appointments available via GP Connect for NHS 111 direct booking and performance is routinely monitored. Practices with low booking activity or poor slot utilisation are proactively supported to improve compliance and utilisation
	4.3	The Board is assured that PCN enhanced access appointments are available and that PCNs make available to NHS 111 any unused on the day slots as per DES requirements.		Enhanced Access services continue to be delivered across all Primary Care Networks, providing additional appointment capacity during evenings and weekends. NHS 111 direct booking arrangements are embedded

				across SSOT and STW with appointment availability supported through GP Connect functionality. Practices and PCNs are monitored to ensure appropriate utilisation of NHS 111 direct booking capacity. The ICB continues to work with PCNs and providers to maximise the use of Enhanced Access capacity and ensure that available appointment slots support whole-system access and admission avoidance objectives during winter pressures.
	4.4	The Board is assured that unscheduled dental care delivery is monitored as part of the mandated number of urgent dental care appointments.		Urgent dental care capacity forms part of the primary care winter resilience approach. Access to urgent dental appointments is available through the locally commissioned Dental Advice Line (DAL), which provides assessment and signposting of urgent dental need and receives referrals redirected from NHS 111. The service is well established across both systems and is promoted through a range of healthcare settings including GP practices, pharmacies and emergency departments. Dental contract reform requires providers to deliver a proportion of contracted activity as urgent and unscheduled care. Delivery is monitored through contractual performance arrangements and supports reduction in avoidable attendances to General Practice, NHS 111 and Emergency Departments.
	4.5	The Board is assured that for community pharmacy, demand, activity and capacity has been assessed, including sufficient out of hours provision across the ICB footprint; and delivery of Pharmacy First and the Discharge Medicines service.		Community Pharmacy forms a key component of the primary care winter resilience model. Demand, activity and capacity have been reviewed across both systems, with pharmacies supporting delivery of Pharmacy First, the Hypertension Case Finding Service, seasonal vaccination programmes and the Discharge Medicines Service. Targeted engagement is planned with GP practices to increase referrals to Pharmacy First and maximise utilisation of pharmacy clinical services to reduce pressure on General Practice and urgent care pathways.

				Additional pharmacy opening arrangements will be commissioned in SSOT during key bank holiday periods, including Christmas Day, New Year's Day and Easter, providing access to medicines, urgent advice and treatment when other services have limited availability. This will support continuity of care and reduce avoidable attendance at urgent and emergency care services.
	4.6	The Board is assured that the NHS 111 Directory of Services profiles are accurate, regularly reviewed, and aligned to available capacity across primary care and community services.		The ICB maintains established NHS 111 direct booking arrangements through GP Connect and works with providers to ensure appointment availability remains aligned to commissioned capacity. Practices with low booking utilisation are contacted and supported to improve booking conversion and functionality. This provides assurance that NHS 111 pathways remain aligned to available primary care capacity and support patients accessing the most appropriate service. Ongoing review of service availability across General Practice, Community Pharmacy and urgent dental services ensures that Directory of Services information reflects commissioned services throughout the winter period.
	4.7	The Board is assured that for all provision, both in and out of hours, there will be communications activity to ensure the public is aware of what services are available.		A comprehensive communications programme will be delivered throughout the winter period across SSOT and STW. This will promote access to available alternative services to emergency departments. A specific primary care access communications campaign will focus on General Practice services, Online Consultations, NHS App functionality and Pharmacy First. A targeted campaign will focus on areas with lower utilisation of digital services and lower patient satisfaction.

				The communications approach will utilise NHS App campaigns, practice websites, local communications channels, libraries, voluntary sector partners and wider system communications resources to ensure patients are aware of available services and can access the right care, first time. This will support demand management, appropriate service utilisation and winter resilience objectives
Community Health Capacity				
5	5.1	The Board is assured that sufficient urgent community capacity, including UCR, Virtual Wards, Hospital at Home and community diagnostic interventions where applicable, has been commissioned, is monitored and utilised effectively to support admission avoidance and discharge, with appropriate escalation arrangements in place and access to senior clinical decision-making through SPOAs at least 12 hours a day, 7 days a week.		These functions are provided by our Community Trusts and SPOA / Care Coordination providers. Our System Coordination Centre monitors usage on a daily basis including during System Ops calls.
Whole System Response				
6	6.1	The Board is assured that a system wide approach is in place to optimise the use of out-of-hospital capacity and admission avoidance pathways to reduce avoidable admissions and support timely discharge.		Connects to 5.1 above. This forms an important component of our Neighbourhood ambition.
Leadership, operational grip and resilience				
7	7.1	The Board is assured that on-call arrangements are in place and have been tested. Staff on-call have access to medical and nursing leaders for urgent advice if needed.		Our combined, two level, Ops on-call on a cluster basis has been embedded since 1 Jul 26. A Clinical supporting on-call has been re-established.
	7.2	The Board is assured there will be an appropriately skilled and resourced operating model for system co-ordination over the winter period to enable the sharing of intelligence and risk balance to ensure this is appropriately managed across all partners.		Our combined System Coordination Centre provides this (since 1 Jun 26) and will have been fully exercised and tested in reality.
	7.3	The Board is assured that tested command, control and escalation arrangements are in place, including OPEL reporting, EPRR arrangements and clearly defined leadership responsibilities.		This connects to 7.1 & 7.2, closely integrating our SCC & EPRR teams with on-call as a unified function under one accountable Directorate.

	7.4	The Board is assured that mutual aid arrangements, business continuity plans, severe weather preparedness arrangements and industrial action contingencies have been reviewed and tested where appropriate.		Our EPRR readiness has recently been thoroughly assured within the core standards process. Although legally distinct, our EPRR team is now combined on a cluster basis.
	7.5	The Board is assured that plans are in place to support staff welfare through periods of high demand.		Specific focus on our on-call staff is being applied within regular training and feedback sessions. Noting that all staff experience additional pressure in winter, not just SCC & EPRR.
System Co-ordination Centres				
8	8.1	The Board is assured that SCCs will be proactive in resolving operational pressures in hours, and that ICBs will maintain on-call functions for the oversight and resolution of operational pressures and patient flow and safety out of hours.		This is business as usual already, within our combined structures outlined above. Transition to a winter-specific posture will be enacted during October.
	8.2	The Board is assured that SCCs will be fully operational 08:00 to 18:00 7 days per week and have the ability to extend hours of operation during periods of extreme pressure.		Already cover these core hours. Provision will be made to supplement our cover in response to peaks of pressure, including over weekends.
	8.3	The Board is assured that ICB SCCs will maintain proactive engagement and communication with NHSE Regional teams.		This is not particularly discretionary, and our SCC team has a positive, collegiate relationship with the NHSE Midlands Ops team.

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

Draft for ICB Board 24 September 2026

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

2026/27 Cluster Winter Plan

August 2026

Contents

Introduction

The Winter Plan for 2026-27 is a clinically led, cluster approach that aligns with NHS England National and Midlands regional planning expectations. The plan is focused on delivering safe, timely and high-quality urgent and emergency care (UEC), maintaining elective performance, improving patient flow, reducing avoidable admissions, and ensuring resilience across health and care services throughout periods of increased winter demand.

The plan has been developed collaboratively with system partners and is underpinned by a system-wide demand and capacity assessment. It incorporates robust escalation arrangements, surge and super surge planning, and aligns with bed modelling assumptions to provide assurance that services can respond to anticipated demand pressures.

Building on learning from Winter 2025-26, the priorities for each system in our cluster is to reduce unnecessary attendances and admissions, improve patient flow across all care settings whilst improving patient outcomes and experience.

Central to the plan is delivery of each system UEC Improvement Plan and alignment with the cluster ICB's 5-year plans and commissioning intentions.

2025/26 Winter Lessons Learnt

For SSOT a Winter Lessons learnt event was held in May 2026, with excellent senior representation from all system partners. Prior to the event, all partners and pillar leads were requested to undertake internal reviews and provide feedback in support of the system event. Responses were populated into themes in line with the SSOT workstreams:

- Alternative Pathways,
- In-hospital,
- Discharge/post-hospital

Wider generic system feedback was also collated that overarched all the workstreams. This supported the event to be focussed on working towards development of our plan for 2026/27.

A high-level overview of key themes and learning is included in table 1 below.

Pathway	Positives	Learning
Pre-Hospital	• Improved collaboration between ICC and WMAS. • Increased utilisation and capacity of UCR services in partnership with the GP Federation. • Mobilisation of Primary Care MDT hubs	• Increase number of referral pathways from ICC to UHNM. • Consider dedicated UCR capacity for Care Homes. • Increase utilisation of Virtual Wards, specifically speciality pathways.
In-Hospital	• Frailty SDEC Units supported early assessment. • Increased physical capacity compared to previous years supported flow across the patient journey.	• Wider communication on winter planning with frontline teams would support better understanding of operational pressures. • Inability to mobilise all planned capacity has impacted on elective capacity – ensure we maximise utilisation of County Hospital Elective Hub
Discharge/Post Hospital	• Home for Christmas campaign • 7-day Discharge Facilitator coverage reduced start of week pressures. • Overnight Wrap Scheme – particularly Stoke. • Not inventing new discharge pathways – focus on strengthening existing pathways.	• Increase the therapy and pharmacy input into IDH. • Reduce overlapping initiatives and have fewer well-resourced pathways. • Reduce the reliance on D2A bed-based pathways.
System	• Pillar approach improved system understanding beyond UEC. • System Coordination Centre enabled a coordinated and targeted approach. • Winter Ready patient events received positive feedback. • Staff vaccination programme were noted as a success. • Targeted and data driven Communications and Engagement campaigns.	• Earlier agreement of finance to support timelier mobilisation of schemes. • Simplified governance arrangements require further review. • Focus on improvements beyond capacity/bed modelling.

Table 1. SSOT Pathway Feedback

The STW UEC Delivery Group reviewed lessons from last winter on 28 Apr 26. This was undertaken against the 5 phases of our Plan, with important insights actionable in this year's planning:

1 – Delivery of **high impact, enduring programmes** such as the modular ward build and bed-base reconfigurations at both acute sites, were achieved. Impact was incremental throughout winter and there is more to be achieved by optimising their use.

2 – **Offsetting the rising pressure** as a combined system effort achieved the decompression we aimed for, with 82% acute bed occupancy on Christmas Day. A successful approach to be repeated this year.

3 – **Recovery** in January, having used the capacity created ahead of the festive break this was the least successful phase. As a system we were unable to keep pace with demand for complex pathway discharge. This point in time and space will be the STW winter main effort for 2026/27.

4 – **Sustaining**. After stabilising our position, the aim was achieved to continue as good a footing as we could for the remainder of winter. *Sustained* improvement was made in Ambulance metrics during the spring reset month of March.

5 – This set the conditions for a **strong exit from winter**; and we tapered off the winter interventions (having learned that hard stop knocked us off course the previous year), taking Easter in our stride. Easter falls in March 2027, which is built into our planning for this winter.

Cluster UEC Governance

Effective leadership, agility of action and robust governance processes are essential components of the plan. This plan will be led by the ICB System Improvement, Coordination and EPRR team, under the leadership of the Phil Smith, Chief Officer for System Development and Integration, and will report into NHS Staffordshire & Stoke-on-Trent and NHS Shropshire Telford & Wrekin Cluster Integrated Care Board in common via agreed system governance. The Cluster Winter Director will be Gareth Wright Director for System Improvement, Coordination and EPRR.

For 2026/27 the SSOT Winter Oversight & Delivery model has been refreshed now reports directly into UEC Delivery & Transformation Groups across the cluster. Providers will provide updates directly to these groups. The ICB chair a Cluster Winter Enabling Group that brings together the ICB led elements of the winter planning process such as Primary Care, Vaccinations and Communications with updates provided in both UEC Delivery Groups.

NHS provider trusts will be completing assurance and approval of the NHSE Board Assurance Statements (BAS) during September ahead of submission on 30th September. The ICB Cluster Winter Plan will be assured through the agreed Cluster Governance and Committees ahead of approval on 24th September at the ICB Board in Common ahead of submission to NHSE on 7th October.

During October Health Overview & Scrutiny Committees (HOSC) and Health and Wellbeing Boards across the STW and SSOT will have the opportunity to review and assure themselves against the ICB approved plans in line with our wider System Governance arrangements.

Regular oversight arrangements will be in place during winter via both UEC Delivery Groups with updates into the Cluster Quality & Performance Committee.

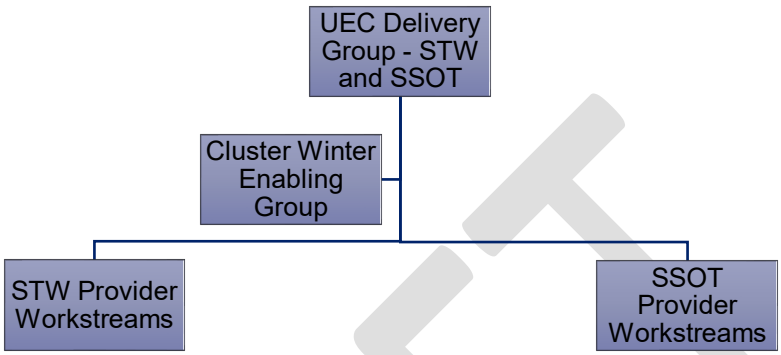


Chart 1. Winter Governance

Winter Preparedness 2026/27

The cluster undertook Exercise Aegis on the 18th August to primarily test our command and control arrangements and winter readiness. The exercise was well attended by partners across both ICS footprints and was an opportunity to test the system and provider winter plans, identify risk, issues and mitigations and ensure plans are sufficiently robust througout winter 26/27. Five injects were focused on for the cluster, with the feedback and outputs being collated. The cluster will be taking part in the regional winter preparedness exercise on 10th September. A NHSE assurance visit to SSOT system is taking place on the 21st September. There is no NHSE assurance visit planned for STW in 26/27. Board assurance statements will be submitted in line with NHSE requirements.

Our approach to Winter will be with a 5 stage approach as summarised in Image 1 below:

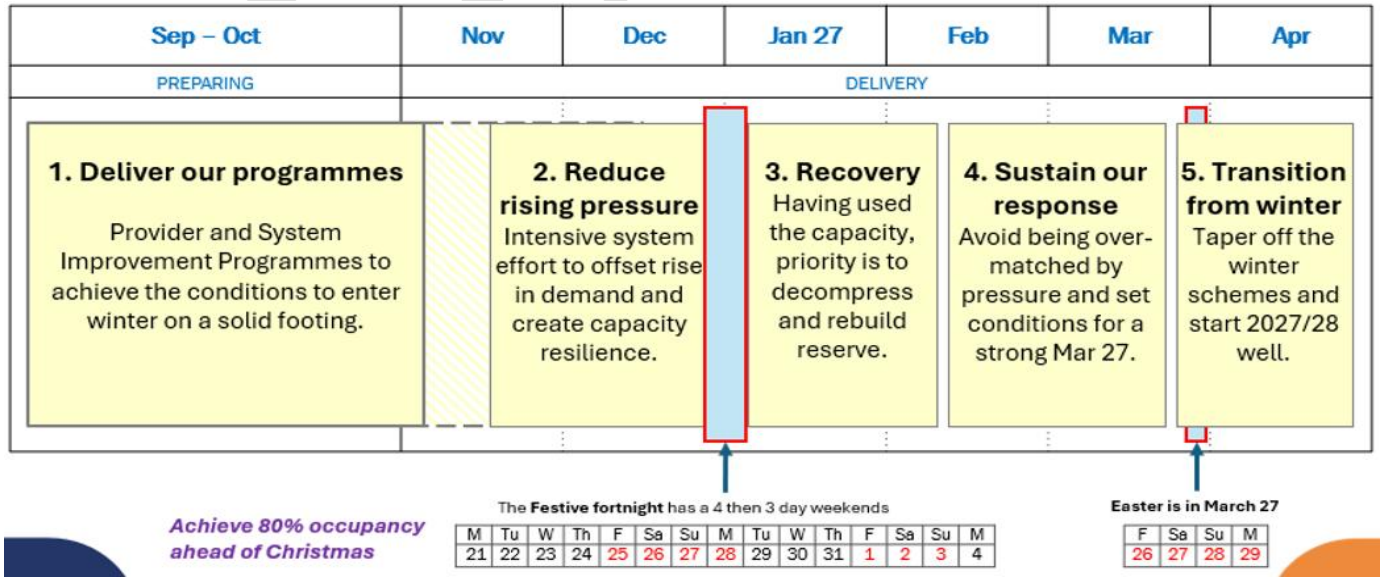


Image 1. Cluster Winter preparedness

To date, UEC Operational Plans are not being achieved by either system, SSOT elective recovery plans are also off track in several key metrics. Across both systems our objective is to recover back to plan in the autumn and then remain there throughout winter.

Winter preparedness is underpinned by a strong system-wide approach, with NHS organisations, local authorities, community providers, primary care, voluntary sector partners and care providers working collaboratively to support population health and maintain flow across health and care services. Local authorities play a key role through the delivery of social care, reablement, housing support, public health initiatives and discharge-to-assess pathways, helping people remain independent and reducing avoidable admissions and delayed discharges. Through established partnership arrangements, system partners coordinate resources, share intelligence and respond collectively to emerging pressures, ensuring residents receive joined-up support throughout the winter period.

Local Authority Public Health teams contribute to system planning through the provision of population health intelligence and assessment of emerging winter health needs. Working with partners across the cluster, they support the identification, prioritisation and evaluation of preventative schemes that address both clinical and wider determinants of health, including vaccination, housing, fuel poverty, social isolation and falls prevention. This enables resources to be targeted effectively towards populations at greatest risk, supporting prevention, reducing health inequalities and strengthening overall system resilience during periods of increased winter pressure.

UEC Improvement and Transformation

Each systems individual plan aligns with wider improvement and transformational plans.

The STW UEC Transformation Programme sets out a two-year, system-wide approach to addressing persistent UEC pressures. It recognises that current performance challenges are structural and cannot be resolved through short-term or seasonal mitigations alone. The programme therefore focuses on redesigning how urgent care, acute flow and discharge operate together as a system.

The programme is built around three connected pillars, summarised as follows and in Image 2:

- **Community Urgent Care**, to reduce avoidable Emergency Department (ED) attendances and admissions through neighbourhood-led care and stronger alternatives to hospital.
- **Acute Flow, Streaming and Care Coordination,** to improve front-door decision-making, ambulance handovers and same-day discharge.
- **Discharge Transformation and Capacity Release,** to deliver a genuine 7-day discharge model, reduce non-criteria-to-reside (NCTR) and shorten length of stay.

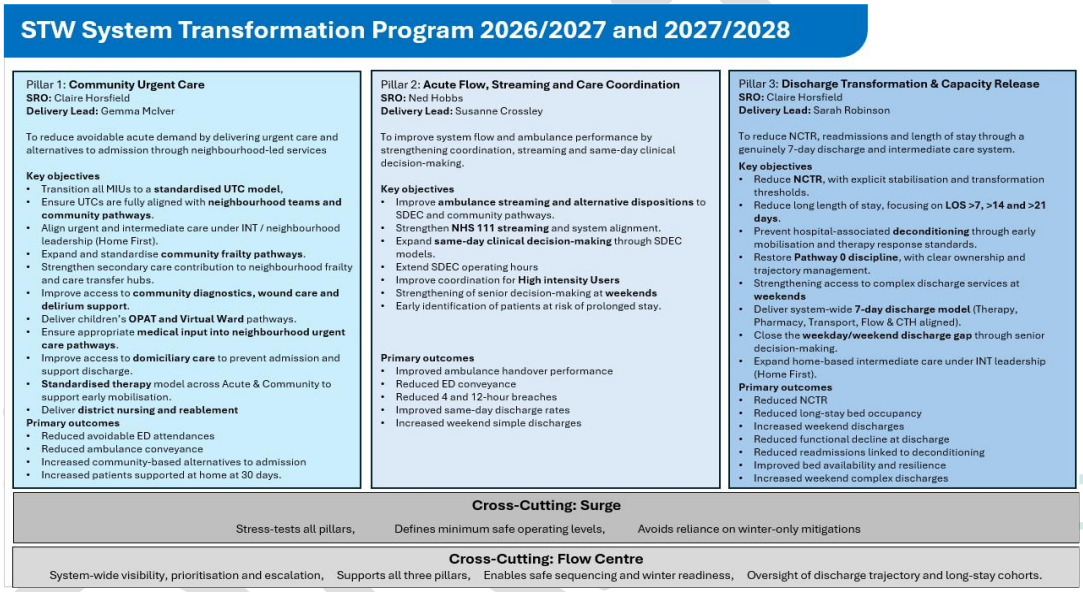


Image 2. STW System Transformation Programme

In SSOT, each element of the improvement plan has embedded Winter planning into each pillar. These are Alternative Pathways, In-Hospital and Post-Hospital workstreams with Surge overarching each. There is a recognition of several interdependencies within UEC that support our wider strategy.

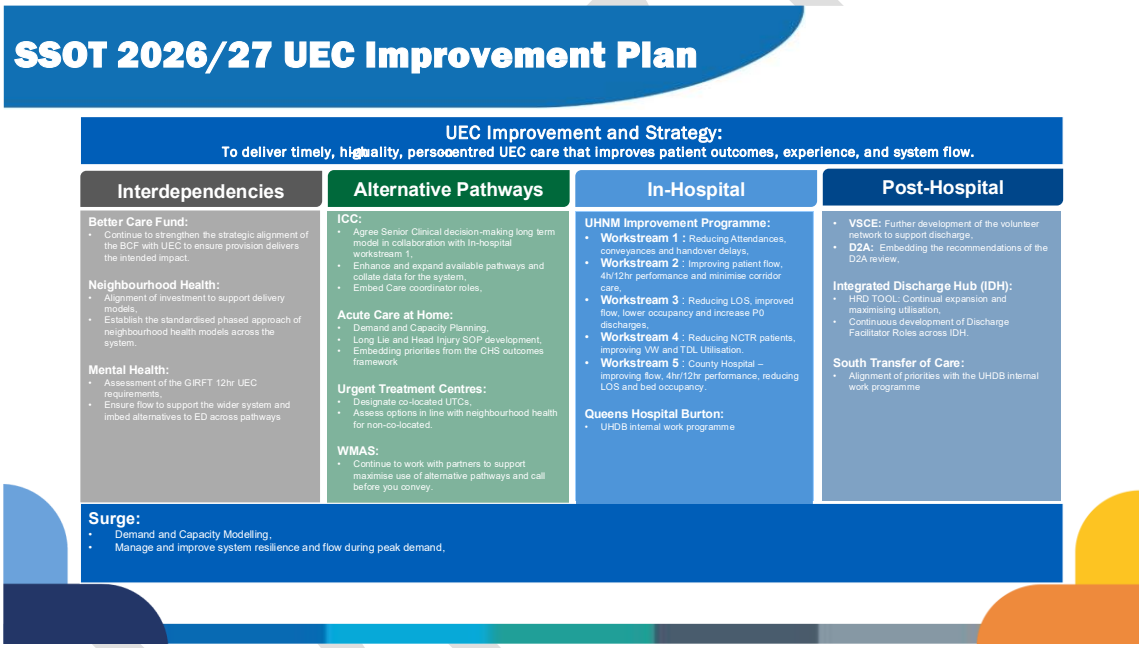


Image 3. SSOT UEC Improvement Plan

Infection Prevention and Control

The STW/SSOT cluster maintains a year-round Infection Prevention and Control (IPC) framework which is strengthened in preparation for the winter period. A weekly system IPC meeting is held throughout the year, providing oversight of outbreaks, emerging risks, vaccination performance, variation in practice and organisational pressures. The group facilitates mutual support, escalation of system risks and coordinated responses to infectious disease incidents during periods of increased winter pressure. This approach enables the early identification of pressures, coordinated escalation where required, and the sharing of good practice and learning across organisations. Providers work collaboratively across organisational boundaries to support outbreak management, patient placement decisions, laboratory access and risk escalation, ensuring a coordinated system response to winter infectious disease pressures.

The principal IPC-related winter risks relate to seasonal influenza, COVID-19, RSV and norovirus activity, with associated impacts on bed capacity, patient flow, workforce availability and service

delivery. These risks are monitored through provider governance structures and system-wide IPC oversight arrangements.

The system has robust arrangements in place to identify, manage and respond to infectious disease incidents and outbreaks. Providers maintain established outbreak management procedures, patient placement and isolation processes, supported by seven-day IPC specialist advice, access to microbiology expertise, rapid diagnostic testing and clear escalation pathways. Enhanced winter preparedness arrangements include seasonal outbreak management training, refresher education programmes, routine assurance visits and readily accessible outbreak guidance. Across the system, operational oversight mechanisms ensure outbreaks and health protection risks are actively monitored and escalated where there is potential impact on patient flow, staffing or service delivery.

Respiratory protective equipment resilience is supported through comprehensive FFP3 fit-testing programmes across provider organisations, with quantitative and qualitative testing capacity maintained and increased where required. Fit-testing records are maintained within workforce systems in line with NHS England requirements, supported by trained fit-testers, stock management arrangements and contingency plans to support surge requirements. Providers have also reviewed personal protective equipment arrangements, including contingency supplies and alternatives where national supply chain changes have occurred. Work continues across organisations to align assurance and recording arrangements in line with NHS England requirements.

A recognised system assurance gap remains in relation to FFP3 fit-testing assurance arrangements within General Practice. Whilst NHS Trusts maintain robust governance and reporting mechanisms for respiratory protective equipment compliance, there is currently no equivalent system-wide assurance framework across General Practice. This risk is acknowledged and will continue to be monitored; however, resolution is outside the scope of the current winter planning period.

The system has adopted targeted approaches to reduce inequalities in vaccine uptake, including focused RSV vaccination outreach in communities identified as having both higher disease burden and lower vaccination uptake. This supports improved access to preventative interventions for vulnerable populations and contributes to reducing winter pressures on healthcare services.

The system also adopts a risk-stratified approach to identifying individuals who may be at increased risk of winter-related deterioration, admission or healthcare-associated infection. Screening processes, surveillance arrangements, enhanced communication between providers, robust transfer documentation and proactive discharge planning support the timely identification and management of infection risks. These arrangements are complemented by community-based services, vaccination programmes, crisis support services and alternatives to admission which collectively help prevent deterioration, reduce avoidable admissions and maintain system resilience during periods of increased winter pressure.

Vaccination remains a key component of the system's winter prevention approach, supporting protection against influenza, COVID-19, RSV and other vaccine-preventable infections. Detailed vaccination delivery arrangements, governance, priority cohorts and performance monitoring are described within the Winter Vaccination Programme section of this submission.

Overall, the system is assured that robust IPC, outbreak management, surveillance, vaccination and escalation arrangements are in place across provider organisations. Established system-wide governance mechanisms support coordinated management of infectious disease risks throughout the winter period. Whilst a recognised assurance gap remains in relation to FFP3 fit-

testing arrangements within General Practice, this does not affect existing provider preparedness arrangements and will continue to be monitored through system governance structures.

Vaccinations

Vaccination programme delivery remains a key priority across STW and SSOT to maximise protection and prevention against flu, COVID-19 and RSV this winter. Plans have been developed collaboratively with system partners including the ICB, NHS Trusts, Local Authorities, Primary Care, Community Pharmacy and School-Aged Immunisation Services (SAIS).

Key arrangements include:

- The ICB has identified an Executive Lead for seasonal vaccinations, with all NHS Trusts having named Board-level vaccination leads.
- Vaccination governance currently operates across both the SSOT and STW footprints, with further work planned throughout 2026/27 to align arrangements across the cluster.
- Delivery performance will be monitored by the ICB from September 2026 using FDP data, through established vaccination governance processes, with escalation and reporting to ICB and Trust Boards where required.
- Uptake and delivery will be monitored against NHS England vaccination ambitions and performance targets, with system partners expected to implement improvement actions where uptake falls below expected levels.
- Primary care provider sign-up through CQRS is progressing well, with no current concerns regarding GP or pharmacy provision. Contingency arrangements are in place should any gaps arise.
- Outreach services have been commissioned to deliver targeted clinics in areas of low uptake, with additional activity informed by vaccination data and local intelligence to reduce health inequalities.
- A comprehensive communications and engagement plan is in place to support awareness and uptake across all eligible cohorts.
- The ICB will offer flu vaccination to all staff and support providers to maximise opportunities to deliver flu, COVID-19 and RSV vaccinations alongside other relevant vaccines, including shingles and pneumococcal vaccination.

Vaccination Priority Cohorts

- Care homes: All care homes have a named vaccination provider, with vaccinations expected to be completed as early as possible and no later than 30 November. Local Authorities will support delivery through established relationships and communication channels.
- Children's flu: Providers are working towards completing most vaccinations by the end of November. Additional support will be targeted at practices with lower uptake rates, supported by community pharmacies, outreach services and targeted communications.
- School-aged immunisations: SAIS providers have plans in place to visit every school by the end of November, supported by community catch-up clinics and community pharmacy provision from 1 December. The ICB continues to work closely with NHS England regional teams to achieve national ambitions.
- Maternity services: Providers are prepared to deliver flu vaccination to eligible pregnant women from 1 September, with actions in place to improve access and uptake.

- Homelessness: Local Authority and community partners are working with healthcare services to introduce targeted vaccination promotion and potential pop-up clinics for people experiencing homelessness.

All NHS Trusts have robust vaccination plans in place, including:

- Delivery of flu vaccinations from 1 October.
- Use of Record a Vaccine Service across all Trusts.
- Vaccination of eligible long-stay inpatients and patients transferring to care homes.
- A commitment to offer vaccination to 100% of frontline staff through a range of delivery models.
- Communications campaigns, vaccine champions and regular monitoring arrangements.
- Board-level oversight of vaccination performance and uptake.

Overall, system partners are working collaboratively to maximise vaccination uptake, reduce inequalities, and ensure delivery against NHS England vaccination ambitions and performance targets throughout the Autumn/Winter 2026 programme.

Primary Care

The Primary Care Winter Plan 2026/27 sets out how general practice, community pharmacy and dental services across Staffordshire and Stoke-on-Trent (SSOT) and Shropshire, Telford and Wrekin (STW) will support system resilience during winter by maintaining timely access to care, reducing avoidable hospital admissions and supporting discharge from hospital.

The plan focuses on expanding community-based capacity to help reduce pressure on UEC services. Key schemes include the delivery of Same Day Urgent Access Hubs, providing an additional 46,154 urgent appointments across SSOT and 15,384 in STW, continued 111 direct booking into GP appointments, expansion of Modern General Practice through cloud-based telephony, online consultations, NHS App uptake and care navigation, alongside the Acute Visiting Service (AVS) and enhanced support to care homes. Community pharmacy will play a greater role through Pharmacy First, vaccinations, the Discharge Medicines Service and extended holiday opening hours, while urgent dental access will continue through the Dental Advice Line and increased utilisation of NHS dental capacity.

The impact of these schemes will be monitored through a comprehensive reporting framework overseen by the Winter governance. Outcomes will be measured through metrics including urgent hub appointment availability, utilisation, attendance and DNA rates; NHS 111 direct booking conversion rates; uptake of cloud-based telephony, online consultations and NHS App registration and usage; Pharmacy First referrals; AVS utilisation and the proportion of patients supported at home without hospital admission; urgent dental appointments delivered against plan; community pharmacy attendance and patient outcomes; and care home measures such as urgent triage within two hours, reductions in emergency department attendances and reductions in hospital admissions.

Practices routinely as part of their core offer provide year-round on lipid optimization, hypertension, including opportunistic screening, internal Long Term Condition reviews and risk stratification to identify patients who may benefit from continuity of care.

In addition, the rollout of OPEL reporting across general practice will provide real-time intelligence on primary care pressures, supporting system-wide operational oversight and enabling a coordinated response to emerging winter demand pressures.

Mental Health Winter Preparedness

Mental health partners have confirmed robust arrangements are in place to maintain access to urgent and emergency mental health care throughout the winter period. Across the cluster, all-age crisis services will continue to operate 24/7, supported by NHS 111 Mental Health, Crisis Care Centres, Crisis Resolution and Home Treatment Teams, liaison psychiatry services, crisis cafés, crisis text services and voluntary sector alternatives to admission. Providers will maintain a focus on admission avoidance through intensive community support, home treatment, crisis alternatives and strengthened gatekeeping processes, ensuring that patients receive care in the least restrictive setting appropriate to their needs.

Mental health providers have identified inpatient flow, out of area placements, clinically ready for discharge delays and crisis demand as key winter risks. Mitigations include enhanced discharge oversight, multi-agency discharge arrangements, strengthened community pathways, daily operational monitoring through SHREWD and OPEL processes, mutual aid arrangements and escalation frameworks aligned to system surge and super-surge planning. Liaison mental health teams will continue to support urgent care pathways and emergency departments, while specific arrangements are in place to support children and young people, including intensive support services, crisis pathways and alternatives to Tier 4 admission where clinically appropriate.

UEC Escalation

The System Coordination Centre (SCC) operates across the cluster seven days a week and will support the day-to-day management of winter pressures and system response. The SCC provides real-time operational oversight across the whole system, utilising SHREWD and the OPEL framework to ensure that pressures are fully understood and appropriately managed.

Daily system coordination calls are held with senior operational leaders from both systems in attendance. Action trackers are maintained to record agreed actions and monitor progress against established thresholds. Daily metrics are used to identify emerging pressures, trigger escalation processes and, where required, initiate strategic calls. These metrics are shared daily and remain dynamic, allowing them to be adapted in response to changing operational pressures. Regular reviews are undertaken to ensure that the measures remain relevant and effective.

Work is currently underway to standardise processes across the cluster, with learning from the 2025/26 winter period being incorporated into future arrangements as appropriate.

Each provider organisation is responsible for implementing actions in line with its own escalation plan, with executive-level accountability for ensuring that plans are enacted, monitored and regularly reviewed.

The SSOT system escalation plan is also being reviewed to establish a consistent approach across the cluster, this will be completed and tested during the autumn ahead of ratification at both UEC Delivery & Transformation groups. Initial agreement has been reached regarding the redeployment of resources in line with organisational and system-wide workforce allocation requirements.

Surge and Super Surge Triggers

The SCC is responsible for alerting partners and coordinating the management of the system response where required. It is anticipated that a coordinated response will be required from OPEL 3, however system actions are identified for all levels to ensure a proactive approach to managing levels of escalation. In line with the Integrated OPEL Framework, action cards have

been developed locally which outline the actions that should be taken at each level of escalation with providers and services having independent action cards.

Delivery Risks

The system has a robust process for the management and escalations of risk in line with agreed governance. The SCC will support manage real time risk across the cluster, utilising SHREWD and other defined key metrics to support actions. Risk assessment for multifactorial decisions will be undertaken to ensure a clear understanding of impact to all, that provides evidence of a governance process that ensures accountability, responsibility and ownership.

Risks relating to winter will be agreed via respective governance and reviewed locally to support.

The system risk register is reviewed monthly with system risks scoring 12 and above being discussed at respective UEC Delivery and Transformation groups. Individual provider risks will be managed through individual provider governance.

Performance Monitoring

As part of the STW and SSOT UEC Winter Planning approach, the system will continue to closely monitor delivery against key national performance standards, including 4-hour emergency care performance, Category 2 ambulance response times, and 12-hour waits in line with Operational Planning submissions.

Alongside these established national indicators, a suite of locally identified metrics for each system will be tracked to provide oversight of the interventions designed to support winter resilience, improve patient outcomes, and maximise system capacity.

These measures, include Average Ambulance Handover times, NCTR, SPOA referrals and deflection rates, Urgent Community Response activity, Virtual Ward occupancy, and discharge pathway utilisation. This will enable the cluster to assess the effectiveness of admission avoidance, patient flow, and discharge initiatives. Where planning trajectories have been established, performance will be monitored against these trajectories to provide assurance on delivery, identify areas requiring targeted intervention, and support timely escalation of risks throughout the winter period.

In addition, each winter scheme and initiative will be supported by a defined set of outcome measures to ensure robust oversight of implementation, benefits realisation, and overall impact on system performance. This will provide a clear line of sight between operational delivery, scheme effectiveness, and the achievement of both local and national winter planning objectives.

Place

Integrated Neighbourhood Teams (INTs) across both Staffordshire and Stoke-on-Trent (SSOT) and Shropshire and Telford & Wrekin (STW) are strengthening locality-based Multidisciplinary team (MDT) working to deliver a range of schemes ahead of, and during, winter 2026/27:

- Children and Young People (CYP) MDTs models in Stoke are being developed with the aim of being in place to provide increased support ahead of winter,
- MDTs are established in Shropshire and will seek to expand support for complex discharges post admission with the aim of reducing re-admission. Re-admission rates will be monitored as part of the outcome measures assessed,

- INT established in North Stoke Locality focusing on frailty cohort with MDT focus on reducing admissions and supporting residents in the community,
- Development of MDTs is coalescing with focus on CYP in STW and the planned expansion of virtual wards and UCR models to include CYP cohorts with the aim to support admission avoidance and delivery of care at home,
- The STW objective this winter is to reduce reliance on hospital-based services by strengthening community-based alternatives and improving response to deterioration with increased usage of our Care Coordination function.

Both ICBs have identified and ringfenced recurrent neighbourhood funding for 2026/27 to accelerate the shift toward proactive, community-based care. Funding will be routed through MPFT and SCHT as anchor institutions via contract variations to their NHS Standard Contracts.

The ICB 2026-27 Outcomes Framework is structured around three key domains with a cross-cutting focus on inequalities: Frailty and ageing well; Cardiovascular risk management; Urgent Care/ Admission Avoidance.

Within SSOT, investment has been secured via the Better Care Fund (BCF), funding from Marie Curie and contributions from the ICB to deliver targeted end of life and palliative care schemes to reduce admissions and conveyances. A proactive in-reach to ED at UHNM, staffed by Palliative Care clinicians, will identify EoL patients at the front door and seek to redirect patients to a more appropriate care setting or expedite admission to the correct ward/service to reduce avoidable admissions and length of stay. Outcome measures are in place to assess EoL admissions and Length of Stay (LoS), with reductions expected in both metrics.

Alongside this, funding has been secured via the BCF to deliver a palliative care virtual ward and enhanced community response service. Specialist care rapid response will be delivered via system Hospice providers and focused on crisis avoidance and tailored specialist care in a person's usual place of residence. Launch date prior to the end of 2026 to support winter capacity. In addition, the 24/7 palliative care advice line is well embedded and will continue to evolve to ensure maximisation of impact. Conveyance and admission metrics will gauge outcome and efficiency.

Targeted work to address conveyances and admissions from Care Homes has been undertaken by the Care Home Improvement Support Team (CHIST) and Provider Improvement and Response Team (PIRT) across Staffordshire, undertaking focused work with the top 10 homes with the highest admission numbers. Education and interventions to "make it easier to do the right thing" at Care Homes and for Care Home staff will form the basis of the programme. Metrics will assess NEL admissions from those homes identified to refine interventions and roll-out learning across the cluster.

BCF funding is being utilised, in addition to those schemes described above, to enhanced neighbourhood-based models prioritising people remaining at home and independent for longer. Key investments relate to Home First reablement, intermediate care, falls prevention, community equipment provision, and additional support for carers. Reducing avoidable hospital admissions (including for target cohorts, i.e. care homes, CYP, falls patients), supporting timely discharges and providing alternatives to conveyance, admission and hospital-based care underpin the aims and objectives for this work. Linkage to UCR services across the area and alignment to the system SPoA support these plans and will feed into achievement of advances in the outcome measures described.

As part of the Neighbourhood Health work, Neighbourhoods across the ICB Cluster are proactively identifying those patients that are most vulnerable as winter approaches.

Targeted care planning and management work will be undertaken for frail patients and those with complex long-term conditions, in advance of winter, to attempt to mitigate utilisation of UEC services during the most pressured periods of the year.

Plans are taking shape and acceleration of actions is being facilitated, to ensure that impacts will be felt prior to the onset of winter and to provide enhanced management and clinical oversight of our most vulnerable population groups this winter.

Communications and Engagement

The Cluster will deliver a coordinated Think Communications Campaign across STW and SSOT during winter to support resilience, improve public understanding of urgent and emergency care services, and encourage people to access the right service first time. Building on the successful 2025/26 STW Think campaign, the approach will use consistent Cluster-wide messaging with local adaptation where service models differ.

The campaign will be informed by operational data, service demand trends, community insight and learning from previous evaluations. The campaign will promote the Think: Right Help, Right Time, First Time approach supported by promotion of self-care, NHS 111, Community Pharmacy, GP practice, MIUs, UTCs, mental health services and community-based alternatives to Emergency Departments. Emergency Departments and 999 will continue to be promoted for life-threatening emergencies only. Alongside supporting prevention and service navigation, activity will increase public understanding of the wider range of community, neighbourhood and urgent care services available closer to home, helping people access the right support in the most appropriate setting. The campaign will support wider system objectives to strengthen prevention, improve care closer to home and reduce avoidable reliance on hospital-based services. In addition to the public-facing activity, communications will support staff and partners to understand seasonal priorities, service developments and key messages, helping to ensure consistent signposting and coordinated delivery across the Cluster.

Success will be measured through communications reach and engagement, partner amplification, website and digital activity, community engagement outputs, and available behavioural indicators. These will include trends in NHS 111 use, Pharmacy First consultations, MIU/WIC and UTC attendances, and relevant urgent and emergency care flow measures, recognising that these are influenced by multiple operational and seasonal factors.

A dedicated Winter Vaccination Communications and Engagement Campaign will run from August 2026 to March 2027 to maximise uptake of flu, COVID-19 and RSV vaccinations, alongside targeted support for MMRV catch-up, HPV and MenB programmes where local uptake data identifies a need. The campaign forms a key part of the Cluster's prevention and winter resilience strategy.

Activity will be data-led and focused on reducing health inequalities by targeting populations and areas with lower vaccination uptake. This includes people living in deprived communities, people with learning disabilities, ethnic minority communities, Gypsy, Roma and Traveller communities, refugees, asylum seekers, people experiencing homelessness and those with limited English proficiency.

The campaign will use national NHS and UKHSA resources alongside locally tailored communications, trusted voices and community outreach. Success will be measured through vaccination uptake by programme, geography and priority population group, reductions in variation between underserved and overall populations, digital engagement metrics, clinic

attendance, outreach activity, Vaccination Champion activity, and qualitative feedback from communities and partners.

Both campaigns will be supported by a robust evaluation framework to assess delivery, engagement, behavioural impact and contribution to winter resilience objectives. Performance data, community feedback and campaign insight will be reviewed throughout the winter period to enable activity to be refined in response to emerging issues and opportunities.

Workforce

Provider organisations across our ICB footprint will be expected to maintain and enact robust workforce resilience arrangements throughout winter 2026/27, recognising workforce availability as a key operational risk during periods of increased demand and operational pressure. Providers will be required to maintain local workforce resilience plans, whilst working collaboratively across the system where necessary, and provide assurance that workforce risks have been identified, mitigations are in place, and arrangements remain under regular review, with escalation plans enacted as appropriate including mutual aid arrangements.

Mitigations should include workforce planning and deployment, targeted recruitment, and actions to maximise workforce availability throughout the winter period. Providers should promote staff vaccination uptake and infection prevention and control measures, maintain up-to-date Emergency Preparedness, Resilience and Response (EPRR) arrangements, including preparedness for any future industrial action and continue to prioritise workforce experience and engagement as well as health and wellbeing, through targeted winter wellness initiatives. This should include support for services experiencing high levels of sickness absence and the implementation of interventions designed to reduce fatigue and burnout.

Each provider will be responsible for developing and implementing local surge and super-surge workforce models to ensure safe staffing levels can be maintained during periods of escalation. Workforce escalation plans should include arrangements for additional hours, staff bank utilisation, agency workforce where required, skill mix optimisation, internal redeployment, volunteer support roles and other appropriate interventions. Providers should establish clear triggers for workforce escalation and ensure these align with wider organisational and system command and control arrangements.

Whilst workforce pressures should be managed through local organisational arrangements wherever possible, providers will be expected to work collaboratively across the Cluster where pressures exceed local capacity. Established workforce mutual aid arrangements will support the deployment of workforce resources and specialist skills between organisations when required. The ICB will act as a system convenor, maintaining oversight of workforce resilience across the Cluster, facilitating collaboration between partners, coordinating mutual aid discussions, and supporting collective responses to system-wide workforce pressures.

The ICB will seek system-level assurance through regular oversight of workforce resilience arrangements and will require providers to demonstrate that appropriate workforce plans, mitigations and escalation arrangements are in place. Monitoring will support the identification of emerging workforce risks, workforce availability challenges, and resilience concerns across the system, enabling timely intervention where appropriate.

Key metrics will include monthly workforce indicators such as sickness absence, turnover and vacancy rates, alongside bank and agency utilisation reported through existing workforce reporting arrangements. The ICB will also monitor workforce mutual aid activity, including the number of mutual aid requests and workforce deployments across the system. These measures will provide assurance regarding workforce resilience, the effectiveness of local mitigation plans,

and the system's ability to respond to surge and super-surge pressures whilst maintaining safe and effective patient care.

Quality Assurance

Maintaining high standards of quality, clinical governance, and patient safety is at the heart of day-to-day work. Entering the high-pressure winter period, the "business as usual" baseline will continue to guide the quality focus. Committed to working in close partnership across the system, using our strategic commissioning approach to bridge performance gaps and support teams when demand spikes.

Key operational priorities for 2026/27 will include enhancing Winter flexibility via:

Providing guidance for winter-specific performance trajectories alongside workforce resilience measures, staff wellbeing initiatives to safeguard a resilient, well-supported workforce during peak seasonal demand and escalation triggers.

Collaborating with system partners in gathering and analysing quality intelligence to measure the direct impact of interventions, required reliable patient flow, streamline discharges, monitoring of high-risk areas/departments, learning from previous experiences.

Encouraging the operational performance during winter pressures, where possible to capture real time data, live clinical decision-making, specific actions/metrics, and cross-agency links to include:

- Patient flow and discharge (D2A, virtual wards, community offer, high risk patient profiling, RESPECT/EOL care)
- Better Care Fund for PIRT, admission avoidance, primary care access hubs, access to diagnostics, cohesion across Walk in centres, NHS 111
- Use of NEWS/PEWS/Sepsis Six, recognition of deterioration, structured screening/early triage and ongoing monitoring

Working with system partners to support the reviews of long waits, ambulance handover delays, and corridor care through established harm review processes and quality assurance processes across sectors/agencies.

Offering additional guidance on patient safety across the cluster through the Patient Safety Incident Response Framework (PSIRF) processes and Martha's Rule into daily clinical pathways and ensuring lessons are captured and shared across the system by means of QI process.

Ensuring robust Impact assessments are in place to support Providers use of their own by using the NQB QIA approach

Contributing to quality oversight for the ongoing development and embedding of mental health crisis pathways, including Crisis Care Centres, Mental Health Liaison Teams, and integrated NHS 111 Option 2 services.

STW Bed Modelling & Mitigations

The peak bed deficit for SaTH under a super surge scenario has been carried forward from bed modelling for last winter as it is still valid based upon what we currently know. The 5 planned interventions detailed by SaTH in their bed model workbook submission to NHSE on 20 Aug 26 provide some mitigation as shown in Image 4 below. However, there will remain a requirement at times to rely upon use of Hospital Full escalation spaces, and higher retention of patients with DTA in our Emergency Departments beyond what has been factored in to the peak deficit start

point. Further iteration of this position will be undertaken with the Trust including further mitigation where possible by System winter interventions.

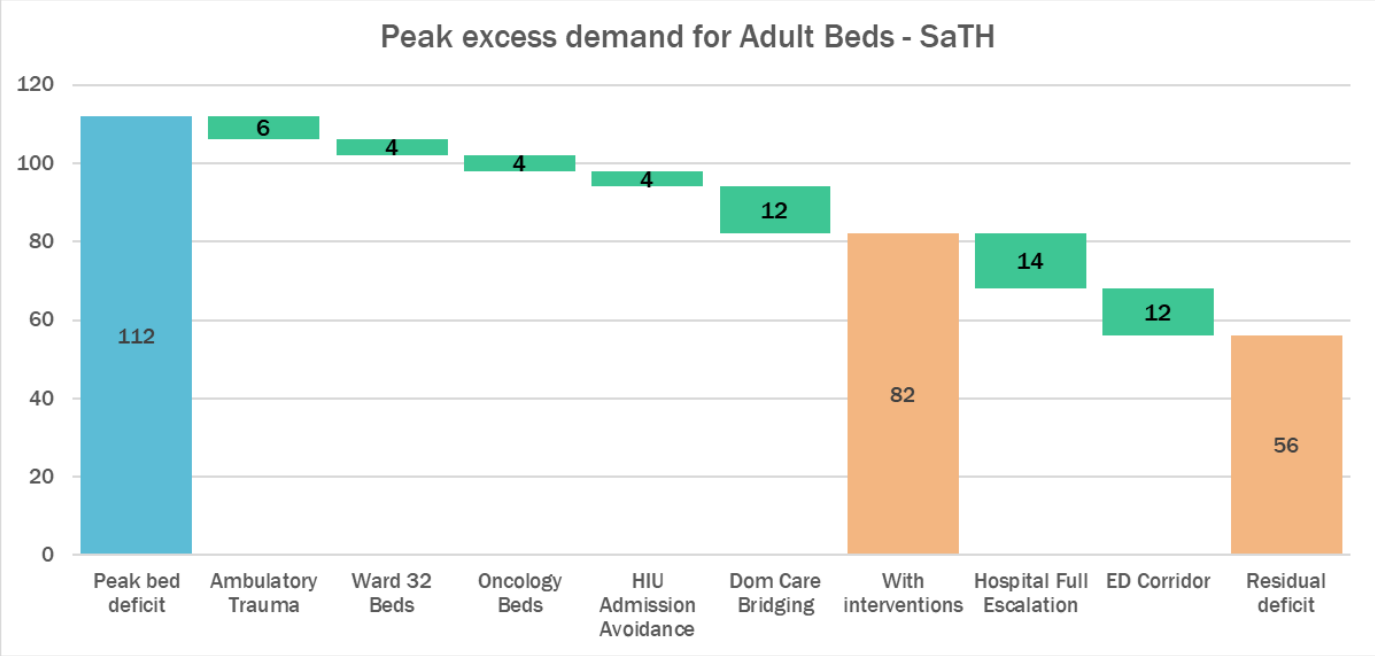


Image 4. SaTH Bed Modelling waterfall

Mitigation Schemes - STW

Winter Schemes are currently still being evaluated to support understand maximisation of impact across the period, below is a summary of plans proposed as of Thursday 27th August.

Scheme	Summary	Impact
Primary Care MDT Hubs	Additional primary care capacity of 15,384 appointments across the system is being commissioned to support more patients within the community.	Demand Management Admission avoidance
Community Diagnostic Vehicle (CDV) Pilot	The CDV will provide portable X-ray, ultrasound and point-of-care blood/UTI testing at the patient's place of residence. Specific focus will be to reduce ED attendances/admissions among over-65s and frail patients, including in rural areas.	ED Decompression Admission avoidance
Extended GATU opening times	Increased hours to 22:00 and Sunday opening for the Gynae Assessment Unit, so more patients are seen through direct assessment rather than ED.	ED decompression Admission avoidance
Bank Holiday Medical uplift	Additional medical consultant staffing over bank holiday periods to support patient discharges that would otherwise stall over the holiday, evidenced in winter reviews.	Improved Flow Reduce NCTR build-up
Additional Post-Take Winter Cover	Additional senior decision-making capacity to support DTA review in both departments and support non-admitted DTA discharge. This will be very specifically	ED decompression Non-admitted discharge

	targeted to address key points of pressure identified in our learning process from Winter 2025/26	
Non-Emergency Patient Transport (NEPTS)	Similar to SSOT albeit under a separate legacy contract, additional non-emergency transport will be ringfenced to support discharges from both acute sites.	LoS Reduction Increased Discharge
Transfer Teams (whole hospital)	Timely movement of patients between departments, wards and onward, hospital-wide, replicating the flow and handover gains proven in a recent PRH trial.	Improved Flow

Table 2. STW Mitigation Schemes

SSOT Bed Modelling & Mitigations

UHNM Capacity Model

UHNM have undertaken local bed modelling alongside completion of the requested regional bed model. Work continues within UHNM to refine their modelling and the below is subject to approval at their board meeting. The below waterfall is based on UHNM bed model with the impact of the proposed schemes for Winter to time included.

The waterfall is focussed on January 2027 that is predicted the most challenged period with a bed gap of 130. With additional mitigations such as use of continuous flow spaces holding additional patients with a DTA in ED and flexing capacity to 96% this would be mitigated to 33 bed gaps. This is shown in image 4 below, image 5 shows a breakdown of the System Mitigations agreed to time.

The ICB are still awaiting submission of the wider UHNM winter plan subject to board approval, however, plans will continue to continue to be revised and reviewed across this period.

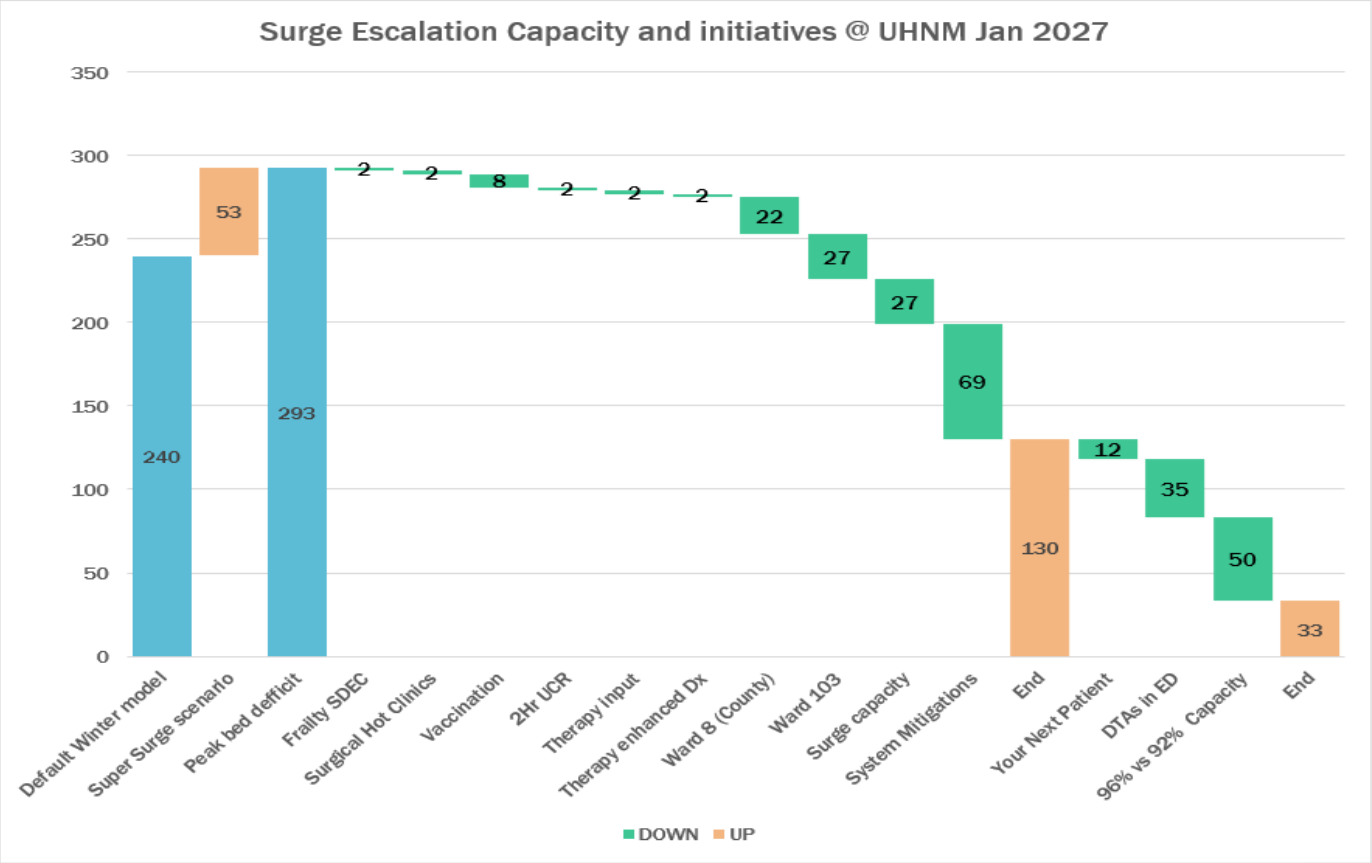

Surge Escalation Capacity and initiatives @ UHNM Jan 2027
350
300
250
200
150
100
50
0
240
53
293
2
2
8
2
2
2
22
27
27
69
130
12
35
50
33
Default Winter model
Super Surge scenario
Peak bed deficit
Frailty SDEC
Surgical Hot Clinics
Vaccination
2Hr UCR
Therapy input
Therapy enhanced Dx
Ward 8 (County)
Ward 103
Surge capacity
System Mitigations
End
Your Next Patient
DTAs in ED
96% vs 92% Capacity
End
DOWN
UP

Image 5. UHNM Bed Modelling Waterfall

Lead Organisation	Scheme Details	Impact (beds)
Hospice Collaborative/UHNM	EoL UCR/VW programme	20
MPFT	In hours ICC	11
PHL Group	Out of Hours ICC	4
IDH	Therapy Pathways	4
IDH	FEAU Pathways	8
IDH	Additional Discharge Facilitators	3
MPFT	Frailty Hot Clinic	2
MPFT	D2A Surge Capacity	13
MPFT	Step up beds	4

Table 3. SSOT System Mitigation Breakdown

UHDB – Queens Hospital Burton Capacity Model

The system is also working closely with UHDB to support their bed modelling assumptions for the Queens Hospital Burton site due to its footprint within SSOT. Formal reporting and submissions for UHDB will be led through the Derby & Derbyshire ICB cluster.

The 2026/27 Queens Hospital Burton (QHB) adult demand reforecast indicates sustained pressure on bed capacity, with core bed demand exceeding the 95% occupancy threshold for most of the year, particularly from August onwards. The NEL bed gap peaks at a projected shortfall of 39 beds in January, although planned escalation capacity through DAU and QHB services, together with the reopening of Ward 801 (10 beds from January), helps reduce the deficit. Even with these mitigations, bed pressures remain significant through winter, with the likely case scenario showing ongoing gaps from October to December before improving to a small surplus by the end of the financial year.

Burton Adult Demand 95% and NEL Bed GAP Detail Re-forecast

2026/27 Bed Model Summary

Burton General and Acute Sites 95% Beds Used Vs Core Capacity (23:59)

Midnight Occupied Beds includes ED queue & DAU

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total Beds Used 95% Occupancy	381	357	378	378	385	380	388	396	387	400	391	387
Total Site Core Bed Capacity	378	378	378	378	378	378	378	378	378	378	378	378
Total NEL Beds used 95% Occupancy	363	340	357	366	354	359	369	375	369	383	371	367
Total Site Core Bed Capacity (Excluding ring fenced beds)	344	344	344	344	344	344	344	344	344	344	344	344
Total Bed Gap (95% Occupancy vs. core)	-3	21	0	0	-7	-2	-10	-18	-9	-22	-13	-9
Total NEL Bed Gap/Projected patient queue (95% Occupancy vs. useable)	-19	4	-13	-22	-10	-15	-25	-31	-25	-39	-27	-23
Closure of the NEL GAP	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Peel Ward										10	10	10
801												
Total Escalation Capacity	0	0	0	0	0	0	0	0	0	10	10	10
Total Bed Gap/Projected patient queue (95% Occupancy vs. useable)	-19	4	-13	-22	-10	-15	-25	-31	-25	-29	-17	-13
DAU	13	13	13	13	13	13	13	13	13	13	13	13
QHB TES (MDU, Endo, SDEC)						6	7	12	12	19	6	6
Total Escalation Capacity	13	13	13	13	13	19	20	25	25	32	19	19
Total Spaces to close gap	13	13	13	13	13	19	20	25	25	42	29	29
Total Bed Gap/Projected patient queue (95% Occupancy vs. useable)	-6	17	0	-9	3	4	-5	-6	0	3	2	6
Best case LOS efficiency	1	2	4	5	5	5	4	5	5	3	3	4
Likely case LOS efficiency	0	1	1	2	2	2	2	2	2	1	1	2
Likely case GAP	-6	18	2	-7	5	6	-3	-4	2	4	3	8
Best case GAP	-5	19	4	-4	8	9	-1	-1	5	6	5	10

Image 6. Burton 26/27 Bed Model Summary

Mitigation Schemes - SSOT

Winter Schemes are currently still being evaluated to support understanding maximum of impact across the period, below is a summary of plans agreed/anticipated to be agreed as Friday 21st August.

Scheme	Summary	Impact
Primary Care MDT Hubs	Additional 46,000 primary care capacity/appointments across the system is being commissioned to support more patients within the community.	Demand Management Admission Avoidance
Bank Holiday Pharmacy	Additional pharmacy provision is being commissioned across Christmas, New year and Easter Periods to support patients access alternative community provision.	Demand Management Admission Avoidance
MPFT Hot Clinics	Hot Clinics will be supported at the Haywood Community Hospital, for frailty patients requiring further clinical assessment. Following the hot clinic assessment, patients will either be returned home with appropriate support, admitted to a step-up bed, or may require escalation.	Admission Avoidance Demand Management
Haywood Hospital Step up Bed	Additional ring-fenced step-up beds available to the ICC, GPs, CRIS team, hot clinics and RSUH ED to support attendance reduction/admission avoidance to acute sites.	Admission Avoidance Demand Management
Additional UCR Capacity	To support more patients to remain at home, additional UCR capacity is supported across the Winter period.	Admission Avoidance Demand Management
IDH Frailty SDEC	Additional resource embedded into the Frailty SDEC at Royal Stoke. This therefore reduces demand on potential inpatient demand, support admission avoidance. From a previous pilot, the additional impact approximately support reduce 2 admissions per day.	Admission Avoidance Demand Management
Therapy Resource within the Integrated Discharge Hub (IDH)	Additional therapy resource within IDH will supports positive risk taking with discharge planning to support more patients return home. The resource will improve efficiency and support reduce bed-based assessments and demonstrated circa 45% increase on earlier discharges following a test of change.	LoS Reduction Increased Discharge
Discharge Facilitators	Increased 7-day Discharge Facilitate presence ensure that patients who are medically optimised across weekend periods can progress without delay. This prevents avoidable extended stays and maintains flow across a 7-day period.	LoS Reduction Increased Discharge
Discharge to Assess Capacity	Across Winter, additional HomeFirst and Bed capacity is commissioned to support predicted increased demand. This is business as usual as part of the contract.	LoS Reduction Increased Discharge
Non-Emergency Patient Transport (NEPTS)	Additional non-emergency transport is commissioned to support increased demand and same day discharges across the system.	LoS Reduction Increased Discharge

Table 4. SSOT System Mitigation Schemes

Conclusion

The STW and SSOT Cluster Winter Plan 2026/27 sets out a comprehensive, clinically led and system-wide approach to managing winter pressures whilst maintaining a focus on safe, effective and compassionate care for our population. Developed collaboratively with partners across health and care, the plan reflects national and regional priorities, builds on learning from Winter 2025/26, and aligns with each system's wider transformation and improvement ambitions.

Whilst winter inevitably presents significant operational challenges, both systems are committed to working collectively as one Cluster, sharing learning, resources and expertise to respond effectively to changing demand. The delivery of the interventions set out within this plan, alongside ongoing UEC improvement programmes and locally commissioned winter schemes, will support greater resilience across urgent and emergency care pathways and help maintain access to planned care services.

The plan continues to be reviewed and refined as wider provider plans and schemes are developed to mitigate demand.

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

Enclosure No: 12

Report to:	Integrated Care Boards in Common
Date:	24 September 2026
Title:	Decision-making business case for birthing services previously provided at County Hospital, Stafford and Samuel Johnson Community Hospital, Lichfield
Presenting Officer:	Vanessa Whatley - Chief Nursing Officer, Adele Edmonson – Head of Communications and Involvement
Author(s):	Gina Gill – Senior Substantive Service Change Lead

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

Is the decision within Scheme of Financial Delegation?	**Yes**	☒	**No**	☐
Any potential / actual Conflict of Interest?	**Yes**	☐	**No**	☒

N/A	*N/A*
Appendices:	00.Decision-making business case, 01. Consultation Overview, 02. Report of Findings, 03. Formal public consultation plan, 04. QIA (2024), 05. QIA (2026 update) 06. EHIA (2024), 07. EHIA (2026 update)

Purpose of the Paper:

To describe the process undertaken to develop and assure the recommendation presented for the long-term solution for birthing services previously provided at County Hospital, Stafford and Samuel Johnson Community Hospital, Lichfield, in order to support decision making.

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

The enclosed decision-making business case (DMBC) outlines the recommendation for the long-term solution for birthing services previously provided at the County Hospital, Stafford and Samuel Johnson Community Hospital, Lichfield. This recommendation is consistent with national and local strategy for maternity services and has been developed following extensive involvement and formal consultation which was considered by the public and stakeholders for 12 weeks from 12 May 2025 to 03 August 2025. The Integrated Care Board (ICB) undertook a further four weeks of engagement that ran from 02 February to 02 March 2026. The purpose of this was to seek additional views from the public and stakeholders on Glucose Tolerance Test[1] (GTT) and Anti-D

[1] GTT is a blood test used to diagnose gestational diabetes, which can occur during pregnancy.

immunoglobulin[2] clinics that have not been available at Samuel Johnson Community Hospital since the pandemic.

The Board approved the pre-consultation business case on 20th March 2025, which detailed how the single viable proposal had been reached. The report of findings from the consultation was received at meetings of the Maternity Technical Group on 27 November 2025 and 23 April 2026 where the group agreed that the feedback received did not suggest any new proposals which had not previously been considered. Therefore, one viable proposal remains. The report findings contained prominent themes of feedback related to the impact of the proposal, on travel, choice and impact on other hospitals. Impact assessments have subsequently been updated to reflect this feedback and outline the mitigations.

The report of findings was subsequently shared with stakeholders and published on the ICB website on 01 June 2026.

The process to develop and assure the recommendation is detailed in the DMBC and adheres to the NHS England Planning, assuring and delivering service change guidelines (2018).

The role of the DMBC is to conscientiously consider the consultation outcomes and ensure that progress to implementation is fully informed by solid detailed analysis of consultation outcomes. The DMBC exists in order to assist the Board to make decisions as opposed to being a decision-making document itself. It should also be noted that the DMBC is a technical, NHS facing document.

Assurance has been obtained for each element of the process as below:

- The clinical model for birthing services has been assured by the West Midlands Clinical Senate.
- The five tests of service change have been assured by NHS England through a Stage 2 Assurance panel.
- The legal duty to involve the public in planning, proposals, and decisions regarding NHS services (as outlined in the National Health Service Act 2006 (as amended by the Health and Care Act 2022)) has been assured through the Staffordshire Health Overview and Scrutiny Committee.

The decision-making business case was presented to the Strategic Commissioning and Transformation Committee on 08 July 2026 where the committee:

CONFIRMED that the process undertaken has adhered to NHS England Planning, assuring and delivering service change guidelines (2018).

AGREED that the decision-making business case can be presented to the NHS Staffordshire and Stoke-on-Trent and NHS Shropshire, Telford and Wrekin Boards in Common for decision making.

Recommendations to Board:

[2] Anti-D immunoglobulin is offered at 28 weeks gestation to women with a RD- negative blood group. This is a preventative safety measure, that protects against small, unpredictable RD-positive fetal blood exposure that could otherwise cause the mother to develop antibodies and affect her current pregnancy.

☑ **APPROVE** the recommendation within the decision-making business case, namely to make permanent the temporary closure of the birthing services at County Hospital and Samuel Johnson Community Hospital and retain GTT and Anti-D immunoglobulin clinics at Queen's Hospital, Burton

History of the paper, incl. date & whether for A / D / S / I (as above):	Date
Strategic Commissioning and Transformation Committee	08 July 2026

Implications:	
Legal / Regulatory	The ICB has a statutory duty to involve patients and the public in the planning, development and delivery of local health services. The aim is to ensure the public receives meaningful information to make informed decisions and provide them with the mechanisms to get involved in the commissioning of local health services and influence ICB decisions at the level of participation they choose as set out in the NHS Act (2006). As part of the Public Sector Equality Duty as contained in section 149 of the Equality Act 2010, decision-makers need to adhere to the Brown Principles to demonstrate their due regard to the aims set out in the general equality duties. The Board must have due regard to the need to: • Eliminate discrimination • Advance equality of opportunity • Foster good relations between different people when carrying out their activities. To 'have due regard' means that in making decisions and in its other day-to-day activities a body subject to the duty must consciously consider the need to do the things set out in the general equality duty. We will consult the Local Authority Health Overview & Scrutiny Committee when the ICB is considering any proposal for: • A substantial development of the health service in the area, or • A substantial variation in the provision of a service. This is underpinned by S244 of the NHS Act 2006 and explained further by the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. The ICB has a legal duty under the Equality Act (2010) to promote equality through the services we commission and establish processes to hear the voices of local people irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender

	reassignment, pregnancy and maternity or marital or civil partnership status. Planning, assuring and delivering service change for patients (PADs) is a key NHS guidance to consider. The guidance is designed to be used by those considering, and involved in, substantial service change to navigate a clear path from inception to implementation. It supports ICSs to consider how to take forward their proposals, including effective public involvement, enabling them to reach robust decisions on change in the best interests of their patients.
CQC / Patient Safety	CQC – service specific inspections were completed at both trusts during 2023 which identified areas for improvement within wider maternity services. Immediate plans were put into place to address the CQC actions and recommendations, and both trusts continue to work on the delivery of their quality improvement plans alongside overall maternity transformation programmes in line with national guidance. Further service specific inspections were completed at both trusts in 2024 where all ratings for areas assessed during 2023 improved. Further detail is included within the business case in Section 11. Patient Safety - Full details of the implications are outlined within the business case and the quality impact assessment.
Financial (CFO-assured)	None
Sustainability	The proposal does not impact our ambition to meet net zero. Both providers are currently auditing their storage and use of nitrous oxide which, depending upon the decision-making process, will be taken into consideration at that point.
Workforce / Training	Positive or neutral impact - Full details of the implications are outlined within the business case
Equality & Diversity	
Due Regard: Inequalities	
Due Regard: wider effect	

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:
	☒	☐	☐		

					Stage 2 assessment approved 03/09/2024, updated stage 1 assessment approved 15/06/2026
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: Gateway 2 QIA signed off 03/09/2024, further gateway 2 assessment signed off 30/06/2026
	☒	☐	☐		
Has there been Public / Patient Involvement?	**Yes**	**No**	**N/A**	2019-2026. Described in detail within sections 2, 3 and 4 of the business case.	
	☒	☐	☐		

Integration with Commissioning Board Assurance Framework (CBAF)			
CBAF1	☒	**CBAF4**	☒
CBAF2	☒	**CBAF5**	☒
CBAF3	☒	**CBAF6**	☒

Decision-Making Business Case

1. Background

1.1. NHS Staffordshire and Stoke-on-Trent Integrated Care Board (ICB), along with colleagues from NHS Derby and Derbyshire ICB have been working with provider partners to outline the current position in relation to the birthing services that were previously provided at County Hospital, Stafford and Samuel Johnson Community Hospital, Lichfield.

1.2. In 2018/19, system partners identified maternity services as one of five clinical areas for review and consideration of alternative future models of care. An options appraisal process commenced in 2019, which included patient and public involvement, however COVID-19 led to a pause in the transformation programme for Staffordshire and Stoke-on-Trent, and to a pause in specific plans for local birthing services.

1.3. In 2020, at the beginning of the Covid-19 pandemic and in line with national guidance, birthing services at both at County Hospital, Stafford and Samuel Johnson Community Hospital, Lichfield were temporarily suspended to consolidate the midwifery workforce at the main acute sites.

1.4. Home birth services were also temporarily suspended at the start of the pandemic and neither Trust had been able to sustainably reinstate these services due to the ongoing midwifery staffing workforce shortage until recently. Both Trusts began booking women into the home birth service during their early pregnancy from 01 April 2024 which now means that women have the full range of low-risk birth settings to choose from.

1.5. During 2022 it was anticipated that both Trusts would be in position to reinstate services either as per the clinical model of 2020 (pre-COVID) or through the implementation of an ‘on-demand model’. However, workforce challenges in relation to recruitment and retention of staff meant that neither provider was able to implement a revised service offer. During this time, both organisations provided regular updates to the Local Maternity and Neonatal System (LMNS) Partnership Board and correspondence was maintained with NHSE via the service change assurance routes.

1.6. Due to continued staffing pressures throughout 2022/23, both organisations informed the ICB in April 2023 they could not reinstate services as per the model of care considered in 2021. Therefore, it was agreed that the service change and public involvement process would be re-established and further work would be undertaken to explore all possible proposals for future service provision.

1.7. County Hospital and Samuel Johnson Community Hospital have remained open for antenatal and postnatal care throughout this period and both trusts continue to offer the choice of a consultant-led or midwife-led birth at Royal Stoke University Hospital and Queen’s Hospital, Burton.

2. Why change is needed

2.1. Before the temporary closure, the number of babies born in a Freestanding Midwifery Birth Unit (FMBU) was very low. Based on the number of births in 2019/20, this amounted to an

average of eight per month at County Hospital in Stafford and 18 per month at Samuel Johnson Community Hospital in Lichfield. This has implications for our staff:

- The units had to be staffed 24/7, with two midwives present for a birth.
- The low number of births meant we were not making the best use of our staff's time. This is a concern, especially given staffing pressures.

2.2. A previous Trust Special Administrator (TSA) review of maternity services at County Hospital recommended that the units manage a minimum of 350 births per year for them to be clinically and financially viable – in other words, for the workforce to be used in the best way possible, to ensure they maintain their skills and competency, and for the services to give value for money whilst being of the highest quality. There were not enough births in the FMBUs to ensure this.

2.3. FMBUs are for low-risk pregnancies only. A Birthrate Plus® assessment completed for UHNM in 2025 showed that pregnancies are becoming more complex. Just over 89% (5,411) of all women who gave birth at UHNM fell into the moderate or high-risk category. This means that just under 11% (669) were suitable for low-risk care – compared to17% in 2022 and 29% in 2017/18 (West Midlands Clinical Senate review). A similar level of complexity is seen at UHDB where the 2025 Birthrate Plus® assessment showed that around 90% of all births fall into the moderate or high-risk categories.

2.4. There are around 10,500 births per year for the Staffordshire and Stoke-on-Trent population when we include births at all hospitals (including those that are outside of our area). Birthrate Plus® assessment can only be completed for a particular trusts footprint and therefore cannot be completed for an ICB population as a whole. However, applying the trends being seen at UHNM and UHDB provides an estimate of the levels of low, and moderate or high-risk pregnancies for the local population. Staffordshire and Stoke-on-Trent would therefore expect 9,345 pregnancies each year to be moderate or high-risk, and 1,155 pregnancies to be low-risk.

2.5. Although the trusts promoted birthing services at the FMBUs, the number of births there continued to fall, as most low-risk women were choosing to give birth in the midwife-led units at the main hospitals instead.

2.6. Providing safe services is vital. Recent national investigations into maternity services have emphasised how important it is to maintain safe staffing levels in line with Birthrate Plus®. Both Trusts have had Birthrate Plus® assessments, and both have run successful recruitment campaigns with the majority of posts filled. However, a proportion of these will still be working through their preceptorship programme. This requires a period of structured support from more experienced midwives for newly registered midwives whilst they integrate into their new team and place of work.

2.7. To run the birthing services at the FMBUs and safely staff them 24/7, a minimum of 12.15 experienced Band 7 midwives (whole-time equivalent) would be needed for each unit.

2.8. The skill mix ratio as a result of the proportion of newly qualified midwives mean that, at present, the Trusts cannot staff the FMBUs for births as well as safely staffing the services at Royal Stoke University Hospital and Queen's Hospital, Burton.

2.9. As the number of women with low-risk pregnancies is getting lower, we needed to consider:

- whether it is viable to re-open the units.
- whether it would make the best use of our workforce if we did, because the low number of births mean midwives will struggle to maintain their skills and competencies if they are based at an FMBU.

3. Proposal development and patient and public involvement

3.1. Patient and public involvement is a priority for the Staffordshire and Stoke-on-Trent Integrated Care System (ICS). Women, their families and carers, staff and clinicians and local people have been informed and involved in developing these proposals for the future of maternity services in Staffordshire and Stoke-on-Trent from the outset. Figure 1 at the end of this paper outlines the process we have undertaken over the past few years.

3.2. The development of the proposals and patient and public involvement that ran alongside this fall into four phases:

- Phase one - the initial proposal development and the patient, public and stakeholder involvement that took place during 2019-20 as maternity services were considered as part of the wider Together We're Better transformation programme.
- Phase two – Targeted maternity involvement in 2020 as part of the Together We're Better transformation programme.
- Phase three – The process of developing proposals for the future of these services was paused in 2020 as a result of the COVID-19 pandemic. In late summer 2021 the process was started again with further engagement to understand whether there were any additional considerations about the future of maternity services
- Phase four – Re-established proposal development process undertaken in 2023 along with public involvement to explore all possible proposals for future service provision.

3.3. The process for developing the proposal included:

- Discussions of proposals with the Health and Overview Scrutiny Committees for Staffordshire, Stoke-on-Trent and Derbyshire County.
- Development and ongoing refinement of a PCBC exploring the proposal and its impacts.
- Regulatory and best practice assurance, including:
  - A review of the clinical model by the West Midlands Clinical Senate.
  - Submission of the PCBC for NHS England regional assurance.

3.4. In March 2025, NHS Staffordshire and Stoke-on-Trent ICB Board received the pre-consultation business case (PCBC), which details the proposal development process and the involvement that had taken place to date. The PCBC was approved at the ICB Board meeting, and it was agreed to proceed to a twelve-week period of formal public consultation on the proposal set out in the PCBC.

3.5. The DMBC is a technical document that follows the PCBC and completion of the public consultation exercise.

3.6. The formal public consultation, which ran from 12 May to 03 August 2025, enabled a robust dialogue with an extensive range of stakeholders.

3.7. A mid-point review was held on 16 June 2025, to review all consultation activity to date, the outputs of that activity and a review of future planned events, in order to highlight any identified gaps in knowledge and/or reach.

3.8. The review concluded that the consultation was largely delivering to plan, but highlighted areas where adjustments could be made to the campaign approach to target specific groups more closely and encourage more traffic to the survey link.

3.9. While birthing services at the FMBUs remained temporarily closed after March 2020, antenatal and postnatal care continued at both sites, except for glucose tolerance testing (GTT)[3] and anti-D immunoglobulin[4] clinics, which have not been offered at Samuel Johnson Community Hospital since the pandemic. Up until 2020, there were 8 bookable slots per week for GTTs and 8 bookable slots per week for Anti-D immunoglobulin available at Samuel Johnson Community Hospital. The GTT slots were regularly filled while the Anti-D immunoglobulin slots were underutilised. Both clinics are now offered at Queen's Hospital, Burton.

3.10. Based on the feedback gathered in the consultation and as agreed by the Maternity Technical Group in November 2026, the ICB undertook a further four weeks of engagement. This ran from 02 February to 02 March 2026 to seek additional views from the public and stakeholders on antenatal and postnatal care.

3.11. The feedback from the additional engagement was added to the report of findings and shared with the Maternity Technical Group for consideration on 23 April 2026.

3.12. NHS Staffordshire and Stoke-on-Trent Integrated Care Board (ICB) commissioned NHS Midlands and Lancashire Commissioning Support Unit's (MLCSU's) Communications and Engagement Service, on behalf of Midlands Partnership University NHS Foundation Trust, to coordinate the independent analysis of the feedback from the consultation and to produce the enclosed report. (Appendix 1)

3.13. Summary of reach during the consultation:

- 1,403 surveys completed, of which 62 were completed on the easy read version.
- 871 copies of standard consultation document and 223 of Easy Read downloaded during consultation were downloaded.
- 24 attendees at online and public events.
- 11 engagement sessions at hospitals, family hubs and baby and toddler sessions – 70 people engaged.
- Separate meetings held for Gypsy, Roma and Traveller communities with 16 attendees.
- 14, 835 views (across 6,517 total users) of information pages on the ICB website.

[3] GTT is a blood test used to diagnose gestational diabetes, which can occur during pregnancy. If a woman has one or more risk factor, they are invited to have a GTT test for diagnosis.

[4] Anti-D is offered at 28 weeks gestation to pregnant people with a RD- negative blood group. This is a preventative safety measure, that protects against small, unpredictable RD-positive fetal blood exposure that could otherwise cause the mother to develop antibodies and affect her current pregnancy

- 529,538 impressions across social media campaigns (Impressions measure the total number of times a post is displayed on users' screens).

3.14. Summary of reach during the additional engagement:
- 160 survey responses collected via:
  - 23 provider site visits.
  - 12 community engagement sessions.

3.15. Some equalities concerns were raised that focused on travel and transport, particularly for those with limited access to private transport and concerns about increased travel times.

3.16. The second theme of feedback was around patient choice with participants expressing their desire to choose midwife-led services.

3.17. The third prominent theme was around the impact on other hospitals with participants raising concerns about the increased demand on other services and the capacity of midwife-led care.

3.18. During the consultation we heard that GTT and Anti-D immunoglobulin clinics were no longer available at Samuel Johnson Community Hospital. These ceased at the beginning of the pandemic when birthing services were temporarily suspended. We therefore undertook 4 weeks additional targeted engagement to gather views on these clinics.

3.19. This feedback and the further consideration and evidence compiled following the public consultation in response to it, together with the evidence contained within the PCBC, have been brought together into a DMBC, which is put before the Board for decision.

4. Impact of the proposals

4.1. It is acknowledged that feedback from the engagement and consultation on the proposal has identified travel and transport as a significant concern for patients and the public.

4.2. This concern was generally expressed in terms of:
- The impact on those with a limited income or non-drivers.
- Concerns over the loss of a local service and having to travel further to other locations.
- Concerns over the safety of the mother and baby when travelling long distances to access care.

4.3. A travel impact analysis has been considered, which contains an assessment of the proposal on people from different geographical areas across Staffordshire and Stoke-on-Trent. The travel analysis within the PCBC highlighted that the average travel time for birthing services would increase by around 6 minutes. Women who utilised the FMBU are most affected by the proposals with travel time increasing by around 14 minutes. Average travel time decreased in a number of geographical areas as women were using alternative units that are closer to their home address.

4.4. When considering the travel impact for the GTT and Anti-D immunoglobulin clinics that are no longer offered at Samuel Johnson Community Hospital, Women living in Lichfield are likely most affected due to the proximity of Samuel Johnson Community Hospital. If all women were to travel to Queens Hospital, Burton for this appointment average travel time would increase

by 12 minutes. If all women were to travel to their closest unit, average travel time would increase by 6 minutes.

4.5. The feedback from the public and the travel impact analysis have been considered in detail and, while it is recognised there will be an impact on a small cohort, the following advantages are significant for the Trusts to deliver the best-quality care:

- A centralised workforce to support clinical pathways and escalation as required. This also provides enhanced opportunities for learning and support given the range of births and deliveries across low, moderate and high-risk births and pathways and the range of specialists involved in such care. This also means our midwives able to maintain their competencies when supporting a mix of low- and high-risk births.
- There is a more efficient and robust staffing model when birthing services are centralised on one site, which supports the longer-term sustainability of the workforce at a time when there are national staffing shortages in midwifery.
- Improved responsiveness to any intervention required as a result of a change from low-risk to high-risk care. This is due to the proximity of interdependent services at the acute units compared to within the FMBUs where an ambulance transfer to an acute site would be required for any additional support e.g. obstetrics, fetal monitoring, neonatal care, epidural etc.
- FMBUs are for low-risk pregnancies only and the vast majority of the population (89%) fall into the moderate to high -risk category. The rising complexity of pregnancies over the years means even fewer women are now suitable for low-risk care. We must therefore ensure our midwives are able to support those who are moderate or high risk and not divert what would be a disproportionate level of resource to an underutilised unit.

4.6. Section 5 of the business case outlines our consideration of the themes raised during the formal public consultation and the additional targeted engagement.

5. Financial and resource implications

5.1. The proposal makes permanent the temporary arrangements that have been in place since March 2020 when birthing services at County Hospital and Samuel Johnson Community Hospital were temporarily suspended.

5.2. Workforce plans have been developed in line with Birthrate Plus® to ensure the appropriate number of midwives according to the clinical needs of the local maternity population. These have not been developed in response to this proposal, instead they have been developed for overall maternity services to ensure the Trusts reach full workforce establishment with sustainable recruitments plans in place for the future workforce.

5.3. The single viable proposal described within this business case would not introduce any new models of care and end-to-end pathways would not be affected. The proposal has no direct implications on staffing levels however workforce plans are described within this document to demonstrate the longer-term workforce sustainability within overall maternity services.

5.4. Both trusts have made significant investment to ensure they are at the full midwifery establishment in line with Birthrate Plus®. The additional investment within each of the trusts mean they are able to safely staff maternity services under the current operating model which mirrors the proposal within this pre-consultation business case. As a result, there are no

additional staffing costs as a result of this proposal and no additional estates costs have been identified.

6. Decision-making business case

6.1. Specifically, the DMBC document sets out the request for the NHS Staffordshire and Stoke-on-Trent and NHS Shropshire, Telford and Wrekin ICB Boards in Common, as the Consulting Authority, to approve the proposal outlined in this business case.

6.2. The document and the recommendations within it have been underpinned by a clinically led review and evaluation process which considered the evidence collated in the PCBC, the feedback received through the public consultation and the consideration by the Steering Group of the consultation feedback received.

6.3. NHS Staffordshire and Stoke-on-Trent ICB is grateful for all the feedback and fully acknowledges both the support and concerns relating to the proposal. Following the extensive programme of work to review the findings of the public consultation and ensure conscientious consideration of the feedback, the overarching conclusions of the subject matter expert groups and clinical leaders were that the change proposal consulted on was still supported.

6.4. It is recommended that the NHS Staffordshire and Stoke-on-Trent and NHS Shropshire, Telford and Wrekin ICB Boards in Common approve the following proposed service change:

- Make permanent the existing temporary closure of intrapartum birthing services at County hospital and Samuel Johnson Community Hospital including the GTT and Anti-D immunoglobulin clinics Samuel Johnson Community Hospital, Lichfield.

6.5. It should be noted that:

- The ICB Board is not bound by the recommendations or conditions put forward in this DMBC. The ICB Board can choose to support, reject or amend the recommendations as members see fit.
- The proposal has been built on a solid base of clinical evidence.
- The proposal has heard, considered and responded to the themes that emerged from public consultation.
- The proposal for birthing services is assured by the West Midlands Clinical Senate.
- The proposal is recommended in order to improve patient outcomes and deliver against national clinical guidance.

6.6. The recommendation is set out below, together with an overview of key areas of consultation feedback, considerations given and identified actions if the proposal is agreed. The full extent of consultation feedback, the consideration given, and the resulting conclusions and actions of the subject matter expert working groups should be read in full and can be found in the DMBC and its appendices.

7. Recommendation

7.1. To make permanent the existing temporary closure of intrapartum birthing services at County Hospital and Samuel Johnson Community Hospital.

7.2. This would mean freestanding midwifery-led birthing units would not be reinstated at County Hospital, Stafford or Samuel Johnson Community Hospital, Lichfield.

7.3. Patients who would previously have attended GTT or Anti-D immunoglobulin clinics at Samuel Johnson Community Hospital, Lichfield will attend these clinics at Queens Hospital, Burton.

7.4. Patients who would previously have chosen to give birth at the freestanding midwifery-led birthing units will be offered choice of a consultant-led or midwife-led birth at Royal Stoke University Hospital and Queen's Hospital Burton alongside the choice of home births.

7.5. The concerns raised by the public during the consultation in relation to travel impacts are acknowledged and were considered and reviewed by UHNM, UHDB and the ICB.

8. Next steps

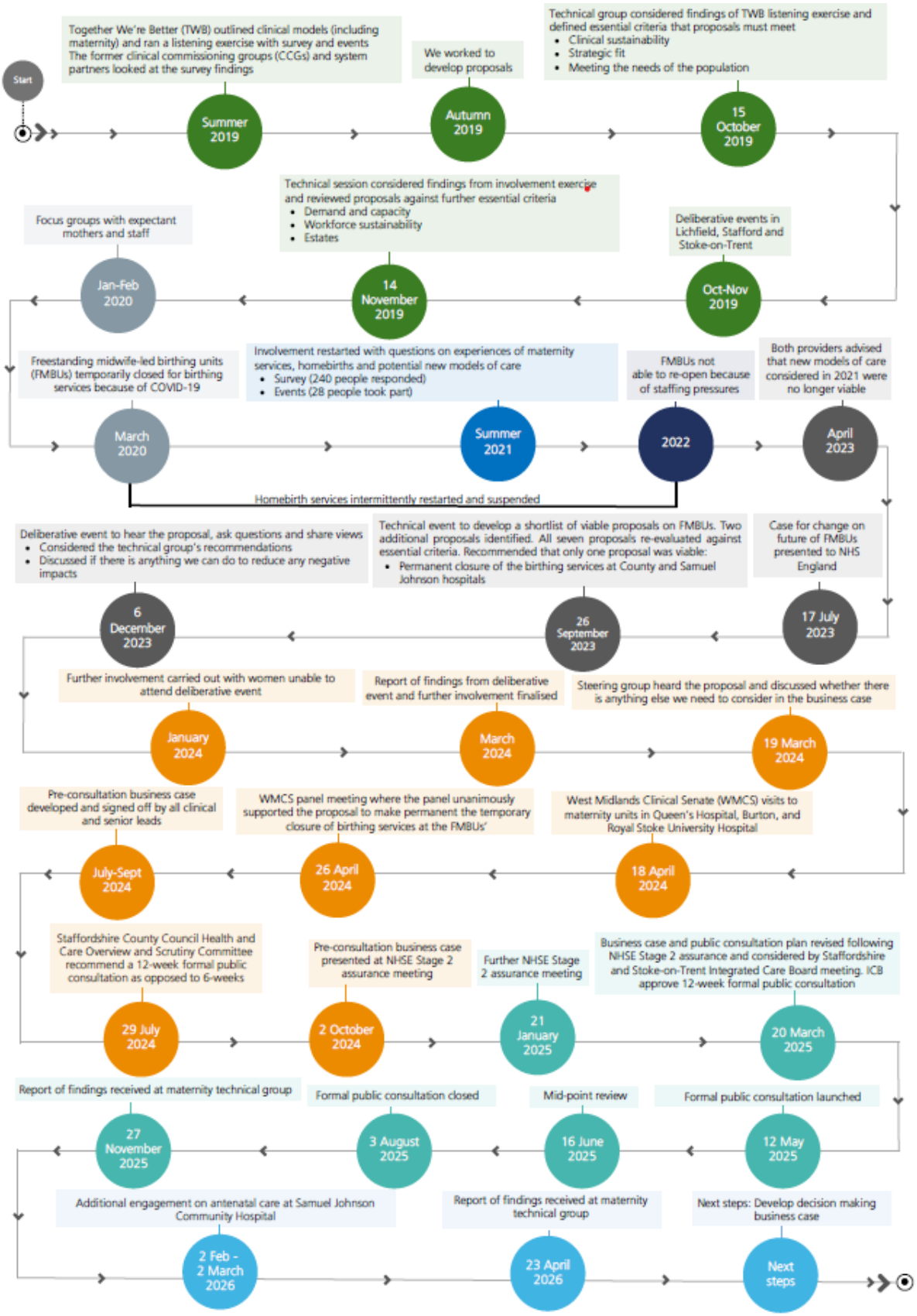
8.1. The decision-making business case will be reviewed by the NHS Integrated Care Board (ICB) as the statutory decision makers.

8.2. The ICB will then consider the proposal and the evidence presented and make a decision on long-term provision. The recommendation is to make permanent the existing temporary closure of intrapartum birthing services at County Hospital and Samuel Johnson Community Hospital including the GTT and Anti-D immunoglobulin clinics at Samuel Johnson Community Hospital, Lichfield.

8.3. If the service change outlined in the business case is agreed by the NHS Staffordshire and Stoke-on-Trent and NHS Shropshire, Telford and Wrekin ICB Boards in Common, implementation and ongoing monitoring of service provision will be driven by the responsible provider organisation.

8.4. The ICB will oversee the strategic commissioning of the new model of care and implementation of the service changes, as the NHS commissioning authority for the Staffordshire and Stoke-on-Trent health system.

Figure 1: Process timeline for the development of this decision-making business case



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

Enclosure No: 13

Report to:	Integrated Care Boards in Common
Date:	24 September 2026
Title:	Integrated Performance Report
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	☐			**Ratification (R)**	☒		

Appendices:	Appendix – Integrated Performance Report

Purpose of the Paper:

This paper presents the latest position against the National Oversight Framework metrics and key areas of performance across both ICBs. It provides assurance on delivery, highlights areas of underperformance and associated risks, and summarises the actions being taken to improve performance.

History of the paper, incl. date & whether for A / D / S / I (as above):	Date
System Performance Group (Performance sections – For discussion). Joint Quality and Performance Committee (Performance sections - for discussion and assurance) Joint Finance committee (Finance section)	4/09/26 23/09/26 29/10/26

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

The integrated performance report has a new structure following changes in the NHS landscape and oversight arrangements. The report is now structured based on the National Oversight Framework (NOF) metrics that are used to assess the Integrated Care Board's (ICB's) performance.

A monthly System Performance Group has been established to ensure that NOF and provider contract performance is effectively managed with mitigating actions identified where performance is off track. This group is a sub-committee of the Joint Quality and Performance Committee and will support in providing assurance to the Committee and the Board that the ICB is effectively managing performance. The actions agreed by the System Performance Group are taken to the Quality and Performance Committee for discussion and endorsement on a bi-monthly basis. Quality and Performance Committee can allocate targeted work to the System Performance

Group to ensure the ICB meets its statutory responsibilities in relation to internal and provider performance assurance and oversight.

National Oversight Framework Summary

Domain: Population health, prevention and reducing inequalities

- No metrics reporting concerning variation

Domain: Allocating resources / access to services

- Community waits within 18 weeks - reporting concerning variation for Staffordshire and Stoke-on-Trent (SSOT). System Performance Group commissioned a deep dive to be undertaken to understand if this is linked to a reporting change or if it is linked to identified specialties. Early indications have identified that the issue is linked to a recording change and further work is being undertaken to understand this.
- Change in waiting list size - not meeting plan for Shropshire, Telford and Wrekin (STW) or SSOT. System Performance Group identified that an elective recovery plan is in place therefore no additional action is required at this time.

Domain: Experience of care

- Mental health out of area placements are showing concerning variation in STW. This is linked to the availability of in area beds and work is in hand to address this. System Performance Group determined no further action is required at this time.
- Learning Disability and Autism (LDA) admission rates to mental health hospitals are not meeting plan for SSOT. A deep dive has already been undertaken and System Performance Group will monitor the impact of identified actions to determine if any further work is required.

Domain: Effectiveness of care

- People on LDA register receiving health checks is reporting concerning variation but this is linked to the way the graph is constructed. System Performance Group will continue to monitor to see if targeted actions are required.

Domain: Patient Safety

- No metrics reporting concerning variation.

Domain: Finance

- Both ICBs are reporting a break-even position year to date and forecasting to hit their plans for breakeven (post deficit support).
- Overspends are being seen in areas such as Continuing Healthcare (£6.4m STW and £4.2m SSOT) and Mental Health (£4.7m STW and £3.2m SSOT), however at this time, are forecast to be fully mitigated by year end.

Domain: People

- The primary care team is offering support to GP practices showing negative variation on GPs per 100k head of population. To note, the metric does not consider the wider workforce mix that some practices are adopting.
- Staff survey is completed annually so a quarterly Pulse survey is used to monitor staff engagement in the interim.

This is the first presentation of the new style performance reporting and further work is taking place to strengthen this reporting. This further work includes:

- Sourcing data for the outstanding metrics
- Strengthening provider contract exception reporting
- Identifying any additional quality metrics required for internal assurance
- Identifying any additional finance metrics required for internal assurance
- Identifying any additional people metrics required for internal assurance

Recommendations:

☑ To note and discuss the content of this report, taking **ASSURANCE** from the information provided.

Impact Assessments:

	Completed?			If N - N/A, Rationale	If Y, Outcome / Date Reported & Signed off
Data Protection Impact Assessment (DPIA)	**Yes**	**No**	**N/A**	Click or tap here to enter text.	*Reported to IG Committee:* Click or tap to enter a date.
	☐	☐	☒		
Integrated Impact Assessment (IIA)	**Yes**	**No**	**N/A**	Click or tap here to enter text.	*Outcome and date of completion:* Click or tap here to enter text.
	☐	☐	☒		

Is the decision within Scheme of Financial Delegation (SOFD) powers & limits	**Yes**	☒	**No**	☐
Any potential / actual Conflict of Interest?	**Yes**	☐	**No**	☒
N/A	*N/A*			

Integration with Commissiong Board Assurance Framework (CBAF)			
CBAF1	☒	**CBAF4**	☒
CBAF2	☒	**CBAF5**	☒
CBAF3	☒	**CBAF6**	☒

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

Integrated Performance Report

September 2026

Contents

1 Overview
1.1 Assurance Matrix Summary

Interpreting SPC charts

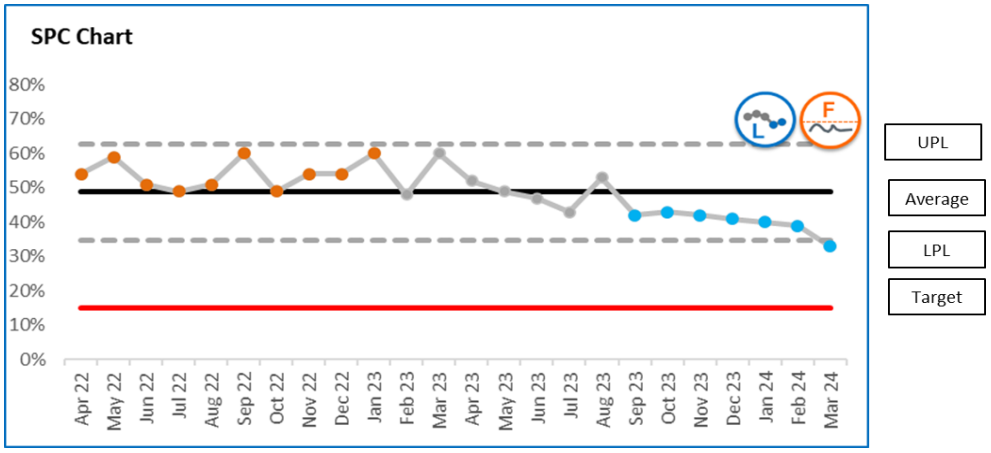
A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly).

The following colour convention identifies important patterns evident within the SPC charts in this report.

Orange – there is a concerning pattern of data which needs to be investigated, and improvement actions implemented.

Blue – there is a pattern of improvement which should be learnt from

Grey – the pattern of variation is to be expected. The key question to be asked is whether the level of variation is acceptable.



The dotted lines on SPC charts (upper and lower process limits) describe the range of variation that can be expected.
Process limits are very helpful in understanding whether a target or standard (the **red** line) can be achieved always, never (as in this example) or sometimes.
SPC charts therefore describe not only the type of variation in data but also provide an indication of the likelihood of achieving target.
Summary icons have been developed to provide an at-a-glance view. These are described on the following page.

1.2 Interpreting summary icons

These icons provide a summary view of the important messages from SPC charts.

	Variation / performance icons		
Icon	**Technical description**	**What does this mean?**	**What should we do?**
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of a CONCERNING nature.	**Something's going on!** Something, a one-off or a continued trend or shift of numbers in the wrong direction	**Investigate** to find out what is happening or has happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an IMPROVING nature.	**Something good is happening!** Something, a one-off or a continued trend or shift of numbers in the right direction. Well done!	Find out what is happening or has happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?
	Assurance icons		
Icon	**Technical description**	**What does this mean?**	**What should we do?**
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is the target will be achieved or missed at random.	Consider whether this is acceptable and, if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	If a target lies **outside of those limits in the wrong direction** then you know the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	If a target lies **outside of those limits in the right direction** then you know the target can consistently be achieved.	**Celebrate the achievement**. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

1.3 Overview Matrix – NHS STW

In summary, for NHS STW metrics, 17.07% (7 metrics) are reporting improving variation, 46.34% (19 metrics) are reporting common cause variation, 4.88% (2 metrics) are reporting cause for concern. (Note that 31.71% (13 metrics) are reporting insufficient data points to provide statistical processing variation and therefore do not report a variation icon). Where SPC is not available for comparison, performance against the plan is used, where available, along with comparison to the mean.

Improving variation	
Under 75's all persons mortality rate from CVD	Population health, prevention and reducing inequalities
% of cases waiting less than 18 weeks for community care	Allocating resources
% of all cancers diagnosed that are diagnosed at stage 1 or 2	Allocating resources
% of clinically urgent appointments that take place on the same day	Allocating resources
% of children (aged 0-9) prescribed antibiotics in the last 12 months	Patient safety
Sickness absence rate	People
Staff survey engagement	People
Common cause variation	
% of people aged 60-74 years screened for bowel cancer in the last 30 months	Population health, prevention and reducing inequalities
Deprivation gap in early cancer diagnosis	Population health, prevention and reducing inequalities
Under 75's all persons mortality rate from cancer	Population health, prevention and reducing inequalities
Eligible referrals to lifestyle/behavioural weight management programmes (per 100k with obesity)	Population health, prevention and reducing inequalities
Deprivation gap in hypertension management	Population health, prevention and reducing inequalities
Adult acute mental health admissions with no contact in the previous year	Population health, prevention and reducing inequalities
Deprivation gap in pre-term births	Population health, prevention and reducing inequalities
% of pregnant women who have quit smoking at 36 weeks gestation	Population health, prevention and reducing inequalities
Ethnicity gap in pre-term births	Population health, prevention and reducing inequalities
Number of people who have started the NHS Diabetes Prevention Programme (rate per 1,000)	Population health, prevention and reducing inequalities
Acute beds days per 100,000 people	Allocating resources
Annual change in waiting list size	Allocating resources
Average number of days between discharge ready and actual discharge date	Experience of care
% of patients able to see their preferred primary care professional	Experience of care
% of patients who describe booking a general practice appointment as easy	Experience of care
% of deaths with 3 or more emergency admissions in the last 90 days of life	Effectiveness of care
Over 65s bed days per 100k head of population	Effectiveness of care
% of hypertension patients treated to target	Effectiveness of care
Talking therapies reliable recovery after 2+ contacts	Effectiveness of care
Concerning variation	
% of adult acute OAPs (bed days)	Experience of care
% of people aged 14+ on the QOF LD register with an annual health check and health action plan	Effectiveness of care

1.4 Overview Matrix – NHS SSOT

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

In summary, for SSOT metrics, 12.5% (5 metrics) are reporting improving variation, 37.5% (15 metrics) are reporting common cause variation, 7.5% (3 metrics) are reporting cause for concern. (Note that 42.5% (17 metrics) are reporting insufficient data points to provide statistical processing variation and therefore do not report a variation icon). Where SPC is not available for comparison performance against the plan is used, where available, along with comparison to the mean.

Improving variation	
Under 75's all persons mortality rate from cancer	Population health, prevention and reducing inequalities
Under 75's all persons mortality rate from CVD	Population health, prevention and reducing inequalities
% of all cancers diagnosed that are diagnosed at stage 1 or 2	Allocating resources
% of clinically urgent appointments that take place on the same day	Allocating resources
Sickness absence rate	People
Common cause variation	
Deprivation gap in early cancer diagnosis	Population health, prevention and reducing inequalities
Number of people who have started the NHS Diabetes Prevention Programme (rate per 1,000)	Population health, prevention and reducing inequalities
Eligible referrals to lifestyle/behavioural weight management programmes (per 100k with obesity)	Population health, prevention and reducing inequalities
Deprivation gap in hypertension management	Population health, prevention and reducing inequalities
Adult acute mental health admissions with no contact in the previous year	Population health, prevention and reducing inequalities
Deprivation gap in pre-term births	Population health, prevention and reducing inequalities
% of pregnant women who have quit smoking at 36 weeks gestation	Population health, prevention and reducing inequalities
Ethnicity gap in pre-term births	Population health, prevention and reducing inequalities
Acute beds days per 100,000 people	Allocating resources
Average number of days between discharge ready and actual discharge date	Experience of care
% of patients able to see their preferred primary care professional	Experience of care
% of adult acute OAPs (bed days)	Experience of care
Over 65s bed days per 100k head of population	Effectiveness of care
% of hypertension patients treated to target	Effectiveness of care
Talking therapies reliable recovery after 2+ contacts	Effectiveness of care
Concerning variation	
% of cases waiting less than 18 weeks for community care	Allocating resources
% of deaths with 3 or more emergency admissions in the last 90 days of life	Effectiveness of care
% of people aged 14+ on the QOF LD register with an annual health check and health action plan	Effectiveness of care

Appendix A: NHSSTW System Performance Group Report

2.1 Population Health, Prevention and Reducing Inequalities

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

Population Health, Prevention and Reducing Inequalities

Metric Table

Metric Name	Workstream	Metric Type	Latest Date	Target	Value	Var.	Ass.	Target Met	Plan Met	Mean
% females 25-64 yrs attending cervical screening within target period	Cancer	STW ICB	Mar 24		73.8%					74.1%
% females aged 53-70 years screened for breast cancer in last 36 months	Cancer	STW ICB	Mar 26		73.4%					74.2%
% people aged 60-74 yrs screened for bowel cancer in last 30 months	Cancer	STW ICB	Mar 26		68.9%					67.5%
Deprivation gap in early cancer diagnosis	Cancer	STW ICB	Mar 26		5.74%					5.22%
Under 75s all persons mortality rate from cancer	Cancer	STW ICB	Jun 26		102					103
% of children to receive two doses of MMRV vaccine before 5th birthday	Primary Care	STW ICB	Mar 26		89.9%					89.8%
Number people who have started the NHS Diabetes Prevention Programme (rate per 1,000)	Primary Care	STW ICB	Mar 26		11.7					9.37
Under 75s all persons mortality rate from CVD	Primary Care	STW ICB	Jun 26		54.7					55.8
Deprivation gap in lipid management	Primary Care	STW ICB	Dec 25		-18.5%					-17.5%
Eligible Referrals to lifestyle/behavioural weight mgt programmes (per 100k with obesity)	Primary Care	STW ICB	Mar 26		328					319
Deprivation gap in hypertension management	Primary Care	STW ICB	Dec 25		-11.4%					-9.35%
Deprivation gap in pre-term births	Quality	STW ICB	May 26		4.22					2.16
% of pregnant women who have quit smoking at 36 weeks gestation	Quality	STW ICB	Sep 25		40%					35.8%
Ethnicity gap in pre-term births	Quality	STW ICB	May 26		1.06					1.27

Escalation charts

No concerning variation reported, therefore no charts required this month

Analyst Commentary:

% females 25-64 yrs attending cervical screening within target period: The most recent published data for this metric is March 2024. National publication of more recent cervical screening data has been delayed due to data quality and publication issues.

% females aged 53-70yrs screened for breast cancer in last 36months: Performance for March 2026, 73.4%, a slight reduction compared to December 2025 (73.8%), below the mean value, 74.2%. Due to insufficient data points, no SPC variation is available.

% people aged 60-74yrs screened for bowel cancer in the last 30months: Performance for March 2026, 68.9%, a reduction compared to December 2025 (69.3%), above the mean value, 67.5%. Reporting normal variation.

Deprivation gap in early cancer diagnosis: Performance for March 2026, 5.74%, sitting above the mean, 5.22%. The metric reports normal variation, however, the rate above 0 indicates those in higher deprivation report a later diagnosis. Awaiting National NOF release for benchmark variation to ascertain the highest and lowest rates

Under 75s all person's mortality rate from cancer: Performance for June 2026, 102, sitting below mean value, 103. Reporting normal variation.

Focus Headlines:

- **Breast cancer screening -** metric deteriorated for the fourth quarter in a row and decreased 0.4% since December.
- **Bowel cancer screening –** metric deteriorated from the last quarter by 0.4% since December.
- **Deprivation gap in early cancer diagnosis** - metric improved from the last month by 0.99% and is reporting normal variation.
- **Under 75s all person's mortality rate from cancer** - metric has not changed from the last month and is reporting normal variation.
- **MMRV** – reported 89.9% for March 26, a slight deterioration of -0.4% compared to December 25, but above the national average of 84.1% in March. National Optimal Standard is set at 95%, STW report a -5.1% variance.
- **Cardiovascular disease (CVD)** – June's position deteriorated from May with a variance of 2.2, however for assurance, improving variation is consistently seen since June 2025.
- **Lipid management** – new monitoring metric, awaiting further national information to facilitate benchmarking and understand STW position regionally/nationally.
- **To note -** some of these metrics have insufficient data points for providing assurance using Making Data Count methodology

Key actions:

- **Breast and Bowel cancer screening –** Continued work ongoing with screening providers and system partners to maximise screening coverage, improve access and encourage participation.
- **Deprivation gap in early cancer diagnosis -** Use deprivation data to identify areas of inequality and target cancer awareness, primary care education and earlier referral initiatives accordingly.
- **Under 75s all person's mortality rate from cancer -** Continue the system-wide cancer improvement programmes, with a focus on earlier diagnosis, reducing inequalities, improving access to effective treatment, and strengthening pathways from primary care through to treatment.

% children to receive two doses of MMRV vaccine before 5th birthday: Performance for March 2026, 89.9%, a reduction compared to December 2025 (90.3%), above the mean value, 89.8%. Due to insufficient data points, no SPC variation is available. **Number of people who have started the NHS Diabetes Prevention Programme (rate per 1,000):** Performance for March 2026, 11.7 per 1,000, sitting above mean value, 9.37 per 1,000. Reporting normal variation. **Under 75s all person's mortality rate from CVD:** Performance for June 2026, 54.7, sitting below mean value, 55.8. Reporting improving variation. **Deprivation gap in lipid management:** Performance for December 2025, -18.5%, an increase compared to September 2025 (-23.3%), sitting below mean value -17.5%. Due to insufficient data points, no SPC variation is available. Rate reporting below 0 reports gap is towards less deprived population. Awaiting National NOF release for benchmark variation to ascertain the highest and lowest rates **Eligible referrals to lifestyle/behavioural weight management programmes (per 100k with obesity):** Performance for March 2026, 328, sitting above mean value, 319. Reporting normal variation. **Deprivation gap in hypertension management:** Performance for December 2025, -11.4%, sitting below mean, -9.35%. Reporting normal variation. Rate reporting below 0 reports gap is towards less deprived population. Awaiting National NOF release for benchmark variation to ascertain the highest and lowest rates **Deprivation gap in pre-term births:** Performance for May 2026, 4.22, above the mean value, 2.16. Reporting normal variation. Rate reporting above 0 reports more deprived population experiencing pre-term births. Awaiting National NOF release for benchmark variation to ascertain the highest and lowest rates **% Pregnant women who have quit smoking at 36 weeks gestation:** Performance for September 2025, 40%, sitting above mean value, 35.8%. Reporting normal variation. **Ethnicity gap in pre-term births:** Performance for May 2026, 1.06, below the mean value, 1.27. Reporting normal variation. Rate above 1 report higher chance of preterm births from – "Other than white "population. Awaiting National NOF release for benchmark variation to ascertain the highest and lowest rates	• **MMRV –** Continued monitoring of quarterly data compared to national benchmarking and of SPC chart once sufficient data points are recorded **Key Risks and mitigations:** • **Breast and Bowel cancer screening - Risk:** Capacity constraints and lower screening uptake may reduce coverage and delay diagnosis. **Mitigation:** Continue collaborative recovery planning with screening providers, maximise appointment capacity and promote equitable access to screening. • **Deprivation gap in early cancer diagnosis - Risk:** Socioeconomic inequalities and variation in symptom recognition may continue to contribute to later-stage diagnosis. **Mitigation:** Target the STW cancer education programme and patient awareness activity towards areas with poorer early diagnosis, while working with Primary Care Networks (PCNs) to identify, address variation and lock at the referral pathways. • **Under 75s all person's mortality rate from cancer - Risk**: Late diagnosis, health inequalities and delays across diagnostic and treatment pathways may continue to contribute to premature cancer mortality. **Mitigation**: Maintain focus on early diagnosis initiatives, cancer pathway improvement, targeted action in deprived communities, diagnostic capacity and treatment pathway recovery. **System Performance Group Summary:** • No additional specific actions identified

Allocating Resources

Metric Table

Metric Name	Workstream	Metric Type	Latest Date	Target	Value	Var.	Ass.	Target Met	Plan Met	Mean
Acute bed days per 100k people	UEC	STW ICB	May 26		5,476					5,747
Annual change in the size of the waiting list	Planned Care	STW ICB	Jun 26		-4.22%					-4.81%
% of cases waiting less than 18 weeks for community care	Community	STW ICB	Jun 26		84.6%					82.0%
Attended community care contacts	Community	STW ICB	Jun 26		495					50,632
% of all cancers diagnosed that are diagnosed at stage 1 or 2	Cancer	STW ICB	Mar 26		58.2%					57.1%
% of clinically urgent appointments that take place on the same day	Primary Care	STW ICB	Jun 26		82.8%					81.2%
Adult acute mental health admissions with no contact in the previous yr	Mental Health	STW ICB	Jun 26		8%					8.28%
% of people with LDA in MH hospital with the longest lengths of stay	LDA	STW ICB	Jun 26		46%					49.3%

Escalation charts

No concerning variation reported, therefore no charts required this month – see below regarding Attended Community Care Contacts.

Analyst Commentary:

Acute bed days per 100k: Performance for May 2026, 5,476, below the mean value, 5,747. Reporting normal variation.

Annual change in the size of the waiting list: Performance for June 2026, -4.2%, sitting above the mean value -4.81%. Reporting normal variation. Plan (-11.9%) not achieved in June 2026.

% of cases waiting less than 18 weeks for community care: Performance for June 2026, 84.6%, sitting above the mean value 81.8%. Reporting improving variation.

Attended community care contacts: Community Care Contacts data has been made available on the Link server in advance of its scheduled publication on 1 September 2026. The data is currently unvalidated and may be subject to change. Please disregard these figures and variation reporting until the official publication date (hence no concerning variation chart included).

% of all cancers diagnosed that are diagnosed at stage 1 or 2: Performance for March 2026, 58.2%, above the mean value, 57.1%. Reporting improving variation.

% of clinically urgent appointments that take place on the same day: Performance for June 2026, 82.8%, above the mean value, 81.2%. Reporting improving variation. Plan (80%) achieved in June 2026.

Adult acute mental health admissions with no contact in the previous year: Performance for May 2026, 8%, sitting below mean value, 8.28%. Reporting normal variation.

Focus Headlines:

- **Change in waiting list size -** metric deteriorated for the fifth month in a row and by 3.08% since May and is reporting normal variation. Plan (-11.9%) not achieved in June 2026. Early indications are that this measure will be reporting concerning variation in July. The System Performance Group will review in October whether additional actions are required in addition to those within the Elective Recovery Plan
- **Community care 18 RTT -** metric improved for the third month in a row and by 0.6% since May and is reporting improving variation.
- **Attended community care contacts -** The data is currently unvalidated and may be subject to change.
- **Cancer diagnosed at stage 1 or 2 -** metric improved for the third month in a row and by 0.4% since February and is reporting improving variation.
- **Same day appointments –** this metric has consistently reported above the plan of 80% during April, May and June, and triggered improving variation in SPC chart in May 2026

Key actions:

- **Change in waiting list size -** Continue delivery of elective recovery through pathway optimisation, productivity improvements, strengthened Patient Tracking List (PTL)management and targeted capacity investment to reduce waiting list growth.
- **Community care 18 RTT -** Continue community recovery programmes focused on reducing long waits through increased clinic capacity, workforce development, pathway redesign, strengthened PTL management and robust waiting list validation.
- **Attended community care contacts -** Continue delivery of community recovery plans through workforce development, pathway redesign, clinic capacity expansion and strengthened performance oversight.
- **Cancer diagnosed at stage 1 or 2 -** Deliver the system-wide early diagnosis programme by strengthening primary care education, increasing public awareness of cancer symptoms, and working with Primary Care Networks to improve earlier recognition and referral of suspected cancers.

Key Risks and mitigations:

% of people with LDA in MH hospital with the longest lengths of stay: Performance for June 2026, 46%, this is a reduction compared to May 2026 (50%), sitting below mean value, 49.3%. Due to insufficient data points, no SPC variation is available.	• **Change in waiting list size – Risk:** Demand continues to exceed available workforce and treatment capacity in our main providers, slowing reductions in the waiting list **Mitigation:** Maintain robust operational oversight, optimise capacity, strengthen waiting list validation, and utilise targeted insourcing and transformation initiatives to maximise available capacity**.** • **Community care 18 RTT - Risk:** Workforce constraints, capacity pressures and increasing demand may limit the ability to sustain reductions in community waiting times. Mitigation: Progress workforce recruitment and service redesign, maximise available clinic capacity, utilise targeted additional capacity where required, and maintain strengthened PTL, validation and performance oversight. • **Attended community care contacts - Risk:** Workforce shortages, estate constraints and increasing demand may impact community service capacity and access. **Mitigation:** Progress workforce recruitment, service transformation, clinic capacity improvements, PTL management and operational performance monitoring to support sustainable recovery. • **Cancer diagnosed at stage 1 or 2 - Risk:** Variation in symptom recognition and continued emergency presentations may limit improvements in early-stage diagnosis. **Mitigation:** Continue targeted education for primary care clinicians, deliver public awareness campaigns focused on lower-performing tumour sites, and use Primary Care Network data to identify unwarranted variation and target improvement initiatives. **System Performance Group Summary:** • There is already an elective recovery plan in place that includes focus on reducing waiting lists, so SPG determined no actions were required in addition to those in the recovery plan. This plan is overseen by the Planned Care Transformation Meeting and the NHSE System Improvement Meeting (replacing the Tiering calls).

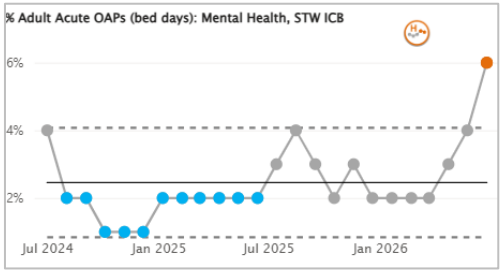
NHS Shropshire, Telford and Wrekin
NHS Staffordshire and Stoke-on-Trent

Experience of Care

Metric Table

Metric Name	Workstream	Metric Type	Latest Date	Target	Value	Var.	Ass.	Target Met	Plan Met	Mean
Average number of days between discharge ready date and actual discharge date	UEC	STW ICB	Jun 26		0.448					0.383
% of patients able to see their preferred primary care professional	Primary Care	STW ICB	Aug 26		64.2%					61.3%
% patients to describe booking a general practice appointment as easy	Primary Care	STW ICB	Aug 26		74.2%					74.7%
% Adult Acute OAPs (bed days)	Mental Health	STW ICB	Jun 26		6%					2.46%
12-month adult admission rate for people with LDA in MH hospital	LDA	STW ICB	Jun 26		25					25.1

Escalation charts



Analyst Commentary:

Average number of days between discharge ready date and actual discharge date: Performance for June 2026, 0.448, above the mean value, 0.383. Reporting normal variation.

% of patients able to see their preferred primary care professional: Performance for August 2026, 64.2%, above the mean value, 61.3%. Reporting normal variation.

% patients to describe booking a general practice appointment as easy: Performance for August 2026, 74.2%, below the mean value, 74.7%. Reporting normal variation.

% Adult Acute OAPs (bed days): Performance for June 2026, 6%, above the mean value, 2.46%. Reporting concerning variation for June 2026 due to sitting above expected upper limit.

12-month adult admission rate for people with LDA in MH hospital: Performance for June 2026, 25 same as May 2026, and is below the mean value, 25.1. Due to insufficient data points, no SPC variation is available. Plan (28) achieved in June 2026.

% Other Adult OAPs (bed days): Due to all data points for this metric being supressed, no SPC is available.

Focus Headlines:

- **Discharge Ready to Discharge** – length of stay following No Criteria to Reside (NCTR) is being closely monitored as a proxy for this.
- **Preferred primary care professional –** reported an improvement of 22% in August from July and is reporting normal variation. It should be noted that the source survey sample size is generally very small and month-on-month variation is usual and confidence intervals are wide (August responses 67, out of approx. 536K residence). Midlands average reporting 68.0%
- **GP appointment booking –** June, July and August are reporting broadly in line, all within 0.7% variation. As above the sample size is generally small and month on month variation is usual.
- **Adult Acute OAPs (bed days) -** Performance for June 2026, 6%, Reporting concerning variation for June 2026.
- **12-month adult admission rate for people with LDA in MH hospital:** Achieved plan for June 2026, and is below the mean value, 25.1. To note there is insufficient data points for providing assurance using making Data Count Methodology

Key actions:

- **Adult Acute OAPs (Bed days) –** NHSE have confirmed that the capital funding has been approved to progress the local development of beds.

Key Risks and mitigations:

- **Adult Acute OAPs (Bed days) - Risk:** Continued placing of patients out of area. **Mitigation:** STW have recently commissioned 6 beds which will mean compliance of continuity of care principles, patients can remain closer to home and physical oversight from MPFT supporting reduced Length of stay (LOS) and repatriation.
- **Discharge Ready / NCTR**: bearing down upon this is a focus area of external consultancy support (Nexus) working with SaTH.

System Performance Group Summary:

- The MH Out of area placement performance is linked to the lack of in area beds. Capital funding has been approved though improvement is not expected until the beds are in place. SPG determined no further actions required at this time.

Metrics in development that will be added to the report at a later date:

- % of complaints open beyond 6 months without a response

2.4 Effectiveness of Care

Effectiveness of care

Metric Table

Metric Name	Workstream	Metric Type	Latest Date	Target	Value	Var.	Ass.	Target Met	Plan Met	Mean
% of deaths with 3 or more emergency admissions in the last 90 days of life	UEC	STW ICB	Jul 26		7.97%					8.18%
Over 65s bed days per 100k head of population	UEC	STW ICB	May 26		15,967					17,815
% of diabetes patients to receive all eight care processes	Primary Care	STW ICB	Mar 26		44.6%					34.7%
% of hypertension patients treated to target	Primary Care	STW ICB	Dec 25		64.3%					63.9%
% of patients with GP recorded CVD who have their cholesterol levels managed to NICE guidance	Primary Care	STW ICB	Dec 25		46.7%					44.7%
Talking Therapies reliable recovery after 2+ contacts	Mental Health	STW ICB	Jun 26	51%	45.2%					49.6%
Proportion of Adult SMI having Physical Health Checks (official)	Mental Health	STW ICB	Mar 26		58%					53.8%
% people aged 14+ on the QOF LD Register with an annual health check & health action plan	LDA	STW ICB	Jun 26	80%	10.2%					34.6%

Escalation charts

Analyst Commentary:

% of deaths with 3 or more emergency admission in the last 90 days of life: Performance for July 2026, 7.97%, below the mean value, 8.18%. Reporting normal variation.

Over 65s bed days per 100k of population: Performance for May 2026, 15,967, below the mean value, 17,815. Reporting normal variation.

% of diabetes patients to receive all eight care processes: Performance for March 2026, 44.6% an increase compared to December 2025 (31.3%), above the mean value, 34.7%. Due to insufficient data points, no SPC variation is available.

% of hypertension patients treated to target: Performance for December 2025, 64.3%, above the mean value, 63.9%. Reporting normal variation.

% of patients with GP recorded CVD who have their cholesterol levels managed to NICE guidance: Performance for December 2025, 46.7% an increase compared to September 2025 (45.7%) above the mean value, 44.7%. Due to insufficient data points, no SPC variation is available.

Talking Therapies reliable recovery after 2+ contacts: Performance for June 2026, 45.2%, below the mean value, 49.6%. Reporting normal variation. Both Plan (49.4%) and National target (51%) not achieved in June 2026.

Proportion of Adult SMI having Physical Health Checks (official): Performance for March 2026, 58%, an increase compared to December 2025 (52%), above the mean value, 53.8%. Due to insufficient data points, no SPC variation is available.

Focus Headlines:

- **% of deaths with 3 or more emergency admissions in the last 90 days of life –** value for July 2026 has increased from 7.64% to 7.97%, however remains within the national ICB benchmarking range indicating a stable level of system performance.
- **Care processes for diabetes** – March 26 reported an improvement of 0.4% from March 25
- **Cholesterol levels management** – during 25/26 reported an improved position from Q1 to Q3 of 1.8%
- **SMI Physical Health Checks** – March 26 reported 58% off the national target of 60%
- **LD health check & health action plan** – cumulative position, with an end-of-year position target of 80%. M3 reporting at 10.2% and not achieving local plan of 11.6%.

Key actions:

- **Neighbourhood shift** is intended to reduce Readmissions by providing alternatives to hospital, with particular focus on the Frail elderly.
- **SMI Physical Health Checks** – STW Primary Care team are working with general practice and the provider to identify challenges and implement improvements, including a dedicated ICB contact point for general practice to raise concerns or access support.
- **LD health check & health action plan** – metric will be monitored closely to identify if further months recover position, or mitigations implemented if this is the start of a continued step change.

Key Risks and mitigations:

- **Neighbourhood delivery – Risk**: There is a risk that 'left shift' work will be insufficient to contribute in the manner required to reduce hospital admission. **Mitigation**: action and delivery method is detailed in our Neighbourhood Outcomes Framework
- **Cholesterol levels management - Risk:** Practice-level variation indicates an opportunity for further targeted improvement. **Mitigation:** Variation will continue to be reviewed to support targeted improvement including

% people aged 14+ on the QOF LD Register with an annual health check & health action plan: Performance for June 2026, 10.2%, below the mean value, 34.6%. Reporting concerning variation. Plan (11.6%) not achieved in June 2026. National target of 80% is to be achieved by March 2027, year-end position.	reviewing patients who are not currently achieving recommended lipid targets or who may benefit from treatment optimisation. • **SMI Physical Health Checks – Risk**: performance continues to decline and does not recover to the expected level to achieve target by end of year. **Mitigation:** continued monitoring of metrics, support from Primary Care team and inclusion and review in Contract Review Meetings and ICB Contract Steering Group. **System Performance Group Summary:** • People on LDA register receiving health checks reporting concerning variation but this issue is linked to the way the chart is formulated. SPG agreed to monitor the metrics to determine if targeted mitigations are required.

Patient Safety

Metric Table

Metric Name	Workstream	Metric Type	Latest Date	Target	Value	Var.	Ass.	Target Met	Plan Met	Mean
% of children (aged 0 - 9) prescribed antibiotics in the last 12 months	Primary Care	STW ICB	May 26		28.1%					31.8%
Number of neonatal deaths and stillbirths per 1,000 total births	Quality	STW ICB	Dec 24		4.9					5.07

Escalation charts

No concerning variation reported, therefore no charts required this month.

Analyst Commentary:

% of children (aged 0-9) prescribed antibiotics in the last 12 months: Performance for May 2026, 28.1%, below the mean value, 31.8%. Reporting improving variation, since April 2025.

Number of neonatal deaths and stillbirths per 1,000 total births: Performance for December 2024, 4.9, an increase compared to December 2023 (4.4), below the mean value, 5.07. Due to insufficient data points, no SPC variation is available. Awaiting updated published data for 2025 value.

Focus Headlines:

- **Children prescribed antibiotics** – improving value from Jul 24 (37.9%) to Nov 25 (27.8%) from where similar monthly values are reported through to May 26 reporting 28.1%, against a national target of 25.0% (at or below). STW are reporting below both average positions for England (28.2%) and the Midlands (28.9%) for May 2026.
- **Neonatal Deaths and Stillbirths -** National NOF reporting for stillbirths and neonatal deaths is currently based on the 2024 MBRRACE-UK Extended Perinatal Stabilised Death Rate methodology. More recent validated national data is not yet available.

Key actions:

- **Neonatal Deaths and Stillbirths –** The ICB Quality Maternity Lead maintains ongoing oversight through regular engagement with local providers and review of local maternity data. Current intelligence identifies no concerns regarding local stillbirth or neonatal death rates.

Key Risks and mitigations:

- **Neonatal Deaths and Stillbirths – Risks:** No significant risks have been identified at this time, except that there is not up to date nationally validated data reported. **Mitigations:** Local infant mortality program continues at pace with September workshop having a focus on inequalities. Maternity quality assurance continues through established governance arrangements. The ICB Quality Maternity Lead reviews performance monthly through Maternity Safety Champions and PQSG, while the ICB Clinical Quality Lead and Quality Analyst produce regular analyses of trust maternity and neonatal dashboard data to identify emerging risks, areas for improvement, and provide assurance to PQSG.

System Performance Group Summary:

- No specific additional actions identified

2.6 Finance

Finance

Metric Table

Metric Name	Workstream	Metric Type	Latest Date	Target	Value	Var.	Ass.	Target Met	Plan Met	Mean
Planned surplus/deficit	Finance	STW ICB	Jun 26		0					0
Year to date variance to financial plan	Finance	STW ICB	Jun 26		0					0

Escalation charts

Due to insufficient data points, no SPC variation charts are available for these metrics.

Analyst Commentary:

Planned Surplus/Deficit: Performance for June 2026 indicates 0 surplus/deficit, same as May 2026 and mean.

Year to date variance to financial plan: Performance for June 2026 indicates 0 variance, same as May 2026 and mean.

Key actions:

- YTD the ICB has reported a break-even position against the submitted plan. This is despite overspends on Continuing Healthcare (£6.4m) and Mental Health (£4.7m) which have both been fully mitigated in the YTD position. Management action has been taken to recover the YTD overspend and therefore the FOT is expected to be in line with the budget/plan.

Key Risks and mitigations:

- **Total Risk £34.6m; fully mitigated**
  - Efficiency risk **£7.6m** – High Risk Schemes (UEC improvement Programme/Impact of Neighbourhoods and readmissions) & Medium Risk Schemes (Hard Decisions, Procurement – VAT Rebate & Individual Commissioning – Fast Track) – mitigated through acceleration of pipeline efficiency schemes and stretch to existing schemes.
  - Cost risk **£27.0m** – Individual Commissioning activity and inflation, 'Category M' drug prices and Prescribing costs, Weight Management Drug rollout, Mental Health Growth (ADHD/ASD, Out of area placements, Non CHC) and Mental Health High Cost Drugs Horizon Scanning– mitigated through Allocation/Growth review, acceleration of efficiency pipeline, Non recurrent underspends and other management actions.

Metrics in development that will be added to the report at a later date:

- Implied productivity growth
- Percentage of clinical trials set up within 90 days – This metric cannot currently be developed as the required data is not publicly available. Reporting will be reviewed should an appropriate data source become accessible in the future.

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

People

Metric Table

Metric Name	Workstream	Metric Type	Latest Date	Target	Value	Var.	Ass.	Target Met	Plan Met	Mean
No. of GPs per 100k head of weighted population	Primary Care	STW ICB	Jun 26		53.5					53.4
Sickness absence rate	Workforce	STW ICB	Apr 26		2.68%					3.79%
Staff survey engagement	Leadership	STW ICB	Mar 26		6.6					6.40

Escalation charts
No concerning variation reported, therefore no charts required this month.
Analyst Commentary:
Number of GPs per 100k head of weighted population: Performance for June 2026, 53.5 per 100k, same as May, above mean value, 53.4. Due to insufficient data points, no SPC variation is available.
Sickness absence rate: Performance for April 2026, 2.68%, a reduction from March (3.5%), below the mean value, 3.79% Reporting improving variation, since October 2025
Staff survey engagement: Performance for March 2026, 6.6, above the mean value, 6.4. Plan (6.2) achieved in March 2026. Reporting improving variation, since March 2025.

Focus Headlines:

- GPs per 100k head of population is above the mean.

Key actions:

- **GP 100k head of population:** Primary Care team continue to monitor variation across practices using the national dashboards, and through the Quality, Contracting and Variation oversight Group. Practices showing as having negative variation are offered support to understand their workforce models. This is a narrow metric and does not consider the wider workforce mix that some practices are adopting.
- **Staff survey:** The staff survey is completed on an annual basis. As the ICB staff opinion is so important to the organisation we undertake a quarterly Pulse survey to gauge staff feelings. The results of the Pulse survey are analysed and shared with Senior Leadership Team (SLT) and with staff via the team huddle. Where areas for improvement are identified SLT discuss potential actions to address across the organisation and at directorate/team level. Identified actions include encouraging staff participation by raising awareness via staff communications, continuing to analyse and share the results with SLT on a quarterly basis, continuing to share the results with staff via the huddle and inviting suggestions from staff on how to improve results.

Appendix B: NHSSSOT System Performance Group Report

2.1 Population Health, Prevention and Reducing Inequalities

Population Health, Prevention and Reducing Inequalities

Metric Table

Metric Name	Workstream	Metric Type	Latest Date	Target	Value	Var.	Ass.	Target Met	Plan Met	Mean
% females 25-64 yrs attending cervical screening within target period	Cancer	SSOT ICB	Mar 24		75.4%					75.7%
% people aged 60-74 yrs screened for bowel cancer in last 30 months	Cancer	SSOT ICB	Mar 26		64.9%					66.0%
Deprivation gap in early cancer diagnosis	Cancer	SSOT ICB	Mar 26		7.85%					7.72%
Under 75s all persons mortality rate from cancer	Cancer	SSOT ICB	Jun 26		99.8					105
% of children to receive two doses of MMRV vaccine before 5th birthday	Primary Care	SSOT ICB	Mar 26		89.2%					88.5%
Number people who have started the NHS Diabetes Prevention Programme (rate per 1,000)	Primary Care	SSOT ICB	Mar 26		22.5					20.7
Under 75s all persons mortality rate from CVD	Primary Care	SSOT ICB	Jun 26		62.5					67.3
Deprivation gap in lipid management	Primary Care	SSOT ICB	Dec 25		-4.27%					-6.16%
Eligible Referrals to lifestyle/behavioural weight mgt programmes (per 100k with obesity)	Primary Care	SSOT ICB	Mar 26		446					316
Deprivation gap in hypertension management	Primary Care	SSOT ICB	Dec 25		-8.89%					-7.81%
Deprivation gap in pre-term births	Quality	SSOT ICB	May 26		1.42					1.38
% of pregnant women who have quit smoking at 36 weeks gestation	Quality	SSOT ICB	Sep 25		28.6%					23.1%
Ethnicity gap in pre-term births	Quality	SSOT ICB	May 26		1.33					1.17

Escalation charts

No concerning variation reported, therefore no charts required this month.

Analyst Commentary:

% females 25-64 yrs attending cervical screening within target period: The most recent published data for this metric is March 2024. National publication of more recent cervical screening data has been delayed due to data quality and publication issues.

% people aged 60-74yrs screened for bowel cancer in the last 30months: Performance for March 2026, 64.9%, a reduction compared to December 2025 (65.8%), sitting below the mean value, 66.0%. Due to insufficient data points, no SPC variation is available.

% females aged 53-70 years screened for breast cancer in the last 36 months: This data cannot be reliably obtained due to it being provided by County Level, and therefore data for SSOT would be inaccurate.

Deprivation gap in early cancer diagnosis: Performance for March 2026, 7.85%, sitting above the mean, 7.72%. The metric reports normal variation, however, the rate above 0 indicates those in higher deprivation report a later diagnosis. Awaiting National NOF release for benchmark variation to ascertain the highest and lowest rates

Under 75s all person's mortality rate from cancer: Performance for June 2026, 99.8, sitting below mean value, 105. Reporting improving variation.

% children to receive two doses of MMRV vaccine before 5th birthday: Performance for March 2026, 89.2%, slight reduction compared to December 2025 (89.5%), above the mean value, 88.5%. Due to insufficient data points, no SPC variation is available.

Number of people who have started the NHS Diabetes Prevention Programme (rate per 1,000): Performance for March 2026, 22.5 per 1,000, sitting above mean value of 20.7 per 1,000. Reporting normal variation.

Focus Headlines:

- **Under 75s all person's mortality rate from cancer** - metric has shown consistent improvement since March 2025 and is reporting improving variation.
- **Cardiovascular disease (CVD)** - Improving performance from November 2025 to June 2026 with a variance of -5.5 during this period.
- **Lipid management -** New monitoring metric, awaiting further national information to facilitate benchmarking and understand SSOT position nationally.
- **Smoking at 36 weeks gestation** – Latest NOF data available is September 2025, however National Maternity Dashboard shows data available up to April 2026 for UHNM:
  - Women (percentage) smoking at booking 8.8% against a national rate of 10.1%
  - Women (percentage) smoking at time of delivery 2.8% against a national rate 4.1%

  Data available from Smoking at Time of Delivery dashboard covers the whole ICB with women smoking at time of delivery at 3.8% for 2025/26 Q4

Key actions:

- **MMRV:** Catch up vaccination programme included within national GP contract for 26/27. Local QIF+ in place to offer 1st and 2nd doses to unvaccinated individuals aged 12 months to 11 years. MMR/MMRV vaccinations to remain available up to age 25. Ongoing local authority awareness raising of the importance of MMR/MMRV vaccinations and increased population risk from measles.

Key Risks and mitigations:

- None identified.

System Performance Group Summary:

- No specific additional actions identified

Under 75s all person's mortality rate from CVD: Performance for June 2026, 62.5, sitting below mean value, 67.3. Reporting improving variation. **Deprivation gap in lipid management:** Performance for December 2025, -4.27%, an increase compared to September 2025 (-5.4%), sitting above mean value -6.16%. Due to insufficient data points, no SPC variation is available. Rate reporting below 0 reports gap is towards less deprived population. Awaiting National NOF release for benchmark variation to ascertain the highest and lowest rates **Eligible referrals to lifestyle/behavioural weight management programmes (per 100k with obesity):** Performance for March 2026, 446, sitting above mean value, 316. Reporting normal variation. **Deprivation gap in hypertension management:** Performance for December 2025, -8.89%, sitting below mean, -7.81%. Reporting normal variation. Rate reporting below 0 reports gap is towards less deprived population. Awaiting National NOF release for benchmark variation to ascertain the highest and lowest rates **Deprivation gap in pre-term births:** Performance for May 2026, 1.42, above the mean value, 1.38. Reporting normal variation. Rate reporting above 0 reports more deprived population experiencing pre-term births. Awaiting National NOF release for benchmark variation to ascertain the highest and lowest rates **% Pregnant women who have quit smoking at 36 weeks' gestation:** Performance for September 2025, 28.6%, sitting above mean value, 23.1%. Reporting normal variation. **Ethnicity gap in pre-term births:** Performance for May 2026, 1.33, above the mean value, 1.17. Reporting normal variation. Rate above 1 reports higher chance of preterm births from – "Other than white" population. Awaiting National NOF release for benchmark variation to ascertain the highest and lowest rates	

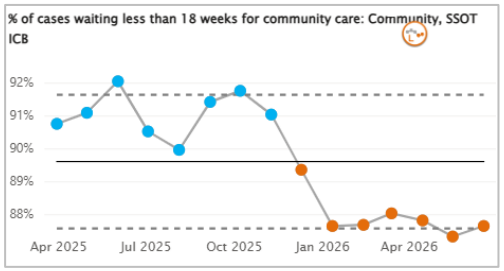
Allocating Resources

Metric Table

Metric Name	Workstream	Metric Type	Latest Date	Target	Value	Var.	Ass.	Target Met	Plan Met	Mean
Acute bed days per 100k people	UEC	SSOT ICB	May 26		4,981					5,125
Annual change in the size of the waiting list	Planned Care	SSOT ICB	Jun 26		1.44%					-7.21%
% of cases waiting less than 18 weeks for community care	Community	SSOT ICB	Jun 26		87.6%					89.6%
Attended community care contacts	Community	SSOT ICB	Jun 26		145,535					146,868
% of all cancers diagnosed that are diagnosed at stage 1 or 2	Cancer	SSOT ICB	Mar 26		55.1%					53.6%
% of clinically urgent appointments that take place on the same day	Primary Care	SSOT ICB	Jun 26		82.6%					79.1%
Adult acute mental health admissions with no contact in the previous yr	Mental Health	SSOT ICB	Jun 26		9%					10.9%
% of people with LDA in MH hospital with the longest lengths of stay	LDA	SSOT ICB	Jun 26		45%					46%

Escalation charts

One concerning variation reported plus see below regarding Attended Community Care Contacts.



Analyst Commentary:

Acute bed days per 100k: Performance for May 2026, 4,981, below the mean value, 5,125. Reporting normal variation.
Annual change in the size of the waiting list: Performance for June 2026, 1.44%, above mean value is -7.21%. Due to insufficient data points, no SPC variation is available. Plan (-12%) not achieved in June 2026.
% of cases waiting less than 18 weeks for community care: Performance for June 2026, 87.6%, below mean value 89.6%. Reporting concerning variation since December 2025 due to value dropping compared to previous months and under mean point.
Attended community care contacts: Community Care Contacts data has been made available on the Link server in advance of its scheduled publication on 1 September 2026. The data is currently unvalidated and may be subject to change. Please disregard these figures and variation reporting until the official publication date (hence no concerning variation chart included).
% of all cancers diagnosed that are diagnosed at stage 1 or 2: Performance for March 2026, 55.1%, below the mean value, 53.6%. Reporting improving variation.

Focus Headlines:

- **Change in Referral To Treatment (RTT) waiting list size -** Comparing June 2026 to June 2025, there has been an increase in the RTT waiting lists for all providers (2024 more, +1.44%).
- **Community care 18 RTT –**June 2026 value (87.6%) is still above the planned value of 82.9%, and above the national expectation of 80% by 2028/29.
- **Attended community care contacts -** The data is currently unvalidated and may be subject to change.
- **Cancer diagnosed at stage 1 or 2 -** Performance is showing improving variation with consistent improvement since February 2025 (53.6%) to March 2026 (55.1%).
- **Same day appointments** - Performance of 82.6% exceeds the local plan and shows improving variation.

Key actions:

- **Change in RTT waiting list size -** Continue to work with UHNM (and NHS England via Tier 2 meetings) to understand and mitigate demand on waiting lists
- **Community care 18 RTT –** Continue to monitor performance through contract review meetings and completing a monthly return to NHSE for areas of concern.

Key Risks and mitigations:

- **Change in RTT waiting list size - Risk**: Demand continues to exceed available workforce and treatment capacity, slowing reductions in the waiting list. **Mitigation**: Maintain robust operational oversight, optimise capacity, strengthen waiting list validation, and utilise targeted insourcing and transformation initiatives to maximise available capacity
- **Community care 18 RTT - Risk**: to delivery include capacity for certain services, as well patient choice. **Mitigation:** Monthly review with MPFT and NHSE around community waiting list long waits.

System Performance Group Summary:

- There is already an elective recovery plan in place that includes a focus on reducing waiting lists, so SPG determined no further actions were required at this time for the change in waiting list size. This plan is overseen by the

% of clinically urgent appointments that take place on the same day: Performance for June 2026, 82.6%, above the mean value, 79.1%. Reporting improving variation. **Adult acute mental health admissions with no contact in the previous year:** Performance for June 2026, 9%, below mean value 10.9%. Reporting normal variation. **% of people with LDA in MH hospital with the longest length of stay:** Performance for July 2026 46%, an increase compared to June 2026 (45%), level with mean value, 46%. Due to insufficient data points, no SPC variation is available.	Planned Care Transformation Meeting and the NHSE System Improvement Meeting (replacing the tiering calls). • Members of SPG to undertake a deep dive to understand whether the community wait issue is linked to MPFT changed reporting methods and to understand whether it relates to specific specialties

Metrics in development that will be added to the report at a later date:

- % of commissioned units of dental activity to be delivered

2.3 Experience of Care

Experience of Care

Metric Table

Metric Name	Workstream	Metric Type	Latest Date	Target	Value	Var.	Ass.	Target Met	Plan Met	Mean
Average number of days between discharge ready date and actual discharge date	UEC	SSOT ICB	Jun 26		0.391					0.356
% of patients able to see their preferred primary care professional	Primary Care	SSOT ICB	Aug 26		75.7%					67.8%
% patients to describe booking a general practice appointment as easy	Primary Care	SSOT ICB	Aug 26		77%					79.4%
% Adult Acute OAPs (bed days)	Mental Health	SSOT ICB	Jun 26		5%					4.17%
% Other Adult OAPs (bed days)	Mental Health	SSOT ICB	Jun 26		11%					10.3%
12-month adult admission rate for people with LDA in MH hospital	LDA	SSOT ICB	Jun 26		15					9.27

Escalation charts

No concerning variation reported, therefore no charts required this month.

Analyst Commentary:

Average number of days between discharge ready date and actual discharge date: Performance for June 2026, 0.391, below the mean value, 0.356. Reporting normal variation.
% of patients able to see their preferred primary care professional: Performance for August 2026, 75.7%, above the mean value, 67.8%. Reporting normal variation.
% patients to describe booking a general practice appointment as easy: Performance for August 2026, 77%, a reduction compared to July 2026 (80%), above the mean value, 79.4%. Due to insufficient data points, no SPC variation is available.
% Adult Acute OAPs (bed days): Performance for June 2026, 5%, above the mean value, 4.17%. Reporting normal variation.
% Other Adult OAPs (bed days): Performance for June 2026, 11%, an increase compared to May 2026 (10%) and mean value, 10.3%. Due to insufficient data points, no SPC variation is available.
12-month adult admission rate for people with LDA in MH hospital: Performance for June 2026, 15, an increase compared to May 2026 (10), above the mean value, 9.27. Due to insufficient data points, no SPC variation is available. Plan (8) not achieved in June 2026.

Focus Headlines:

- **Preferred primary care professional –** reported an improvement of 1.4% in August from July and is reporting normal variation. It should be noted that the source survey sample size is generally very small and month-on-month variation is usual and confidence intervals are wide (August responses 136, out of approx. 1.2m residence). Midlands average reporting 68.0%
- **GP appointment booking**. Showing an overall reduction of 4.4% between June (81.4%) and August (77%). As above the sample size is generally small and month on month variation is usual.
- **12-month adult admission rate for people with LDA in MH Hospital:** During 2025/26 Q4 there was a spike in admissions which is still impacting the rolling average. Performance has been above the mean for 5 consecutive months and has increased from 10 in May 2026 to 15 in June 2026.

Key actions:

- **12-month adult admission rate for people with LDA in MH Hospital:** Deep dive and review of all admissions and implement identified mitigations to reduce all avoidable admissions and increase system knowledge of community support options.

Key Risks and mitigations:

- **12-month adult admission rate for people with LDA in MH Hospital: Risk:** Inappropriate admission may lead to an extended length of stay, adverse experience or harm and may reduce availability of service for individuals where admission is required clinically indicated. **Mitigation:** Transferring Care Programme (TCP) (Inpatients) team prioritising referral to Dynamic Support Register (DSR) to ensure a proactive multi-agency approach maximising community options and mitigate risk of an inappropriate inpatient admission. Post admission review completed to ensure - any learning is taken forward to prevent recurrence.

System Performance Group Summary:

- No specific additional actions identified

Metrics in development that will be added to the report at a later date:

- % of complaints open beyond 6 months without a response

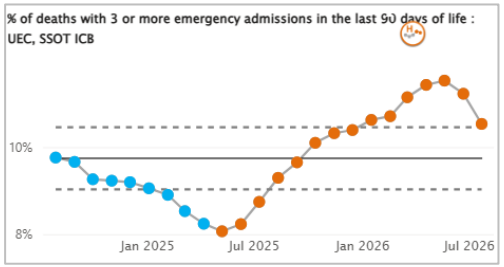
2.4 Effectiveness of Care

Effectiveness of care

Metric Table

Metric Name	Workstream	Metric Type	Latest Date	Target	Value	Var.	Ass.	Target Met	Plan Met	Mean
% of deaths with 3 or more emergency admissions in the last 90 days of life	UEC	SSOT ICB	Jul 26		10.5%					9.74%
Over 65s bed days per 100k head of population	UEC	SSOT ICB	May 26		15,402					17,839
% of diabetes patients to receive all eight care processes	Primary Care	SSOT ICB	Mar 26		61.7%					48.0%
% of hypertension patients treated to target	Primary Care	SSOT ICB	Dec 25		68.9%					68.2%
% of patients with GP recorded CVD who have their cholesterol levels managed to NICE guidance	Primary Care	SSOT ICB	Dec 25		50.8%					49.0%
Talking Therapies reliable recovery after 2+ contacts	Mental Health	SSOT ICB	Jun 26	51%	49.4%					48.9%
Proportion of Adult SMI having Physical Health Checks (official)	Mental Health	SSOT ICB	Mar 26		69%					61.6%
% people aged 14+ on the QOF LD Register with an annual health check & health action plan	LDA	SSOT ICB	Jun 26	80%	13.8%					38.4%

Escalation charts



Analyst Commentary:

% of deaths with 3 or more emergency admission in the last 90 days of life: Performance for July 2026, 10.5%, a reduction compared to June 2026 (11.2%), above the mean value, 9.74%. Reporting concerning variation since May 2025.
Over 65s bed days per 100k of population: Performance for May 2026, 15402, below the mean value, 17839. Reporting normal variation.
% of diabetes patients to receive all eight care processes: Performance for March 2026, 61.7%, an increase compared to December 2025 (43.3%), above the mean value, 48%. Due to insufficient data points, no SPC variation is available.
% of hypertension patients treated to target: Performance for December 2025, 68.9%, a slight increase compared to September 2025 (68.3%), above the mean value, 68.2%. Reporting normal variation.
% of patients with GP recorded CVD who have their cholesterol levels managed to NICE guidance: Performance for December 2025, 50.8%, a slight increase compared to September 2025 (50.4%), above the mean value, 49%. Due to insufficient data points, no SPC variation is available.

Focus Headlines:

- **% of deaths with 3 or more emergency admissions in the last 90 days of life –** value for July 2026 has reduced from 11.2% to 10.5%, however remains above the national ICB benchmarking range.
- **Hypertension patients treated to target –** The value of 68.9% is slightly below the England average of 69.5%.
- **Talking Therapies reliable recovery after 2+ contacts**: June performance (49.4%) is slightly below target of 51%.
- **To note: LD health check & health action plan** – This is a cumulative position, with an end-of-year position target of 80%, local plan in place but not shown in SPC chart. M4 achieved local plan with a variance of 1.8%.

Key actions:

- **% of deaths with 3 or more emergency admissions in the last 90 days of life**: Deep dive of data to take place to understand if there is a data quality issue
- **Diabetes Type 1** included in Quality Improvement Framework (QIF) for 2026/27 to improve uptake of 8 Care processes.
- **Talking Therapies reliable recovery after 2+ contacts** – Memorandum Of Understanding (MOU) signed for ring fenced treasury investment for TT, focus on throughput by therapists and workforce changes to increase treatment capacity. Psychological Wellbeing Practitioner's (PWP) undertaking am additional weekly clinic.

Key Risks and mitigations:

- **Talking Therapies - Risk:** There is a risk of poorer patient outcomes. **Mitigation:** A 3-month enhancing outcomes project has been completed, and the provider will be acting on the findings of this project at service, team, and individual practitioner level to reduce variance and consistently achieve higher recovery rates.

System Performance Group Summary:

Talking Therapies reliable recovery after 2+ contacts: Performance for June 2026, 49.4%, above the mean value, 48.9%. Reporting normal variation. Both Plan (51%) and National target (51%) not achieved in June 2026. **Proportion of Adult SMI having Physical Health Checks (official):** Performance for March 2026, 69%, an increase compared to December 2025 (58%), above the mean value, 61.6%. Due to insufficient data points, no SPC variation is available. **% people aged 14+ on the QOF LD Register with an annual health check & health action plan:** Performance for July 2026, 18.5%, below the mean value, 38.4%. Reporting concerning variation. Plan (16.7%) achieved in July 2026. National target (80%) is to be achieved by March 2027, year-end position.	• A deep dive is planned for deaths with 3 or more admissions within 90 days to determine if there is a data quality issue and whether further action is required • People on LDA register receiving health checks reporting concerning variation but this issue is linked to the way the chart is formulated. SPG agreed to monitor the metrics to determine if targeted mitigations are required.

Patient Safety

Metric Table

Metric Name	Workstream	Metric Type	Latest Date	Target	Value	Var.	Ass.	Target Met	Plan Met	Mean
Number of neonatal deaths and stillbirths per 1,000 total births	Quality	SSOT ICB	Dec 24		4.9					5.19

Escalation charts

Due to insufficient data points, no SPC variation charts are available for these metrics.

Analyst Commentary:

Number of neonatal deaths and stillbirths per 1,000 total births: Performance for December 2024, 4.9, below the mean value, 5.19. Due to insufficient data points, no SPC variation is available. Awaiting updated published data for 2025 value.

Focus Headlines:

- **Neonatal Deaths and Stillbirths** - National NOF reporting for stillbirths and neonatal deaths is currently based on the 2024 MBRRACE-UK Extended Perinatal Stabilised Death Rate methodology. More recent validated national data is not yet available.

Key actions:

- **Neonatal Deaths and Stillbirths -** Ongoing commitment by system partners to the LA led System Mortality Group with focus on
  - Preconception, antenatal and pregnancy health: screening and smoking
  - Data, intelligence and infrastructure
  - Neonatal and maternal care
  - Inequalities, wider determinants and disparities
    Health Literacy Approach tackling communication and engagement with families - Health Literacy and Making Every Contact Counts (MECC)
  - Engagement, co-production, families' voice and communication
- System workshop led by ICB CNO being arranged from October 26
- UHNM Have completed their own in depth review of themes and included wider determinants with PH consultant data, this is to be shared next month

Key Risks and mitigations:

- **Neonatal Deaths and Stillbirths - Risk:** UHNM Have developed an infant mortality action plan which will be shared with the ICB once it has gone through internal governance. **Mitigation:** Maternity quality assurance continues through established governance arrangements. The ICB Quality Maternity Leads reviews performance monthly through Maternity Safety Champions and PQSG, while the ICB Clinical Quality Lead and Quality Analyst produce regular analyses of trust maternity and neonatal dashboard data to identify emerging risks, areas for improvement, and provide assurance to PQSG.

System Performance Group Summary:

- No specific additional actions identified

Metrics in development that will be added to the report at a later date:

- % of children (aged 0 – 9) prescribed antibiotics in the last 12 months

2.6 Finance

Finance

Metric Table

Metric Name	Workstream	Metric Type	Latest Date	Target	Value	Var.	Ass.	Target Met	Plan Met	Mean
Planned surplus/deficit	Finance	SSOT ICB	Jun 26		0					0
Year to date variance to financial plan	Finance	SSOT ICB	Jun 26		0					0

Escalation charts

Due to insufficient data points, no SPC variation charts are available for these metrics.

Analyst Commentary:

Planned Surplus/Deficit: Performance for June 2026 indicates 0 surplus/deficit, same as May 2026 and mean.
Year to date variance to financial plan: Performance for June 2026 indicates 0 variance, same as May 2026 and mean.

Focus Headlines:

- YTD the ICB has reported a break-even position in line with the submitted plan. This is despite overspends on Continuing Healthcare (£4.2m), Mental Health (£3.2m) which have both been fully mitigated in the YTD position. Management action has been taken to recover the YTD overspend and therefore the FOT is expected to be in line with the budget/plan

Key Risks and mitigations:

- **Total Risk £40.3m; fully mitigated**
  - Efficiency risk **£4.5m** – High Risk Schemes (Better Care Fund - CHC) & Medium Risk Schemes (Individual Commissioning, Prescribing & Primary Care) – mitigated by acceleration of pipeline efficiency schemes and stretch to existing schemes.
  - Cost risk **£35.8m** – Individual Commissioning activity and inflation, 'Category M' drug prices and Prescribing costs, Weight Management Drug rollout, Mental Health Growth (ADHD/ASD, Out of area placements, Non CHC) and Mental Health High Cost Drugs Horizon Scanning– mitigated by Allocation/Growth review, Efficiency, non recurrent underspends and management actions.

Metrics in development that will be added to the report at a later date:

- Implied productivity growth
- Percentage of clinical trials set up within 90 days - This metric cannot currently be developed as the required data is not publicly available. Reporting will be reviewed should an appropriate data source become accessible in the future.

2.7 People

People

Metric Table

Metric Name	Workstream	Metric Type	Latest Date	Target	Value	Var.	Ass.	Target Met	Plan Met	Mean
Staff survey engagement	Leadership	SSOT ICB	Dec 25		6.28					6.72
No. of GPs per 100k head of weighted population	Primary Care	SSOT ICB	Jun 26		59.4					59.8
Sickness absence rate	Workforce	SSOT ICB	Apr 26		3.25%					3.55%

Escalation charts

No concerning variation reported, therefore no charts required this month.

Analyst Commentary:

Staff survey engagement: Performance for December 2025, 6.28, above the mean value, 6.72. Due to insufficient data points, no SPC variation is available.
Number of GPs per 100k head of weighted population: Performance for June 2026, 59.4 per 100k, a slight reduction compared to May 2025 (59.8 per 100k), below mean value, 59.8. Due to insufficient data points, no SPC variation is available.
Sickness absence rate: Performance for April 2026, 3.25%, a reduction from March 2026 (3.49%), below the mean value, 3.55% Reporting improving variation.

Focus Headlines:

- GPs per 100k head of population is below the mean

Key actions:

- **GP 100k head of population:** Primary Care team continue to monitor variation across practices using the national dashboards, and through the Quality, Contracting and Variation oversight Group. Practices showing as having negative variation are offered support to understand their workforce models. This is a narrow metric and does not consider the wider workforce mix that some practices are adopting.
- **Staff survey:** The staff survey is completed on an annual basis. As the ICB staff opinion is so important to the organisation we undertake a quarterly Pulse survey to gauge staff feelings. The results of the Pulse survey are analysed and shared with Senior Leadership Team (SLT) and with staff via the team huddle. Where areas for improvement are identified SLT discuss potential actions to address across the organisation and at directorate/team level. Identified actions include encouraging staff participation by raising awareness via staff communications, continuing to analyse and share the results with SLT on a quarterly basis, continuing to share the results with staff via the huddle and inviting suggestions from staff on how to improve results

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

Board Assurance Committee "Triple A" Highlight Report

Report To:	Integrated Care Boards in Common
Date:	24th September 2026
Reporting Committee:	Joint Remuneration Committee
Date of Meeting:	24th June 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

None.

ADVISE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

None.

ASSURE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

The Staffordshire and Stoke-on-Trent Integrated Care Board Remuneration Committee and Shropshire, Telford and Wrekin Integrated Care Board Remuneration Committee met jointly to discuss the following:

Terms of Reference
The Committee received and approved a new set of Terms of Reference for the Cluster Remuneration Committee.

Appointment of the Chief Nursing Officer
The Committee received a report detailing the recruitment process for the Cluster Chief Nursing Officer noting the pay principles and pay ranges set out in the VSM Pay Framework. The Committee approved the appointment and the appropriate remuneration.

Appointment of the Chief Medical Officer
The Committee received a report detailing the recruitment process for the Cluster Chief Medical Officer noting the pay principles and pay ranges set out in the VSM Pay Framework. The Committee approved the appointment and the appropriate remuneration.

Extension of Notice
The Committee received and approved the content of a report requesting a 12-month extension of notice for the current Chief Business Officer, to provide (subject to recruitment processes) continuity, leadership and assurance across critical corporate governance and programme workstreams required to deliver the safe and effective technical merger of the two Integrated Care Boards.

Compulsory Redundancy

The Committee received and approved a paper in relation to compulsory redundancy for 4 members of the Senior Leadership Team following a robust management of change process.

Cluster On Call Policy
The Committee approved the use of a Cluster On Call Policy including costs associated with the appropriate remuneration.

Key Risks & Mitigations

Policies & Procedures Approved
Cluster On Call Policy Terms of Reference

Decisions to be Escalated to ICB Board
None.

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

Board Assurance Committee "Triple A" Highlight Report

Report To:	Integrated Care Boards in Common
Date:	24th September 2026
Reporting Committee:	Audit Committee in Common
Date of Meeting:	8th July 2026
Meeting Quorate Y/N?	Y
Presenter:	Roger Dunshea
Author:	Paul Winter/Melanie Glover

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

Risk Registers
The Committee noted the update on the implementation of the new risk management system (Corestream), which is now live, with training for Risk Owners and Executive Leads ongoing. Risk Owners are currently reviewing and rationalising legacy risks, including consolidating duplicate SSoT and STW risks and aligning former system risks with the ICB Strategic Commissioner model. This work is being undertaken in line with the new Cluster Risk Management Strategy and will support a revised approach to risk management, with the focus on key strategic cluster risks. Following completion of this review, a new risk reporting process will be introduced for the Audit Committee in Common and Board Assurance Committees.

Review of Waivers for Single Contract Tenders
The Committee were advised of two Single Tender Waivers which had been approved for SSoT (STW/2026/042 Intuiti Solutions Limited) which related to the extended contract of an existing provider and (STW/2026/043 Civica UK Limited) which related to the TRAC system which was being brought in-house. The Committee were advised of one Single Tender Waiver which had been approved for STW (ICB 01-2627 S12 Solutions Limited) regarding Section12. The waiver supported an embedded solution that operated across the Cluster and provider and was included in the proactive prevention plan to look at Section 12 as a solution for this year.

Counter Fraud
The Committee were advised of work due to commence around the Policy and Response Plan and Undertake Detection Activity. A local proactive exercise would be undertaken around Section 12 Mental Health Act Assessments and an updated Cluster Anti-Fraud, Bribery and Corruption Policy. MIAA will be attending the Team Huddle to introduce MIAA as the new fraud provider.

SSoT Internal Audit
The Committee were provided with an Internal Audit Progress Report for SSOT which outlined the Data Security and Protection Toolkit (DSPT) which received a 'low risk' assurance rating.

There were two Audit Reviews in progress (Contract Management Review) (Appraisal, Training and Staff Wellbeing)

STW Internal Audit
The Committee were provided with an Internal Audit Progress Report for STW which outlined the DSPT Review currently in draft report stage. The Contract Management Review is in the fieldwork stage, with the Appraisal, Training and Staff Wellbeing in the planning stage.

Governance Update
A report was provided which outlined the work underway to align the Conflict of Interest (COI) and Gifts, Hospitality and Sponsorship Polices. This will be reported to the Audit Committee in Common for approval when completed. The Cluster Policy Review Group Terms of Reference were presented to Audit Committee with the aim to establish an ICB Cluster Policy Review Group, whereby all policies would report through the Group, providing assurance that policies had gone through a robust process.

ASSURE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions
Emergency Preparedness, Resilience and Response (EPRR) update The Committee were provided with a report that provided an overview of the minor updates made to the EPRR documents, following the decision by NHS England to assure ICB's separately and to continue with separate documentation and to ensure compliance with the NHS EPRR annual assurance process (Core Standards) **Information Governance (IG) Sub Committee Update** An update from the IG Sub Committee held in July was provided which focused on the DSPT and the two compliance standards that had been met. The IG Committee also discussed the IG risks due to the DSPT requirement for the ICB to undertake a sample upload and work would be undertaken around IG risk and Cyber risk which formed part of the 'cleansing process.'

Key Risks & Mitigations

Policies & Procedures Approved
STW ICB Incident Response Plan – approved Employee Privacy Notice – approved Cluster Policy Review Group Terms of Reference – approved

Decisions to be Escalated to ICB Board
None

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

Board Assurance Committee "Triple A" Highlight Report

Report To:	Integrated Care Boards in Common
Date:	24th September 2026
Reporting Committee:	Joint Finance Committee – Part 1 (ICB) & Part 2 (System)
Date of Meeting:	28th July 2026
Meeting Quorate Y/N?	Part 1 – Yes Part 2 - No
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)

Chief Finance Officer Update (inc Finance Transformation Update)

The Committee received an update from the Chief Finance Officer which covered: -

- Feedback relating to the system visit from Prof Claire Fuller (NHS England National Team) to review progress on neighbourhood and place-based plans.
- The impact of ICB Restructuring for the ICB Finance Team, including the substantial progress made in redesigning the operating model, supporting the delivery of key organisational milestones and maintaining statutory responsibilities while achieving the required financial savings.

STW/SSOT Month 3 Finance Report

The Committee received an update on the latest position regarding delivery of the ICB finance plan for revenue (including efficiency) and capital.

STW

The month 3 position was reported as break even against the submitted balanced plan. This is despite overspends on Continuing Healthcare (£3.4m) and Mental Health (£4.2M) which have both been fully mitigated in the position. The efficiency plan has delivered £11.7m savings against a target of £10.2m, a favourable variance of £1.4m. This relates to Individual Commissioning Review Programme, reduced WMAS ambulance handover costs, and generic drug switch savings. STW ICB has a total capital allocation of £3.2m which is a capital allocation of £1m designated for General Practitioner Services Capital, £1.7m for Strategic Capital and £0.5m for Primary Care Modernisation and Utilisation Fund.

SSOT

The month 3 position was reported as breakeven, in line with plan. This is despite overspends on Continuing Healthcare (£4.2m) and Mental Health (£2.4m) which have both been fully mitigated in the position. The efficiency plan has delivered £18.8m savings against a target of

£7.8m, a positive variance of £11m. This position was driven by the phasing of the Efficiency Plans. SSOT ICB has a total capital allocation of £7m which is a capital allocation of £2.3m designated for General Practitioner Services Capital, £3.7m for Strategic Capital and £1m for Primary Care Modernisation and Utilisation Fund.

AACC Quarter 1 Stocktake
The Committee were presented with an update on the All Age Continuing Care financial performance and efficiency delivery.

AACC continues to make a significant contribution to financial efficiency and cost reduction across both ICBs. Key achievements include:

- Strong delivery of savings and efficiencies over recent years, with AACC accounting for a substantial proportion of each ICB's overall efficiency programme.
- Significant reductions in CHC spend, with both systems moving from being among the highest spenders nationally to a much-improved position compared to other ICBs.
- Improved value for money, while maintaining safe, high-quality care and appropriate outcomes for individuals.

Current performance shows a mixed picture, with SSOT slightly behind planned savings at this stage of the year, although this is expected to be a timing issue and full-year delivery remains achievable. STW is performing ahead of plan, driven by effective review activity and reductions in some high-cost care packages. Both systems are currently forecasting a break-even financial position, although there are risks linked to increasing care costs, demand pressures and workforce capacity. Mitigation plans are in place, including strengthened review processes and additional delivery support where required. Overall, the report provided assurance that AACC is delivering financial benefits, improving efficiency. The team continue to strengthen commissioning arrangements, while recognising that ongoing monitoring and careful management of financial risks will remain essential.

Reflections from the Strategic Commissioning & Transformation Committee
The Committee were presented with an update on the development of the Strategic Commissioning Framework and how the Board can gain assurance that the new approach will deliver the intended outcomes. The five-year commissioning strategy sets out a long-term vision for transforming health and care services in response to rising demand and financial pressures. Focusing on several major shifts such as moving care closer to home, expanding Integrated Neighbourhood Teams and community-based services, increasing the use of digital solutions, prevention rather than treatment, reducing health inequalities, and building a sustainable workforce and financially sustainable health system. The Strategic Commissioning Framework as a major long-term transformation programme is designed to create a more sustainable, community-focused health and care system, while emphasising the importance of establishing robust assurance processes so that the Board can monitor progress and impact effectively.

Finance Committee in Common Part 2 (System)

STW/SSOT Month 3 System Finance Report
The Committee received an overview of system financial performance at month 3. 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 3, for SaTH this is deemed to be recoverable by year end. UHNM have indicated a risk to efficiency delivery in year, detailed mitigations are under development. Contract status was collected at month 3 from the ICB and provider submissions, these show that in-system contracts are signed and out of

system contract values are agreed but, in some cases, not yet signed. There were no capital risks to report at month 3.

ASSURE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions
There were no items of assurance from the meeting.

Key Risks & Mitigations
The Committee received a System Risk Management update. The report outlined all current system level risks, relevant to the committee which were presented for assurance and appropriate action. Full details of each risk, including current status, mitigating actions, and scoring history were provided in the appended Risk Register. The committee agreed to maintain oversight of those risks scoring above 12 and also agreed the closure of one risk relating to the relocation of SSOT's GP Out of Hours service which has passed without issue.

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
None.

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

Board Assurance Committee "Triple A" Highlight Report

Report To:	Integrated Care Boards in Common
Date:	24th September 2026
Reporting Committee:	Joint Strategic Transformation & Commissioning Committee
Date of Meeting:	10 June 2026 - Trevor McMillan, Chair of the Meeting 8 July 2026 - Ian Green, Chair of the Meeting 12 August 2026 - Trevor McMillan, Chair of the Meeting
Meeting Quorate Y/N?	Yes
Presenter:	Trevor McMillan, Non-Executive Member
Author:	Vanessa Ridout, Executive Assistant

Summary of Key Discussions & Decisions from the Committee Meeting

ALERT

Replacement Make Ready Ambulance Hub in Shrewsbury, Shropshire – Short Form Business Case (meeting held on 8 July 2026)
Members received the report which provided an update on the WMAS Shrewsbury Hub Short Form Business Case and Commissioner Letter of Support provided by NHS STW ICB.

The Committee **noted** the NHS STW ICB Commissioner Letter of Support for the WMAS Shrewsbury Hub for information, with no financial implications to the ICB.

Commissioning Working Group (meeting held on 12 August 2026)
The paper shares the key discussions that took place at CWG held on 22 July 2026. Key point to note:

- St Edward's Resettlement Agreement (Item 2.2.9) - the CWG had held a detailed discussion regarding the proposal to cease an existing financial agreement with Stoke-on-Trent City Council relating to the closure of St Edward's Hospital. The agreement was originally established to support a specific cohort of former residents who have moved into supported living arrangements following the hospital's closure. As those individuals have now moved on and alternative Section 117 arrangements are in place, it was agreed that the funding agreement should cease.

ADVISE

Draft Terms of Reference – Subgroups of SCTC (meeting held on 10 June 2026)
Following some amendments the Committee approved the Terms of Reference for the following subgroups of SCTC:

- Commissioning Working Group
- Population Health Improvement Group
- Transformation and Digital Group
- A Primary Care Group will be established, although terms of reference have not yet been drafted as two existing groups first need to be aligned and merged.
- A Financial Improvement Group will continue to support the committee's work.

- A Procurement Oversight Group will also be established, with terms of reference currently in development.

County Hospital Urgent Treatment Centre – Business Case/Revenue Costs (meeting held on 10 June 2026)
Members received and noted the report which provided details of a Business Case requesting revenue funding for the UHNM County UTC following approval of capital through the constitutional standards/left shift funding allocation. Members noted the recommendation from Commissioning Working Group and approved the UHNM County UTC revenue Business Case subject to a further financial discussion on overheads scheduled to take place on Monday 15th June 2026.

Public Sector Equality Duty (PSED) Patient & Population Report (SSoT) (meeting held on 10 June 2026)
The Committee received and noted the report which provided details of how effectively the ICBs are delivering the three core aims of the PSED. The Public Sector Equality Duty (PSED) report summarised a year of work across both ICBs demonstrating compliance in reducing health inequalities and improving access, experience and outcomes across services and protected groups. The report includes examples from key service areas and confirmed ongoing assurance of statutory duties. It was proposed to have two high-level future objectives for the next two years: reducing avoidable inequalities and strengthening system leadership and accountability, supported by four underpinning actions.

The Committee:

- Were **assured** in relation to compliance with the PSED in relation to Patients and Population.
- **Approved** the proposed joint PSED equality objectives for Patients and Population.
- **Approved** the publication of the full reports on each ICBs respective platforms.

FMBU Decision-Making Business Case (meeting held on 8 July 2026)
Members received the report which described the process undertaken to develop and assure the recommendation presented for the long-term solution for birthing services previously provided at County Hospital, Stafford and Samuel Johnson Community Hospital, Lichfield, in order to support decision making.

The Committee:

- **Confirmed** that the process undertaken has adhered to NHSE Planning, assuring and delivering service change guidelines (2018).
- **Agreed that** the decision-making business case can be presented to the NHS Staffordshire and Stoke-on-Trent and NHS Shropshire, Telford and Wrekin ICB Boards in Common for decision making.

Efficiency Oversight Group Terms of Reference (ToR) (meeting held on 8 July 2026)
The Efficiency and Oversight Group is a newly established operational group across Shropshire, Telford and Wrekin ICB and Staffordshire and Stoke-on-Trent ICB cluster arrangements. Its role is to oversee delivery of agreed ICB efficiency schemes, ensure robust tracking, assurance and financial reconciliation against Medium-Term Financial Plan targets, support escalation of risks and issues, triangulate system efficiency programmes, identify new opportunities for the pipeline and report progress through a robust Gateway Process. The group would report to SCTC via a monthly highlight report.

The Committee **approved** the ToR.

Stoke-on-Trent GP Out of Hours (meeting held on 12 August 2026)
The Committee received the report and were asked to support the Direct Award C to PHL Group for Staffordshire and Stoke-on-Trent GP Out of Hours (GP OOH) provision for 1 year Staffordshire GP Out of Hours was awarded in 2021 to an organisation called VoCare, part of the Totally Group, and went live on the 1 April 2022. In January 2025, the service was extended to include the ICC overnight function as part of the UEC requirements from Winter 2024/25. In June 2025 Totally and all of its subsidiary organisations, including VoCare, went into administration. Parts of their organisation were acquired by PHL Group and as an ICB, an urgent award process was undertaken in line with PSR to award the Staffordshire GP out of hours contract, including the ICC overnight to PHL. The ICB has been working closely with PHL over the last 12 months to stabilise the service, improve performance and to get the service to where it needs to be. Currently, the contract is due to expire on the 31 March 2027.

The Committee was also requested to support the immediate commencement of the open procurement process for the service provision after the temporary period of the proposed Direct Award.

The Committee:

- **Assured** of delivery of GP OOH's services within SSOT.
- **Approved** the Direct award C process and the recommendations within the paper.
- **Supported** the immediate commencement of the open procurement process for the service provision after the temporary period of the proposed Direct Award.

ASSURE

Quarterly Update Green Agenda (meeting held on 10 June 2026)
A sustainability update was provided to the Committee which reported continued reductions in inhaler emissions (11.6%), mixed nitrous oxide (14.6%), and pure nitrous oxide (20%), alongside completion of nitrous oxide infrastructure improvements at UHNM. Providers have delivered a range of carbon reduction, training, and sustainability initiatives, while partners have adopted a coordinated approach to climate-related financial reporting requirements. Key developments included work on a cluster-wide sustainable travel strategy, emerging evidence linking air pollution and dementia, assessment of the environmental impact of hybrid working, and new collaborative initiatives on waste reduction and sustainable primary care. The report highlighted climate adaptation risks, particularly from heat and flooding, and noted challenges around energy infrastructure capacity, emissions data gaps, and reduced NHS England sustainability support. Members were assured on the progress being made by the system to deliver the local Green Plan and performance against regional targets.

Annual Review of 25/26 Health Inequalities Improvement Programme (STW) (meeting held on 10 June 2026)
Members received and noted the report which provided progress across 2025 to 2026 on the ICB led system Health Inequalities Improvement Programme. Members were **assured** of the progress made against the 2025/26 STW plan and the move to a new format in the population health improvement plan for 2026/27 in line with the ICB organisational restructure and fulfilment of the ICB strategic commissioner functions. Members **approved** the recommendations to support the continuation of work aligned to key enablers to support the population health improvement for 2026/27:

- Complete current Health Equality Ambassadors Programme and evaluate for potential future cohorts.
- Implementation of year 2 of the Digital Inclusion Programme.
- Development and implementation of System Health Literacy Toolkit

Highlight reports/updates (meeting held on 10 June 2026)
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.

- Mental Health, LD & A programme
- MSK Transformation Programme
- Primary Care Forum (SSoT)
- Primary Care (STW)
- Equality & Involvement Committee Report (STW)

STW SSoT Strategic Cluster Review Meeting notes of 6 May 2026 (meeting held on 8 July 2026).
Members received the Strategic Cluster Review Meeting notes which detailed the key discussions from the meeting held on 6 May 2026. This included an overview of the strategic commissioning plan, progress towards strategic commissioning capability and development, closing 2025/26 and 2026/27 performance and risks and the key actions.

STW SSoT Strategic Cluster Review Meeting Notes 1 July 2026 (meeting held on 12 August 2026)
Members received the Strategic Cluster Review Meeting notes which detailed the key discussions from the meeting held on 1 July 2026. It was noted that NHSE are looking to set up cluster oversight meetings which will include ICB and providers and would be a more strategic review every six months. The first is proposed for September/October time.

Strategic Commissioning Framework – Neighbourhood Health (meeting held on 12 August 2026)
Whilst the initial focus is on the priority areas of frailty, and CVRM, further iterations would expand to include additional priority groups identified by the Board which includes children and young people and mental health services. The overarching ambition remains to achieve a level playing field with 100% Integrated Neighbourhood Team (INT) coverage across the system and the key outcome metrics around the year one priority groups of frailty and CVRM but also linked to UEC and winter planning. The Commissioning Working Group (CWG), under delegated authority from SCTC, will approve mobilisation plans and release associated funding into the anchor institutions which will enable rapid mobilisation. CWG will review plans in September with implementation commencing from 1 October 2026.

The Committee:

- **Approved** the Strategic Commissioning Framework for Neighbourhood Health for 2026-27.
- **Noted** the ambitions moving forwards into 2027-28 and the commitment for continuous review as our Places and Neighbourhoods mature.
- **Approved** the Commissioning Working Group as the ICB mechanism to review, check and challenge the proposals put forward by the anchor organisations and for the Committee to delegate authority to proceed to CWG including the release of the six months funding for 2026-27.

Neighbourhood Health Cluster Highlight Report (meeting held on 8 July 2026)

Members received the report which provided an update on the delivery of neighbourhood health within Staffordshire Stoke-on-Trent, Shropshire and Telford & Wrekin

The Committee received an update from the following: (meeting held on 8 July 2026)

- Commissioning Working Group
- MSK Transformation Programme
- Primary Care Forum Triple A Report (SSoT/STW
- Equality & Involvement Committee Report

Neighbourhood Health and Dr Claire Fuller Visit Report (meeting held on 12 August 2026)
The Committee received a paper which provided an update on Neighbourhood Health for the Staffordshire, Stoke-on-Trent, Shropshire and Telford & Wrekin Neighbourhood Health programmes, with detailed feedback from the July visit from NHS England National Medical Director, Dr Claire Fuller.

The Claire Fuller visit was well attended with strong representation from the ICB leadership team, provider organisations both acute and community, primary care, local authorities and the voluntary sector and provided a valuable opportunity for collaborative discussion. The overall feedback from CF was positive, recognising significantly stronger partnership working, greater system maturity and improved collaboration across the ICB, providers, local authorities and the VCSE sector.

Strong foundations were acknowledged, including:
- Development of the operating framework.
- The Five-Year Strategic Commissioning Plan.
- The agreed vision for place and neighbourhood delivery.

Whilst progress was recognised, it was noted that the system remains at an early stage in translating strategic intent into measurable service improvement and population outcomes. The Committee had detailed discussions on the neighbourhood health agenda and Place including the need to now accelerate the move to delivery of outcomes and the establishment of the full governance framework including the work of Health and Wellbeing Boards and Place Boards that are critical in the delivery of these critical transformations.
A report would be submitted to the next committee and would include:
- A progress update.
- Delivery milestones achieved.
- Risks and challenges.
- Consideration of alternative governance options

Members were **assured** of progress in the delivery of neighbourhood health.
The Committee received an update from the following: (meeting held on 12 August 2026)
Efficiency Oversight Group
The Group continues to monitor delivery of this year's efficiency savings programme. £3.6m remains as high risk however there are mitigations in place and work ongoing. The EOG is also looking to the years ahead and the requirement from NHSE is to identify £100m recurrent savings from 2027/28 onwards.

Key Risks & Mitigations
There were no risks or mitigations to alert to the Board.

Policies & Procedures Approved
The Hybrid Closed Loop (HCL) Policy (meeting held on 10 June 2026) This was submitted to the Committee however it **was not approved**. It was suggested that it returns to the Commissioning Working Group for further review, incorporating updated financial information alongside a wider STW-level review with Medicines Optimisation colleagues to consider policy alignment and harmonisation. The Policy would be submitted to a future SCTC.

Decisions to be Escalated to ICB Board
None.

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

Board Assurance Committee "Triple A" Highlight Report

Report To:	Integrated Care Boards in Common
Date:	24th September 2026
Reporting Committee:	Joint Quality and Performance Committee
Date of Meeting:	29th July 2026
Meeting Quorate Y/N?	Yes
Presenter:	Cheryl Etches, Non-executive Director and Committee Chairperson
Author:	Vanessa Whatley, Chief Nursing Officer, NHS STW & NHS SSOT

Summary of Key Discussions & Decisions from the Committee Meeting

ALERT – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

- The risk relating to infant and neonatal mortality is the highest sored risk and has increased to a score of 20 following the creation of a single cluster risk. Concerns remain particularly within Stoke-on-Trent, Staffordshire and Telford & Wrekin where infant mortality rates are more than 5% above the national average. The risk is expected to reduce following system actions in progress and a refreshed governance approach strengthened child death review processes, and a multi-agency improvement workshop. A focused maternity and perinatal paper, including neonatal mortality, will be presented to the September Committee.
- Performance against key operational standards, including ED waits and ambulance handovers, remains below plan. Ongoing pressures relating to patient flow, discharge delays and workforce sustainability continue to drive system risk. A cluster-wide winter plan is being developed and will be presented to QPC prior to Board approval in September 26.
- Continuing concerns exist regarding ADHD waiting times and wider neurodevelopmental assessment pathways delays due to increasing demand and capacity constraints, this is being reviewed to reflect a new neurodevelopmental/autism pathway risk has being added to the risk register. Contractual levers are in place in Shropshire Telford and Wrekin and action plans monitored.
- Ivetsey Bank, a private mental health hospital in south Staffordshire remains subject to enhanced monitoring arrangements and is not accepting new admissions while improvement work continues. A Quality Improvement Group is in place with oversight from the ICB, NHSE and the childrens mental health collaborative who commission the beds.

ADVISE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

- Both ICBs have successfully migrated to the Corestream risk management platform, providing a single approach to risk identification, scoring, mitigation and reporting across the cluster.
- Risks are now reviewed through the Joint System Quality Group, strengthening cluster-wide oversight and assurance. A Joint System Performance Group is to commence in September.

- 11 quality and performance risks scoring 16 or above, it was noted that this is the first time risk registers have been brought together across the cluster and each needs review in regard to scoring, removal of duplication, impact across the cluster and ownership. This work is underway.

ASSURE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

- The Committee received assurance the following risks have been successfully mitigated and closed:
  - Tuberculosis service capacity.
  - Child Protection Medicals capacity
- Progress has been made in reducing mental health out-of-area placements although this remains an area under close observation with significant effort from providers to maintain the position.
- The newly established Cluster Perinatal Partnership Group is operational and strengthening system oversight. This follows review of the perinatal governance in the system in line with NHSE direction.
- The SSOT Learning Disability Mortality Reviews (LeDeR) Annual Report was supported and will come to November Board with the STW report.

Key Risks & Mitigations

Policies & Procedures Approved

☑ None

Decisions to be Escalated to ICB Board

None.

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

Board Assurance Committee "Triple A" Highlight Report

Report To:	Integrated Care Boards in Common
Date:	24 September 2026
Reporting Committee:	Joint People, Involvement and Inclusion Committee
Date of Meeting:	27 August 2026
Meeting Quorate Y/N?	Yes
Presenter:	Shokat Lal, Non-Executive Member
Author:	Vanessa Ridout, 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 alerts to notify the Board.

ADVISE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

Terms of Reference
The proposed Terms of Reference were submitted to the Committee as an introduction to start the broader conversation around the remit of the Committee.

The Terms of Reference proposed two distinct parts:

Part A : ICB Workforce which would concentrate on the ICB's own workforce and its effectiveness as a strategic commissioning organisation.

Part B : Strategic Commissioning Focus which would focus on ensuring workforce, people, OD and EDI considerations are embedded within the ICB's strategic commissioning responsibilities.

Proposed Supporting Groups
Potential sub-groups reporting into the committee include:

- Equality and Involvement Sub-Committee.
- WorkWell programme governance.
- Staff Side Forum.
- Employee Voice Forum.

These groups would support both workforce and population-facing aspects of equality, inclusion and workforce development.

Membership
Draft proposals have been developed for core and optional committee membership. Initial feedback has already been received from across the organisation, and further refinement is expected.

The Committee **received** and **noted** the Terms of Reference and the ongoing work around these.

ASSURE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

Key Risks & Mitigations

There were no risks to escalate.

Policies & Procedures Approved

Agile Working Policy

The Policy was submitted to the Committee. The Policy had been developed to create a single, consistent approach across the newly merged organisation. Historically, STW and SSOT operated under different arrangements:

- **SSOT** operated largely as a home-based organisation.
- **STW** had hybrid working expectations, although these were previously encouraged rather than mandated.

A unified policy will support greater integration of teams and consistent ways of working across the organisation.

Key points within the policy include:

- Staff will be expected to spend 40% of their working time either:
  - Working from an office location, or
  - Working within the local patch through activities such as partner engagement, patient-facing work, stakeholder meetings, site visits or engagement events.
- For SSOT staff, this represents a shift away from predominantly home-based working.
- For STW staff, the policy formalises existing expectations by making them a requirement rather than a request.
- The organisation recognises that some employees live significant distances from office locations, including staff who joined under previous home-based arrangements and colleagues living outside the immediate area.
- The policy therefore includes provisions for considering travel exemptions or travel-related arrangements where appropriate.
- These provisions are intended to support individual circumstances while maintaining the principle that staff remain connected to the workplace and local system.

The Committee were:

- **assured** that the proposed Hybrid Working Policy provides a robust and consistent framework for hybrid working arrangements across the Cluster.
- **approved** the Hybrid Working Policy for implementation from 1 December 2026.

Decisions to be Escalated to ICB Board

There were no decisions to be escalated to the Board.

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

Board Assurance Committee "Triple A" Highlight Report

Report To:	Integrated Care Boards in Common
Date:	24th September 2026
Reporting Committee:	Shropshire Integrated Place Partnership (ShIPP) Joint Committee
Date of Meeting:	18th June 2026
Meeting Quorate Y/N?	Y
Presenter:	Rachel Robinson, Shropshire Council, Executive Director for Public Health (DPH)
Author:	Rachel Robinson, Shropshire Council, Executive Director for Public Health (DPH)

Summary of Key Discussions & Decisions from the Committee Meeting

ALERT – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

Neighbourhood and place-based delivery: ShIPP noted that the process for translating the Five-Year Strategic Commissioning Plan into place-based delivery, including governance, prioritisation and alignment with neighbourhood ambitions, is still being worked through. Members emphasised the need for Shropshire-led models of care, clarity on how local models will access funding, and timely routes through ICB governance.

Estates planning as a critical enabler: Members highlighted the need for a clearer, joined-up understanding of the "one public estate" across health, local authority and voluntary sector assets. There was strong support for neighbourhood-level estates planning, brought together into an overall Shropshire view, to support future service delivery and wider programme delivery.

Housing enforcement and vulnerable residents: ShIPP received an update on the Renters Rights Act 2025 and noted the implications of phased implementation for private and social rented sectors, including strengthened enforcement powers, landlord registration, public reporting and future standards.

ADVISE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

Drug and Alcohol JSNA: ShIPP received the Shropshire Drug and Alcohol JSNA, which set out local need, service strengths, gaps and recommendations. Key issues included rural access barriers, unmet drug treatment need, mixed completion rates, mental health needs, housing instability and the need for stronger aftercare, safeguarding links and integrated pathways with mental health and family support.

HealthHero out of hours and care coordination: ShIPP noted strong performance from the HealthHero service since mobilisation, including high patient satisfaction and contribution to reduced category 3 ambulance admissions. Continued development of care coordination, integration with virtual wards and resolution of Bed Bureau challenges will be monitored through the planned one-year review.

Place Universal Offer: ShIPP approved the work of the Place Universal Offer Steering Group to date and supported the proposed focus on North Shrewsbury, Market Drayton and Highley for targeted investment, based on identified need, existing community and partnership capacity, alignment with transformation activity, prevention opportunities and a balance of urban and rural contexts.

ASSURE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

Governance and quorum: The meeting was quorate, with no declarations of pecuniary interest recorded. Minutes of the previous meeting were accepted with no amendments, and completed actions were reported, including establishment of the ShIPP risk register and escalation of key issues to the ICB.

Strategic commissioning alignment: ShIPP noted that the Five-Year Strategic Commissioning Plan is aligned to NHS England planning requirements, the 10-year delivery plan, the three strategic shifts and local population health priorities. The plan is supported by JSNA and population health intelligence, with risks, governance and delivery enablers identified.

Approval of Place Universal Offer focus areas: The Board approved the next stage of Place Universal Offer development and the rationale for the three identified focus areas, providing assurance that local selection considered need, inequalities, community capacity, partnership working and prevention opportunities.

Key Risks & Mitigations

- Key risks discussed included workforce capacity, financial pressures, digital infrastructure and system complexity in relation to delivery of the Five-Year Strategic Commissioning Plan.
- Mitigations include continued development of governance arrangements, place-based oversight, use of JSNA and population health intelligence, and alignment of estates, digital and neighbourhood delivery workstreams.
- Drug and alcohol risks include unmet treatment need, rural access barriers, treatment dropout, mental health need and safeguarding links for adults with children or contact with children. Progress will be monitored through the Drug and Alcohol Task and Finish and commissioning group, with an update to ShIPP in 12 months.

Policies & Procedures Approved

☑ No policies or procedures were approved.

Decisions to be Escalated to ICB Board

- ShIPP requests that the ICB Board notes the continued need for clarity on place-based delivery arrangements, including governance, prioritisation, access to funding and timely decision-making routes for Shropshire-led models of care.
- The Board is also asked to note the importance of a joined-up “one public estate” approach and support development of neighbourhood-level estates planning as a core enabler of transformation.
- The Board is asked to note the approved Place Universal Offer focus areas of North Shrewsbury, Market Drayton and Highley.

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

Board Assurance Committee "Triple A" Highlight Report

Report To:	Integrated Care Boards in Common
Date:	24 September 2026
Reporting Committee:	Telford and Wrekin Integrated Place Partnership (TWIPP)
Date of Meeting:	15-07-26 & 09-09-26
Meeting Quorate Y/N?	Y
Presenter:	David Sidaway Chief Executive TWC / Chair of TWIPP
Author:	Louise Mills Neighbourhood Health Lead (TWC)

Summary of Key Discussions & Decisions from the Committee Meeting

ALERT – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

- At the September meeting the Committee received the Neighbourhood Health Outcomes Framework for Shropshire, Telford and Wrekin recently issued by the ICB. While TWIPP agreed the importance of the focus on the top 5% of patients in CVRM and frailty cohorts, committee members, especially local authority and VCSE representatives were hoping for investment and more focus on prevention and left shift. The majority of attendees' view is that the Outcomes Framework should more explicitly prioritise and fund upstream prevention and early intervention with a focus on health inequalities, given the system's strategic commitment to prevention, aligned to the NHS 10-Year Plan expectation. Committee members were also concerned regarding the deliverability of the expectations within the time scales expected, and PCN representatives raised a series of clarification questions.
- There was also a request that collaborative work on the other two agreed priority cohorts – children and young people and mental health, is started by the NHS as soon as possible, so development work can evolve at pace for the next stage of neighbourhood health implementation, as described in the outcomes framework.
- The Committee participated in a workshop session led by the VCSE Alliance. TWIPP clearly recognises the Alliance as an essential strategic partner within the Integrated Care System and discussions highlighted that expectations the sector's strategic contribution should be matched by appropriate and sustainable investment. Members noted that, to operate as an equal partner and maximise its contribution to neighbourhood, the VCSE Alliance requires sufficient capacity and infrastructure, with investment levels that are comparable to those seen elsewhere across the ICB footprint.

ADVISE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

- Neighbourhood health initiatives continue to be delivered successfully across the borough, including Live Well Hubs, Family Hubs and the Healthy Conversations Campaign, which support improved wellbeing and community resilience. The Malinslee and Dawley Live Well Hub, the first based in a GP Practice, was successfully launched this month further strengthening local access to community-based support and services.
- Plans continue to progress for the new purpose-built community hub in Sutton Hill, which will incorporate a Neighbourhood Health Hub to improve access to health and wellbeing services for residents.
- The Committee endorsed the Place Expansion Full Award application to Sport England, seeking £1.2 million investment for Telford & Wrekin in 2027/28 to support increased physical activity and movement to improve health outcomes across the borough.
- The Annual Report of the Director of Public Health 2026 - Healthy Neighbourhood - Prevention First has been published and will be presented at Health & Wellbeing board on 17th September. The report showcases the community prevention work undertaken across the Council and VCSE, with the NHS during the past year. The contents of the report and recommendations aimed at influencing the neighbourhood health implementation plan, will be discussed at the next TWIPP meeting.

ASSURE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

- The TWIPP Committee continues to provide strong senior leadership across all key partners, ensuring strategic oversight and alignment, and further development of place collaboration to progress the neighbourhood health agenda and improve population outcomes for residents.

Key Risks & Mitigations

Risk: The contribution of the VCSE Alliance and community-based prevention initiatives is not sufficiently specified within the Neighbourhood Health Outcomes Framework, creating a risk that future investment decisions do not adequately support the capacity and infrastructure required to deliver preventative outcomes and reduce health inequalities.

Mitigation: Ensure future iterations of the Neighbourhood Health Outcomes Framework explicitly recognise the role of the VCSE sector and prevention in delivering agreed outcomes, with associated funding and investment.

Risk: The ICB one off investment to TWIPP for prevention projects in 2025/26 has delivered clear outcomes and further investment was expected in 2026/27 through the neighbourhood health implementation programme. However, sustainability of funding is a key issue for programmes, which clearly align to ICB priority cohorts for neighbourhood health.

Mitigation: Urgent discussions with ICB strategic commissioners regarding sustainability of funding for vital neighbourhood programmes in the short term, while the initial phase of the outcomes framework is rolled out.

Risk: Agreement of neighbourhood footprints remains work in progress, this was raised by the HWB Chair and agreed as a key at the July TWIPP meeting.

Mitigation: A collaborative session will be convened with TWIPP and Health and Wellbeing Board members to support discussion and reach consensus.

Policies & Procedures Approved
N/A

Decisions to be Escalated to ICB Board
None.

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

Board Assurance Committee "Triple A" Highlight Report

Report To:	Integrated Care Boards in Common
Date:	24th September 2026
Reporting Committee:	Staffordshire and Stoke-on-Trent Health and Care Senate
Date of Meeting:	16th July 2026 and 13th August 2026
Meeting Quorate Y/N?	N
Presenter:	Dr Salma Reehana, 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

April IMOG
a) There were several NHSE funded NICE technology appraisals (TAs), which were all specialised drugs and added to the formulary as RED drugs.
b) There was clarification provided in the formulary around the difference between long-acting and very long-acting depot preparations of antipsychotic injections.

May IMOG
c) There were several NHSE funded NICE technology appraisals (TAs), which were all specialised drugs and added to the formulary as RED drugs.
d) There were two ICB funded NICE technology appraisals (TAs), which were all specialised drugs and added to the formulary as RED drugs.
e) Biological treatment pathways were introduced for atopic dermatitis, which provide clarity on how the available biological drugs should be used sequentially.
f) Cequa® cyclosporine eye drops were added as a formulary alternative to Ikervis.

June IMOG (fast track item)
g) New paediatric antimicrobial prescribing guidance has been produced, which is aimed at treatment of common infections in Primary Care.

IMOG approved a minor amendment to the asthma guidelines (for under 5s) with the addition of AeroChamber PLUS Flow-VU spacer device, without a mask. The formulary entry for Tiotropium Respimat was aligned, with the asthma treatment guidelines, and is now listed as a GREEN drug in the guidelines and on the formulary.

Paediatric Antimicrobial Prescribing Guidance:
Discussions were held regarding the Paediatric Antimicrobial Prescribing Guidance including the scale of the issue, with concerning levels of antibiotic prescribing among children aged 0–9 years, in Staffordshire and Stoke-on-Trent, which ranks 40th out of 42 ICSs, nationally. Last year

approximately 35% of children received an antibiotic, which equates to around 42,000, with 9,000 receiving 2 or more. The comprehensive guidance was developed by the Antimicrobial Stewardship (AMS) Group, which included system representation and the aim is to improve prescribing quality and reduce unnecessary antibiotic use.

The Senate discussed common themes, preventative interventions, the pressure clinicians face to prescribe and how the system can support through policy, as well as the need to capture community pharmacy data as antibiotic services expand. A small allocation of NHS funding has been received to progress collaborative system antimicrobial stewardship initiatives. The Senate highlighted the opportunity to support the AMS conversation and that it should be brought back to the Senate for further discussion, in the future, given the high levels of prescribing involved.

The Senate **approved** IMOG decisions (a - g) which applies to the Staffordshire and Stoke-on-Trent Medicines formulary only. 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 21/07/2026.

1) Integrated Medicines Optimisation Group (IMOG) Approvals June and July

June IMOG

a) NHSE funded NICE technology appraisal approvals, which are all specialised drugs and will be added to the formulary as RED drugs.
b) ICB funded NICE technology appraisal approvals including: -
- Dupilumab should be red on the formulary but has been given a temporary BLUE status, whilst an internal business case progresses through UHNM.

c) Wynzora® cream for treating psoriasis was given a GREEN status.

The IMOG members approved the Paediatric Antimicrobial Guidance, and associated one page summary, which was fast tracked to the July Senate for ratification.

July IMOG

d) NHSE funded NICE technology appraisals, which are all specialised drugs and will be added to the formulary as RED drugs.
e) ICB funded NICE technology appraisal approvals, including: -
- Semaglutide for reducing the risk of major adverse cardiovascular events in people, with cardiovascular disease and overweight or obesity, was assigned a BLUE status due to current uncertainty over delivery.
- Atogepant for treating migraine was given a GREEN status, so is available for all clinicians in primary and secondary care to initiate.

f) IMOG agreed the NICE pathway for the use of oral Calcitonin Gene-Related Peptide receptor antagonists, in the acute treatment of migraine, which explains the range of drugs that are available, on the formulary, for treatment of migraine.
g) IMOG approved the inclusion of Bibecfo® and Proxor® inhalers for asthma, on the SSOT Formulary, and agreed an update to the SSOT Asthma Guidance. These inhalers are cost-effective alternatives to those already on the formulary.
h) Following patient queries, and Freedom of Information requests, IMOG members agreed to update the SSOT Liothyronine Formulary monograph, to align with the latest NHS England guidance. This has not changed the formulary RAG status of AMBER-I, but the formulary entry will be annotated to align with NHS guidance.

i) IMOG members approved the Low-Priority Medicines Policy and Over-the-Counter Vitamins and Minerals Leaflet.
j) IMOG members agreed to update the existing SSOT formulary entry for FreeStyle Libre 3 Plus (FSL3+) by removing restrictions.
k) IMOG members agreed the proposed revisions to the palliative care section of the SSOT Formulary.

For Information:
A review of the shared care prescribing protocols and agreements is being undertaken.

Semaglutide
Discussions were held regarding the delivery of GLP1s, and it was suggested that the GLP1 working group could report into the Senate on a regular basis and that GLP1s needed proper debate in the Senate. Item added to October Senate agenda.

Low-Priority Medicines Policy:
Discussions were held regarding the Low-Priority Medicines Policy and, whilst a compromise has been reached of supplementing bariatric patients for 2 years post-surgery, UHNM wanted the reasons for their concerns noted regarding the withdrawal of Forceval vitamins and the adverse effects beyond the 2-year period and the monitoring of those patients. Health inequalities were also discussed, and it was agreed that the wording from the policy, around this, would be shared with the Senate members.

The Senate **approved** IMOG decisions (a - k) which applies to the Staffordshire and Stoke-on-Trent Medicines formulary only.

Single National Formulary (SNF)
The Single National Formulary (SNF) will be introduced across England, on a phased basis, from 2027, starting with a digital tool and some therapeutic areas. Organisations are being asked to transition away from existing formulary categorisation, to the standardised SNF wording categorisation. STW/SSOT is one of the early adopter sites and has undertaken a mapping exercise, which demonstrated that the cluster is predominantly aligned, with the proposed national categorisation, except for the BLUE (SSOT) and GREY (STW) categorisation, which allows for any commissioning, or service implications to be resolved. Concerns have been raised that removing these categories and using the clinically relevant categories of the formulary, straight away, may raise patient and prescriber expectations that it is readily available, when there are still commissioning issues to be resolved. The expert panel view, during category development, was that they should not be included and that commissioning and pathway decisions sit outside of formulary decisions and position and should be addressed separately, through appropriate ICB governance and commissioning routes. The approaches of other areas, to this issue, have been scoped and the most common approach was assigning an intended clinical formulary category and annotating the appropriate formulary monograph, with appropriate wording. The Senate is asked to support the removal of the BLUE/GREY formulary category, to aid the implementation of the SNF, and the annotation with appropriate monographs.

The Senate members raised the following points/concerns: -

- If the BLUE/GREY categories are to be removed, then there is a need for a united system response to managing patient expectations, clear communication and consistent messaging to assist clinicians will the difficult conversations they face, when medicines are available on the formulary, but not within the system.

- Concerns have been escalated to NICE, and the outcome of any further discussions can be reported to the Senate, however, there has been no movement from their position so far, despite challenge.
- The significant benefits of having a SNF were highlighted and the need to support the national direction of the SNF.

The Senate **approved** the removal of BLUE (SSOT) formulary category in line with the Single National Formulary (SNF) categorisation and the proposed approach for formulary decisions going forward.

Talking Therapy for the Deaf addition to the ERP Policy

The request was for the Talking Therapy provision for the deaf to be added to the Excluded and Restricted Procedures Policy (ERP). This is because several Individual Funding Requests (IFRs) have been received, over the past 12-18 months, following the closure of a previously NHSE funded service provision, with Sign Health, in March 2025. There is a Midlands Region contract in place now, with Sign Health, which can be accessed via the mainstream Talking Therapy provision, which is provided by Midlands Partnership University NHS Foundation Trust (MPFT). This service will assess the patient and make a recommendation, about whether the patient needs to be referred to Sign Health, as part of that contract. The Senate is asked to approve addition of this service to the ERP to ensure that the access to the service is via the mainstream Taking Therapy, who will assess and recommend Sign Health, if appropriate.

In response to comments/questions from the Senate the following clarification points were provided: -

- Derby ICB is hosting the service, on behalf of the Midlands, and information around the effectiveness of the service will be gathered, as part of the contract management arrangements.
- Assurances were given that Sign Health are one of the biggest providers in the country and other regions are seeking to enter into contractual arrangements with them too.
- Discussions were held regarding the importance of the wording in the policy, as it is not totally excluded, but has restricted access and is only available via the commissioned Talking Therapy service. It was agreed that the Senate would need to see the specific wording, for the ERP policy before they could approve and that this would be sent out to the Senate members for virtual approval.

The wording below was sent out to the Senate members on 27th August 2026.

Talking Therapy for the Deaf via BSL Trained Therapists (Talking Therapy is available from the mainstream Talking Therapy service via BSL interpreters)	Patients must have been seen in the mainstream Talking Therapy Service (hosted by Midlands Partnership NHS Trust) who will recommend treatment via BSL trained therapists if appropriate.	**Restricted**

On 7th September 2026 the Senate virtually **approved** the addition of the above wording to the Excluded and Restricted Procedures (ERP) policy.

ASSURE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

None.

Key Risks & Mitigations

A Risk Management Update was provided by Paul Winter including the continuing development of the risk management programme and embedding of a new system, CoreStream and that, in the future, risks will become more focused around the expert role of Strategic Commissioner, more thematic and less geographical based.

Discussions were held regarding the importance of the Senate having visibility of clinical risks, but that it is an approvals Board, not an assurance Board, so will have visibility but would not own its own Risk Register.

Policies & Procedures Approved

- ☑ The Senate **approved** IMOG decisions (a - g) from the virtual IMOG approvals in April, the IMOG meeting held on 6th May and the fast-track item from the IMOG meeting held on 3rd June. These apply to the Staffordshire and Stoke-on-Trent Medicines formulary only.
- ☑ The Senate **approved** IMOG decisions (a - k) which applies to the Staffordshire and Stoke-on-Trent Medicines formulary only.
- ☑ The Senate **approved** the removal of BLUE (SSOT) formulary category in line with the Single National Formulary (SNF) categorisation and the proposed approach for formulary decisions going forward.
- ☑ The Senate **virtually approved** the addition of Talking Therapy for the Deaf via BSL Trained Therapists to the Excluded and Restricted Procedures (ERP) policy and the wording for the policy.

Decisions to be Escalated to ICB Board

None.

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

Board Assurance Committee "Triple A" Highlight Report

Report To:	Integrated Care Boards in Common
Date:	24th September 2026
Reporting Committee:	Stoke-on-Trent Place Board (Shadow)
Date of Meeting:	16th July 2026
Meeting Quorate Y/N?	Y
Presenter:	Phil Smith, Chief Officer System Development & Integration, STW-SSOT ICB
Author:	Hayley Allison, Place Director Staffordshire & Stoke-on-Trent, STW-SSOT ICB Darren Birks, Head of Place Stoke-on-Trent, STW-SSOT ICB

Summary of Key Discussions & Decisions from the Committee Meeting

ALERT – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

Place and Neighbourhood Governance: The S-o-T Place Board met for the very first time in shadow form. Agreed to review the current governance structure that feeds into the Place Board, but also to ensure relevant structure is in place to enable oversight and assurance of neighbourhood delivery

Healthy Neighbourhoods: Recognition that the Place Board will focus on the Healthy neighbourhoods agenda rather than simply the Neighbourhood Health aspects of the framework. Further work required to develop.

ICB reform and management of change (MoC): A recognition that the 'Place' team are new in post, part of a new function and the wider MoC within the ICB has impacted on ability to move at pace with the wider Neighbourhood Health agenda

ADVISE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

S-o-T Place Board Development: The agenda for the first board meeting in shadow form was wide reaching and ambitious. There was recognition of the development work required but a commitment to progress with a focus on the Place Board being a 'doing' Board.

Frailty, Healthy Neighbourhoods & Childhood obesity: These areas were presented as three priority areas for the Place Board to engage in meaningful action. Development of a specification to set these priorities moving forward

Frailty stocktake: A presentation on the current frailty schemes, services and wider support for the frailty cohort of patients was given to develop the understanding with all partner organisations

ASSURE – the "Top 3 Issues" ref. Alignment to ICB Objectives & Core Functions

S-o-T Place Board Development: There will be a development session on 28th September 26 for the Place Board following its initial meeting in shadow form in July 2026. The Development will focus on the vision and priorities of the board, the outcomes to be achieved, a roadmap to financial delegation and the outlines of the Place Plan

System architecture: A presentation was given on the Place Board's standing in the wider governance structure, along with the principles of financial delegation and decision making, as outlined in the April 2026 ICB Board paper

Neighbourhood stocktake and BCF: There was commitment to a thorough review of the existing BCF schemes to ensure they align with the requirements of Neighbourhood delivery

Key Risks & Mitigations

Policies & Procedures Approved

None

Decisions to be Escalated to ICB Board

No specific decisions at this stage following the initial meeting of the Place Board in shadow form in July.