NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Five Year Strategic Commissioning Plan

April 2026

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Chair and Chief Executive Foreword

We are pleased to introduce this ambitious Five Year Strategic Commissioning Plan for Staffordshire and Stoke-on-Trent. It sets out our shared ambition for transforming health and care at a time when our system faces both significant pressures and real opportunities. Our population is growing and becoming more diverse, with rising levels of long-term conditions, high demand for urgent care, marked inequalities – particularly in parts of Stoke-on-Trent – and increasing expectations of the services we provide. This creates real challenges for our communities and for the health and care system that serves them.

Yet alongside these pressures, we see enormous strength. We have a dedicated workforce, committed partners across health, local government and the voluntary sector, and Primary Care Networks with a strong sense of identity and community. This plan builds on those strengths – setting out how we will work differently over the next five years to improve outcomes, reduce inequalities and ensure our services remain sustainable for the future.

Our direction is clear. We are shifting from a system centred on hospital-based, reactive care to one that focuses on prevention, early intervention and support delivered through Integrated Neighbourhood Teams. This means more care closer to home, stronger community services, improved access to diagnostics, modernised primary care, and a digital-first approach that still protects choice and inclusion for those who need non-digital routes.

These changes will help people stay well for longer, reduce avoidable demand on urgent and emergency care, and free up capacity for those who need specialist treatment. This shift will be supported by improved population health data, stronger clinical leadership and new ways of commissioning. Our approach to the place agenda remains central to all of this and we will work closely with our local authority partners to maximise this opportunity.

Tackling inequalities is at the heart of this plan. Residents in our most deprived communities face poorer health outcomes from birth through to older age – simply, this is unacceptable. Through targeted investment, improved population health intelligence, stronger collaboration with local partners and targeted action on childhood health, long-term conditions, screening and immunisation, we will focus our efforts where they will make the greatest difference.

We also recognise the scale of financial challenge across our system. Delivering this plan requires a disciplined, value-based approach to stewardship, redirecting resources towards prevention, neighbourhood models and digital innovation, reducing unwarranted variation, and improving value and productivity across all parts of the system. As we move towards a single organisation across Staffordshire, Stoke-on-Trent, Shropshire, and Telford and Wrekin in 2027, our ability to plan, invest and manage resources collectively will strengthen further.

None of this change will happen without our workforce. Their skill, compassion and commitment remain our greatest asset. We are determined to support their wellbeing, build new skills and capabilities, and create a culture that empowers teams to innovate and deliver the best possible care.

Above all, this plan is about improving the lives of the people and communities we serve. We will continue to listen, involve people meaningfully, and maintain transparency as we deliver the changes set out here. Thank you to everyone who has contributed to the development of this plan, and to all those who will play a part in delivering it.

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Executive Summary

About this document

This five-year plan sets out how we will improve health and care for the 1.18 million people of Staffordshire and Stoke-on-Trent. It explains the challenges our communities face, the changes we need to make, and how we will work with partners to deliver better, more joined-up and sustainable services.

Why change is needed

Our population is growing, ageing, and becoming more diverse. Some areas face higher levels of poverty, which is linked to poorer health.

- Children and young people face challenges such as higher infant deaths, lower vaccination rates, poor dental health, rising obesity, and increasing long-term conditions.
- Working age adults have higher levels of obesity, smoking, alcohol-related harm, and late diagnosis of illnesses such as cancer.
- Older people are more likely to have multiple long-term conditions, to experience falls, need more help during the winter, and spend more time in hospital towards the end of their lives.

Alongside these health challenges, the NHS is also adapting to rapid technological change, new ways of spotting illness earlier, emerging diseases and rising expectations. These pressures mean many people do not receive help early enough. Closer working with councils, the voluntary sector and community partners is essential.

Our role

The Staffordshire and Stoke-on-Trent Integrated Care Board (ICB) is responsible for improving health outcomes, reducing inequalities and ensuring the best use of NHS resources. As a clustered ICB working jointly with Shropshire, Telford and Wrekin, we support delivery of the four Integrated Care System (ICS) aims:

1. Improving population health and care
2. Tackling inequalities
3. Enhancing productivity and value
4. Supporting wider social and economic development.

Our Five Year Strategic Commissioning plan

This plan builds on our Joint Forward Plan and the ambitions of the NHS 10 Year Plan. It explains how we will improve health and wellbeing for people living in Staffordshire and Stoke-on-Trent over the next five years. It sets out:

- The key health challenges in our communities
- Five major changes we will drive
- How we will deliver our commissioning intentions
- How we will work with partners for more coordinated care
- How we will improve access, quality and financial sustainability.

Our commissioning intentions and this plan have been developed by our portfolio teams. These teams bring together clinicians, commissioners and other specialists who work together to translate local needs and evidence into the key actions and the five major changes set out.

What success looks like by 2030/31

Our vision is to help make Staffordshire and Stoke-on-Trent some of the healthiest places to live and work. We have identified five major changes that will make the biggest difference. They are all equally important and must work together:

Over the next five years we want:

1. **More care closer to home –** Helping more people to receive care in their community rather than in hospital.
2. **Better use of digital tools –** Making it easier for people to access services and manage their own health.
3. **A stronger focus on prevention –** Helping people stay well for longer and tackling problems earlier before they become more serious.
4. **Improving access to services –** Reducing waiting times and making it easier for people to get the right care when they need it.
5. **Getting the best value from NHS resources –** Using our resources, whether money, workforce, or carbon, in a sustainable way and reducing duplication.

At the centre are ‘Our People’, meaning everything we do is focused on the needs of local residents, supported by our workforce working in neighbourhoods, places and across the whole system.

A key focus in our plan is neighbourhood health. This means organising services including bringing together GPs, community services, social care and voluntary sector partners to meet the needs of residents and deliver high-quality care in the right place, at the right time. Central to this is developing and implementing our Integrated Neighbourhood Teams (INTs) for both adults and children.

How we will deliver this plan

We will strengthen local partnerships and clinical leadership, enhance digital tools such as the NHS App and shared care records, and coordinate proactive, preventative support through neighbourhood teams. This is supported by modern estates, strong data and analytics, and a skilled, flexible workforce.

Finance and productivity

We are committed to using every pound wisely. Working collaboratively, planning ahead and using data effectively will help us maintain a financially sustainable system.

People and workforce

We will develop a flexible, resilient workforce, supporting wellbeing, retention and inclusion. We will invest in leadership, culture, and career pathways, while widening access to employment and apprenticeships to help reduce inequalities.

Enablers

Strong population health insights, robust digital and data infrastructure, modern estates and a skilled workforce underpin this plan. We remain committed to our legal responsibilities around sustainability, net zero, equality, reducing health inequalities and safeguarding.

Governance

To support effective delivery, both ICBs are adopting a transitional clustering model – working as a single team through shared leadership and aligned functions while remaining legally separate. This strengthens joint planning and decision making and prepares us for a full merger in April 2027.

This plan provides a clear, realistic path for improving health and care over the next five years. By focusing on prevention, partnership working, digital innovation and stronger neighbourhood-based care, we will deliver better outcomes, reduce inequalities and build a more sustainable health and care system for future generations.

Quality and patient safety, assurance, and improvement

People across Staffordshire and Stoke-on-Trent deserve safe, high-quality care every time they use NHS services. The National Quality Board guidance sets out a shared single view of quality as: high-quality, personalised and equitable care for all, now and into the future. Our role as an ICB is to ensure that the services we commission meet these expectations and continue to improve year on year.

Our vision is for quality and safety to shape everything we do, every decision we make, every partnership we form, and every plan for the future. We are committed to building a system that learns, improves and listens, so that standards of care rise for everyone in our communities.

Our ICB Quality Strategy, developed jointly with NHS partners, supports the priorities of the ICS and aligns with the ICB Statutory duties, as outlined within the Joint Forward Plan. Quality and safety remain the golden thread running through our work. The Strategy sets out our quality ambitions, supports delivery of the NHS Patient Safety Strategy and NHS IMPACT (Improving Patient Care Together), and describes how we respond to risk in line with National Quality Board guidance. As updated National Quality Board guidance is published throughout 2026, our Strategy will evolve to reflect this.

High-quality care is only possible when partners work together. We recognise the vital role that all organisations – NHS providers including primary care, councils, regulators, voluntary sector partners and local communities – play in maintaining high standards and fostering a culture of openness, learning and continuous improvement. Our System Quality Group brings these partners together, including the Care Quality Commission, Healthwatch organisations and NHS England (NHSE). This provides a trusted forum for sharing intelligence, discussing quality concerns, learning from incidents, and driving improvement. Quality and performance are closely linked – delivering high-quality care is our goal, and performance standards help us check how well services are meeting that goal.

As we implement the Model ICB blueprint and deepen our partnership with Shropshire, Telford and Wrekin ICB, and create new models of care that are safe, effective and sustainable, we will build on our shared strengths. This collaboration will allow us to draw on a wider range of expertise, adopt joint approaches, and learn from each other as we deliver system-wide improvements.

Quality is strongest when it is built in from the start. Our commissioning approach will ensure that quality is considered at every stage – planning, designing, procuring, monitoring and improving services. We will focus on:

1. Improving population health
2. Reducing inequalities in access, experience and outcomes
3. Ensuring services remain high quality, safe and sustainable
4. Supporting a skilled and confident workforce with the capability to drive improvement.

Quality and Equality Impact Assessments are part of our routine commissioning processes. They help us understand the impact of decisions before they are made and ensure effective monitoring and accountability. These processes will be further strengthened through our partnership arrangements.

Working with our partners, we will build a culture where everyone has the skills, confidence and commitment to continually improve the quality and safety of care for our communities.

Health and care work best when organisations act as one team. By bringing together the NHS, councils, the voluntary and community (VCSE) sector and residents, we can design services that are joined up, compassionate and shaped around what people need. While each partner has a different role, we share the same goal – improving health and reducing inequalities.

The ICB operates through six functions – Strategy and Improving Outcomes, System Development and Integration, Chief Nursing Officer, Chief Medical Officer, Chief Finance Officer, and Chief of Staff. Each has a clear role in delivering our strategic commissioning responsibilities.

Our Place-based partnerships and neighbourhood teams, bringing together councils, NHS trusts, Primary Care Networks, primary care contractors, voluntary, community and social enterprises (VCSE) organisations, and local communities, will be at the heart of how care is delivered. Supported by the ICB, which provides leadership and coordination, these partnerships will increasingly become the 'engine room' of our system, driving local decisions.

Health and Wellbeing Boards

In Staffordshire and in Stoke-on-Trent, Health and Wellbeing Boards bring together leaders from across health, care and the community. They set shared goals, agree priorities and ensure our work reflects local need.

Provider collaboratives

Increasingly, our NHS providers are working together through both established and developing provider collaboratives. In mental health, where collaborative arrangements are already well developed, partners have shown the benefits of coordinated planning and shared delivery. They will play a growing role in delivering the changes we need for our population, with providers working together to integrate pathways, support care closer to home, and create the scale and resilience that individual organisations cannot achieve alone.

In 2026/27, the three trusts in the ICB footprint – University Hospitals of North Midlands NHS Trust (UHNM), Midlands Partnership University NHS Foundation Trust (MPFT) and North Staffordshire Combined Healthcare NHS Trust (NSCHT) – will build on the collaborative foundations established in 2025/26. They remain committed to the 10 Year Plan and will prioritise areas where stronger partnership working enables greater system impact.

Significant work in progress across the system provides the foundations for delivering the change required. This will also include an ongoing commitment to strengthening integrated approaches and partnership working, continuing to evolve governance arrangements through the provider collaborative, the Mental Health, Learning Disability and Autism Portfolio, and neighbourhood-level structures. Integral to this will be the continued evolution and strengthening of existing partnership across NSCHT and MPFT at both a strategic and operational level.

Governance will shift to a Strategic Collaborative Board of partner organisations, chaired by a trust chair and involving all CEOs, to provide assurance, strategic direction and guide future partnerships. An Executive Committee with broad partner representation will drive 2026/27 priorities and coordinate collaborative work across clinical pathways, workforce, finance and digital innovation to enable meaningful system change.

Joint commissioning

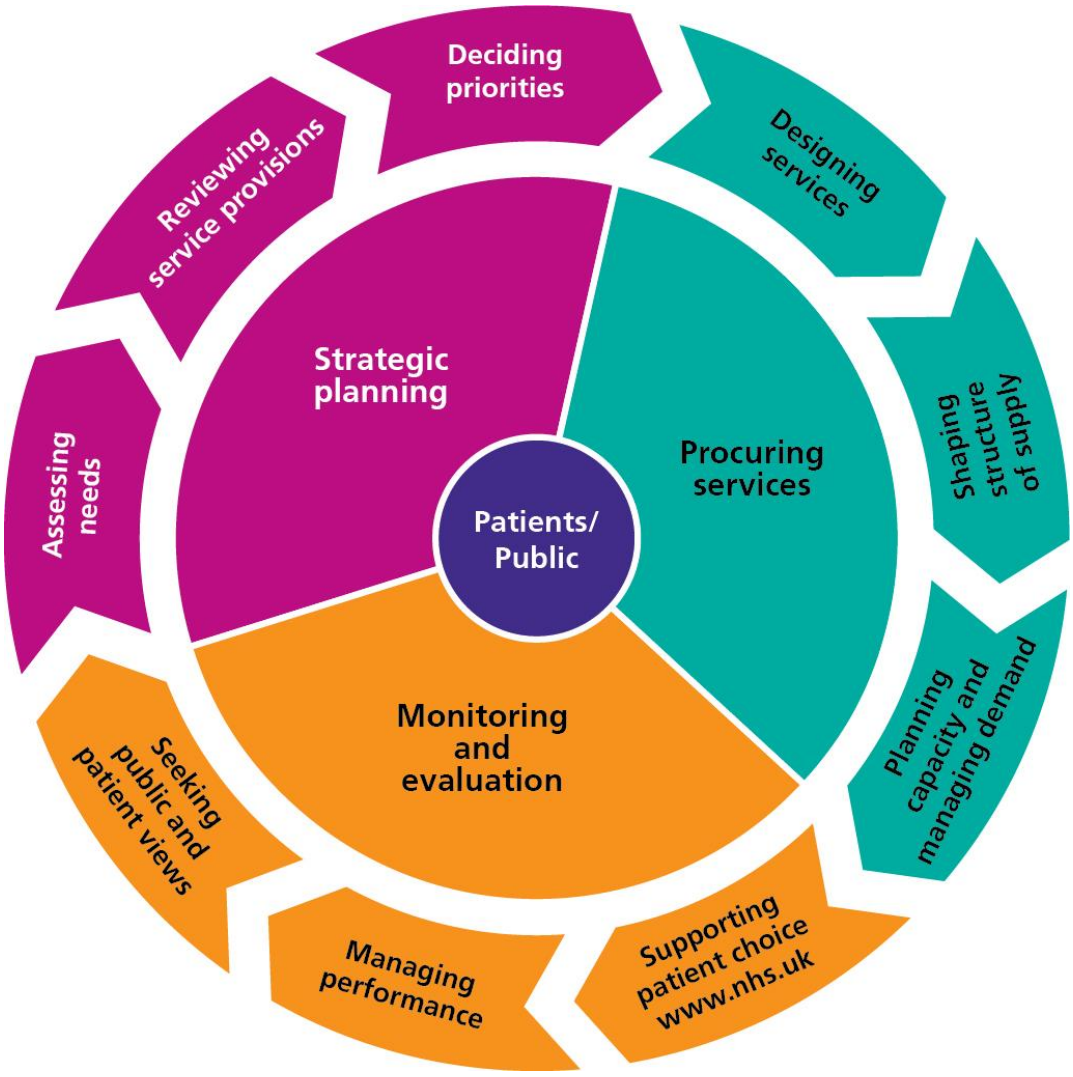
We work closely with Staffordshire County Council and Stoke-on-Trent City Council to plan services jointly, particularly for people with complex needs. Through shared governance and pooled budgets –

such as the Better Care Fund – we can deliver more preventative, community-based care and reduce reliance on hospital services.

NHSE Specialised and Public Health (Section 7A) Commissioning

One ambition of the government's 10 Year Plan is to establish ICBs as strategic commissioners. As a result, commissioning functions and services are expected to transfer, via legislation, from NHSE Specialised and Public Health (Section 7A) Commissioning to ICBs from April 2027.

Throughout 2026/27, the ICB will continue to engage and work with NHSE Specialised and Public Health (Section 7A) Commissioning Leads and NHS England's regional commissioning teams to ensure the smooth transition of commissioning arrangements. This includes engagement in the development of the Offices for Pan-ICB Commissioning (OPICs). These will play a key role in supporting ICBs across each NHS region to efficiently and effectively commission specified services – including commissioning 'at scale' where appropriate to improve patient outcomes.



In anticipation of delegated commissioning, the ICB will plan and develop local partnership arrangements. This will be essential for understanding local population needs and priorities, and identifying opportunities for joint working on inequalities and pathway quality improvement in advance of delegation.

As part of supporting system-wide pathway redesign, we will work with providers and NHSE commissioning teams (as appropriate) to improve the continuity, quality and sustainability of services through robust contracting that has a strong focus on value, access to the right treatment at the right time, and outcomes for patients.

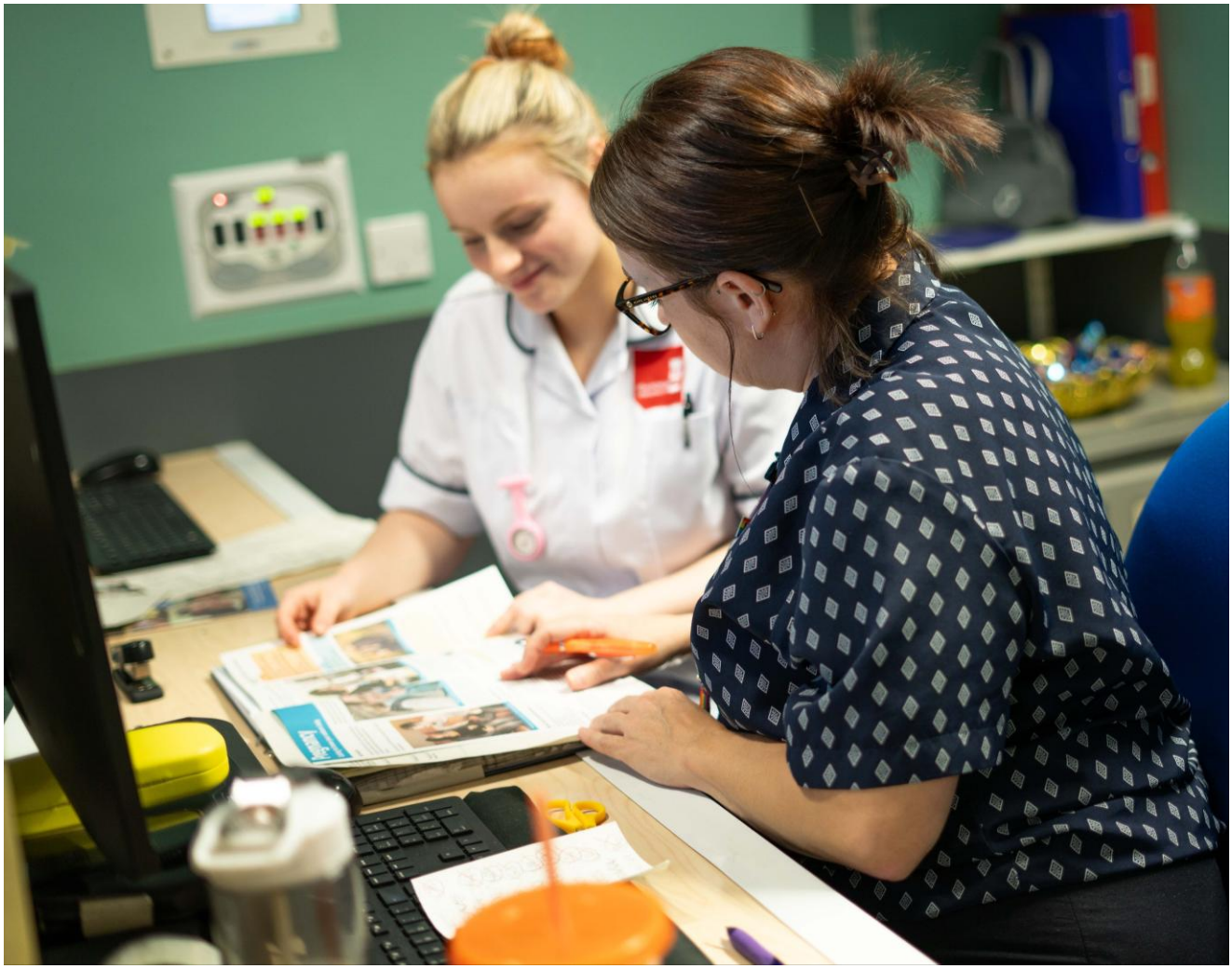
Co-production with people and communities

As part of our statutory duties we work with residents, community groups and the voluntary sector to shape how services are planned and improved. Through citizens' panels, focus groups and community forums, we ensure a wide range of voices influence decisions – helping create a health and care system that is transparent, trusted and rooted in what matters most to our communities.

Using the commissioning cycle and Strategic Commissioning Framework

We use a simple, continuous cycle to guide how we plan and improve services:

- **Strategic planning –** We look at local needs, the evidence, and what people tell us. We use this information to design the right support and decide what we need to focus on.
- **Buy and organise services (procuring) –** We make sure the right organisations provide the care people need. We develop contracts, measure quality and make sure services deliver value for money.
- **Check and improve (monitoring and evaluation) –** We review performance, listen to feedback, and make changes so services get better over time.



Looking ahead – How the operating model will mature over five years

Working together for better health and care

During 2025/26, Staffordshire and Stoke-on-Trent Integrated Care Board (ICB) began working in a closer partnership, or 'Clustered ICB' with Shropshire, Telford and Wrekin ICB. This closer working relationship is helping us prepare for a planned full merger in 2027.

What this means for local people

- Over the next few years, the two ICBs will increasingly plan and deliver services together. One of the first major steps will be creating a single Five Year Strategic Commissioning Plan by April 2027.
- We are also gradually aligning the way we make decisions and oversee services. This will help reduce duplication, ensure consistent standards and allow us to focus more time and energy on improving care. By bringing our provider collaboratives into closer alignment, we can support services to work more closely together, develop joint workforce plans, and create smoother pathways for patients across the wider area.
- By taking a gradual, phased approach, we aim to ensure that by the time a formal merger happens, the system is already working well as one joined-up organisation focused on improving health outcomes and value for local people.
- As our joint working develops, we will:
    - Strengthen neighbourhood teams, making it easier for people to get the support they need closer to home.
    - Work more closely with local authorities to plan and commission services together.
    - Give greater independence and flexibility to neighbourhood and place-based partnerships.
    - Align governance and provider collaboratives, so services can operate more smoothly across both ICBs.
    - Improve how we manage cost, quality and performance, ensuring services are safe, effective and sustainable.

Governance and accountability

Our Five Year Strategic Commissioning Plan replaces the previous Joint Forward Plan, but it keeps the same core purpose – improving health and care for our local communities. The plan brings together everything we know about local health needs, our five big changes, the financial resources available, and the commitments we share with our partners.

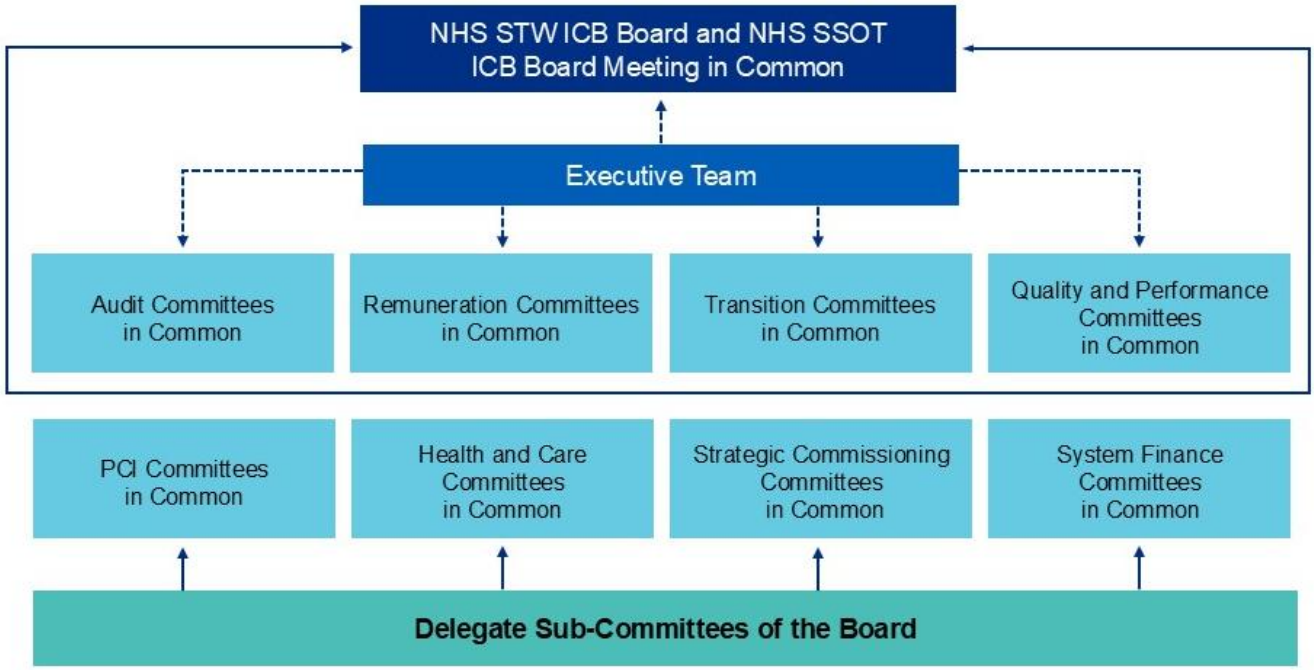
This provides one clear framework that guides the decisions we make across all aspects of planning and commissioning health and care services. It also helps ensure we meet our legal responsibilities, being transparent, involving the public and showing strong joint leadership across the system. Most importantly, it gives us a stable, long-term foundation to support improvements in care and drive meaningful transformation.

Although both ICBs remain separate legal organisations for now, we are aligning how we plan, oversee and assure our services so that we can deliver our shared ambitions for the next five years. As part of this transition, both ICB Boards are now meeting 'in common' – enabling them to discuss issues together and take aligned decisions that benefit people across both areas. We are also establishing new committees and subcommittees that operate across both ICBs. These will become fully joint committees when the time is right. This shared governance structure will have direct oversight

of delivery of our Five Year Strategic Commissioning Plan.

The new arrangements will also support the development of a single staff structure across the two ICBs. This will help us reduce duplication, make the best use of our workforce and ensure teams are working in the most coordinated and effective way possible.

Cluster Joint Working Governance Structure



Foundations for success

As a strategic commissioner, the ICB helps shape the health and care system, so it meets the long-term needs of local people. This means more than planning services – it involves providing strong leadership for population health, tackling inequalities, and making sure resources are used where they have the greatest impact. To deliver this plan, we need a forward-looking approach. The Strategic Commissioning Framework sets out the key foundations, including:

System leadership for population health

Strong leadership across the whole health and care system is essential to improve population health and reduce inequalities. Leaders need to understand how services connect, use good data, and work confidently with many partners. Population health leadership involves influencing change without always having direct authority, and balancing collaboration with the need to ensure quality and value for money, ensuring that decisions benefit the whole population – not just single services or organisations.

Clinical and professional leadership and governance

Clinical and professional leadership is essential throughout all stages of strategic commissioning, to ensure that commissioning decisions are grounded in evidence and best practice and make the best use of resources. Through the Health and Care Senate, leaders provide expert oversight, shape clinical

strategy, support value-based healthcare, and guide the identification of clinical priorities using data and intelligence.

Over the next five years, we will build on and strengthen clinical and professional leadership at every level to enable the commissioning and delivery of integrated and outcome-focused models of care, aligned to the three shifts of the 10 Year Plan.

ICB competency and capability development

Through the life of this plan clinical and professional leaders will continue to drive service transformation through:

- Development of clinical strategy and identification of Clinical Priorities using data and intelligence
- Leadership of the top clinical priorities across the health and social care system
- Developing leadership capability for commissioning
- System leadership and partnership working
- Fostering a culture of collaboration and stewardship
- Supporting outcome-based commissioning

Development of the plan

We have developed this plan in line with the regulatory and statutory requirements, and how the ICB is exercising its key functions and statutory duties in an effective and timely way. The plan will demonstrate how the ICB is contributing meaningfully to the achievement of the ICS's four core purposes. This plan sets out a clear and realistic roadmap for improving health and tackling inequalities and will be refreshed annually as part of our strategic commissioning cycle. Our operating model sets out the leadership, decision-making processes, and commissioning cycle used to turn our planned work into real changes across neighbourhoods, places, and the wider system. Meanwhile, our workforce and finance plans will ensure we have the people, skills and funding needed to deliver new ways of working, strengthen neighbourhood teams, and support digital and prevention-focused improvements.

Our commissioning intentions for 2026/27–2030/31, which we shared with partners in October 2025, form the basis of this plan. We have taken a cross-organisational view – looking at how commissioning intentions link together and how changes in one area can affect demand, access and outcomes in another. As a result, the plan is organised around the five major changes we need to make, rather than traditional service groupings. To support these intentions, we have outlined the main measures of progress and more detailed baselines and indicators are included in the information that sits beneath this plan.

These foundations allow us to plan and commission services in a way that genuinely reflects the needs of our population. The next section of this plan explains the actions we will take to deliver our commissioning intentions.

This section sets out a summary of our Integrated Strategic Needs Assessment (ISNA), which helps us understand the health needs, inequalities and changing population trends across Staffordshire and Stoke-on-Trent. The section also outlines our commissioning plan for 2026/27–2030/31.

It sets out the focus against our five major system shifts over the next five years:

- Hospital to community
- Analogue to digital
- Sickness to prevention
- Improving access
- Value and productivity.

Summary of Integrated Strategic Needs Assessment

Effective strategic commissioning depends on understanding local need and reviewing current provision to inform decisions and evaluate impact. The ISNA brings together the Joint Strategic Needs Assessment, the Integrated Partnership Strategy, Health and Wellbeing Board priorities, and thematic analysis to identify the greatest areas of need across Staffordshire and Stoke-on-Trent.

It recognises that health outcomes are shaped by both clinical care and wider determinants such as housing, education, employment, the environment and social connection. This evidence base enables us to target prevention, tackle avoidable inequalities and commission models of care that reflect the lived experience of local communities. By creating a shared picture of local need, the ISNA highlights where change is most required and strengthens our focus on prevention, early support and effective community partnerships.

The Staffordshire and Stoke-on-Trent population of 1.18 million is changing. The 2021 Census shows that between 2011 and 2021, the population grew by 3.3% – with an ageing population and increasing ethnic diversity.

The population is becoming more diverse but remains largely UK-born (92%) and White (91.3%) – both above the England average. Asian British communities make up the largest minority group (4.8%) – mainly in Stoke-on-Trent, Tamworth, Burton upon Trent and Stafford – with distinct health needs.

Deprivation varies sharply across the ICS. Stoke-on-Trent has some of England's most deprived neighbourhoods, with 53% of residents in the 20% most deprived communities in England. Although Staffordshire overall is less deprived, significant pockets exist in Cannock, Burton upon Trent, Tamworth and Stafford – with clear evidence of health inequalities in communities with multiple social inequalities.

Children and young people

Giving children the best start in life is critical to long term health and life chances. Infant mortality is high, the eighth highest of all ICBs, and unevenly distributed – with some areas experiencing

disproportionately poor neonatal and infant outcomes. Contributing factors include maternal health, prematurity, low birth weight and lower breastfeeding rates, alongside high neonatal hospital admissions. Improving pre-conceptive care, maternity service quality, and addressing child poverty is essential.

Vaccination uptake is good but there are stark inequalities and risking outbreaks in susceptible communities with low uptake. Measles, mumps and rubella (MMR) coverage is lower in deprived and ethnic minority communities, increasing the risk of outbreaks, and the ICB has the sixth lowest HPV uptake nationally among 12–13-year-olds.

Dental health remains a significant issue, with Stoke-on-Trent recording the fifth highest rate of hospital admissions for dental caries (the medical term for tooth decay) in 0–5-year-olds. Admissions are notably higher in more deprived areas, highlighting ongoing challenges in access to routine NHS dentistry.

Childhood obesity is above national levels, with the ICB ranking sixth highest at Reception age and 11th highest at Year 6, particularly in Stoke-on-Trent. Childhood obesity strongly predicts adult obesity and related long-term conditions.

Long-term conditions already place heavy pressure on services. The ICB has the third highest diabetes admission rate in under-19s and elevated asthma emergency admissions in deprived and ethnic minority groups. Early support for children and young people is vital to reduce future disease burden and improve lifelong health.

Working age adults

Good health in the working-age population is essential for individual health and wellbeing, social and economic productivity. Healthy adults are more likely to remain in work, be financially secure, and require fewer health and care services later in life. Risk factors for poor health from health-related behaviours are significant across the ICB.

The population has the seventh highest adult obesity rate nationally, with particularly high levels in Stoke-on-Trent, Cannock, Newcastle-under-Lyme and Tamworth – with higher prevalence in deprived urban areas and some ethnic minority groups. Smoking rates are also elevated, with Stoke-on-Trent having the seventh highest smoking prevalence and 11th highest smoking-related mortality in England. Alcohol-related harm is substantial: the ICB has the second highest alcohol-related admission rate and 10th highest premature mortality from alcohol, with higher rates in deprived areas and among White British residents.

More than half of adults in the population live with a long-term condition (LTC), disability or illness. Effective prevention and management of LTCs is essential, yet the ICB has the second lowest NHS Health Check uptake among adults aged 40–74. Hypertension and chronic kidney disease are significantly under-diagnosed, and there are opportunities to significantly improve quality and outcomes in LTC management by services and self-management by people living with LTCs.

Rates of premature mortality in people living with a LTC are significantly higher than the ICB average:

- Respiratory disease (87.7% higher)
- Asthma (87.8% higher)
- Alcoholic-specific conditions (82% higher)
- Alcoholic liver disease (80% higher)
- Lung cancer (79% higher)
- Liver disease (77% higher)
- Ischaemic heart disease (76% higher).

Cancer outcomes also require improvement – the ICB has the second lowest proportion of cancers diagnosed at Stage 1–2, the eighth highest emergency cancer admission rate, and the fifth highest urgent suspected cancer referral rate.

Older people

Ageing well is essential for maintaining independence, quality of life, and the sustainability of health and care services. Older people account for a large share of hospital admissions, social care and primary care use due to rising multi-morbidities, frailty, and complex health and care needs. The ICB's population aged 65+ is projected to grow by 20,000 people (9%) over the next five years – driving increases in LTC prevalence and demand for health and care services. We expect a 9% rise in older people living with cardiovascular disease, obesity and diabetes, and a 13% rise in those living with dementia.

Hospital admissions from falls among people aged 65+ are expected to increase by 13%. Both Staffordshire and Stoke-on-Trent already have fall-related admission rates significantly above the average in England, with Cannock Chase and East Staffordshire ranking ninth and 15th nationally for falls in those aged 80+. Multi-morbidity and frailty are major contributors to falls risk and management of these conditions needs to be optimised in future – especially in the context that the proportion of people aged 65+ with one or more LTCs is expected to rise by 9%, and those with six or more LTCs by 11%.

Seasonal illness has a disproportionate impact on older people. The ICB has the third highest emergency admission rate for respiratory disease and the fifth highest for COPD nationally. Stoke-on-Trent has the 15th highest mortality rate for flu and pneumonia. Winter pressures are likely to worsen given high local rates of smoking, alcohol use and obesity.

Quality of life and being able to make choices near the end of life are important for people who need palliative and end of life care. Staffordshire and Stoke-on-Trent have the second highest proportion of deaths where there were three or more emergency admissions in the last 90 days, and the ninth highest proportion of deaths occurring in hospital. Evidence shows many people would prefer to die at home or in their usual place of residence. Access to palliative and end of life care and improved advance care planning are critical to achieving this.

Health inequalities

Health inequalities are differences in health between groups, often linked to social, economic and environmental factors such as housing, education and employment, and access to healthcare. They affect life expectancy and healthy life expectancy with some people needing more support to achieve the same opportunities for good health.

In our ICS, male life expectancy at birth is 79.5 years in Staffordshire and 76.4 for Stoke-on-Trent – with England at 79.1 years. For females, life expectancy at birth is 83.2 years in Staffordshire and 80.1 years for Stoke-on-Trent – with England at 83 years.

Healthy life expectancy is significantly lower than life expectancy – meaning that, on average, people can expect to live 16–25 years in later life in poor health and needing care for LTCs, frailty and disability. Women are more likely to live longer in poor health, and people in more deprived communities are at increased risk of early onset of poor health and premature mortality. The slope index of inequality is used to understand differences in life expectancy as a result of deprivation. In Staffordshire, it is significantly lower than England for males (8.7 years compared to 10.5 years for England) and comparable to England for females (8.0 years compared to 8.3 years for England). In Stoke-on-Trent, it is significantly higher for males (11.5 years) while comparable to England in females (8.5 years). Causes

of premature mortality that result in these differences in life expectancy are available in the supporting data pack.

These inequalities lead to poorer health throughout life, earlier onset of disability, and greater demand for healthcare, making prevention and targeted action essential to improve outcomes and reduce costs. For more details, please review our Health Inequalities Strategy.

Core20PLUS5 framework

The Core20PLUS5 approach is an NHS England framework designed to reduce health inequalities by focusing on the most deprived 20% of the population, locally-defined inclusion groups, and five clinical areas – maternity, respiratory disease, severe mental health and cardiovascular disease, and early cancer diagnosis.

In Staffordshire and Stoke-on-Trent, inclusion groups include people experiencing homelessness, people with drug and alcohol dependence, vulnerable migrants and refugees, Gypsy, Roma and Traveller communities, people in contact with the justice system, victims of modern slavery, sex workers, and other marginalised groups. By embedding Core20PLUS5 principles across our work, the aim is to improve access and outcomes through targeted interventions and partnerships with local public bodies and the voluntary and community sectors to address wider determinants of health.

Commissioning Plan – the five big changes

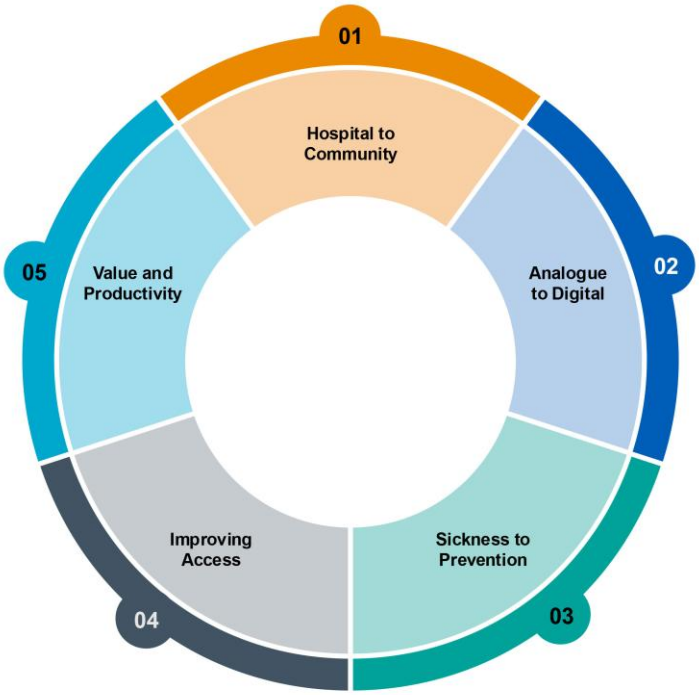
Commissioning intentions

Our operating model provides the architecture, leadership, governance and commissioning cycle required to set these in motion – enabling effective planning, procurement and evaluation across neighbourhood, place and system levels. The following sections of the plan set out the key actions against our five big changes – more care closer to home, better use of digital tools, a stronger focus on prevention, improving access to services, and getting the best value from NHS resources.

The commissioning intentions set out for our providers show what success looks like and the outcomes they need to deliver. They were written to translate the Integrated Strategic Needs Assessment into clear expectations for 2026/27–2030/31, outlining what is required of providers, places, neighbourhoods and collaboratives. They guide decisions on where to invest or disinvest, support the shift toward a new system operating model, including neighbourhood working, provider collaboratives, and emerging integrated health organisations. They also define the measurable outcomes and deliverables required across all pathways.

Our commissioning intentions guide us to focus on what matters most to local people – fair access, good experiences of care, and support that feels joined up. They also emphasise the importance of prevention and early help, so that more people stay well for longer and receive the right support before problems become more serious. We use strong evidence and local insight to understand where need is greatest, reduce unwarranted variation and target resources where they will have the biggest impact.

We are shifting from hospital-based care to community and primary care, helping people get support earlier and closer to home. Digital tools such as the NHS App, shared care records and remote monitoring will help staff work more efficiently and give people better control over their health. Embedding Net Zero and value-based approaches will help us to ensure care is delivered sustainably, efficiently, and in a way that benefits both current and future generations.



Our commissioning intentions and this plan have been developed by our multidisciplinary portfolio teams. These teams bring together clinicians, commissioners and other specialists who work together to translate local needs and evidence into the key actions set out in this section.

Hospital to community

This section describes how we will shift more care from hospitals into local communities by strengthening neighbourhood health teams and expanding community diagnostics and virtual wards. It outlines how we will improve care for people with frailty, long-term conditions, palliative and end-of-life needs, and help achieve better coordination of all-age continuing healthcare across organisations.

Our ambition

We want more people to receive the care they need at home or in their community, so they don't have to go to hospital unless necessary. That means building stronger neighbourhood teams, offering same day urgent appointments in general practice (GP), expanding community services and diagnostics, increasing the use of community pharmacy and improving access to urgent dental care. Together, these changes will reduce unnecessary hospital visits, shorten stays, and improve people's experience and outcomes, especially for those with long-term conditions, frailty or palliative needs.

We will strengthen our neighbourhood health and care programme, bringing together primary care, community services, social care and voluntary sector partners so that people can receive proactive, personalised support closer to home, whether in their own home or a local community setting, where it is clinically appropriate. Our approach is built on strong place-based partnerships, joint commissioning and effective provider collaboration.

In 2026/27, we will implement the first phase of Integrated Neighbourhood Teams (INTs), with neighbourhood multidisciplinary teams (MDTs) established for both adults and children. We will look to provide sustainability to the voluntary sector organisations the work to deliver pathways of care aligned to our model of care. Community-based diagnostic capacity will expand, and urgent community services, including virtual wards, two-hour urgent care response and intermediate care will be positioned as the default offer for escalating needs.

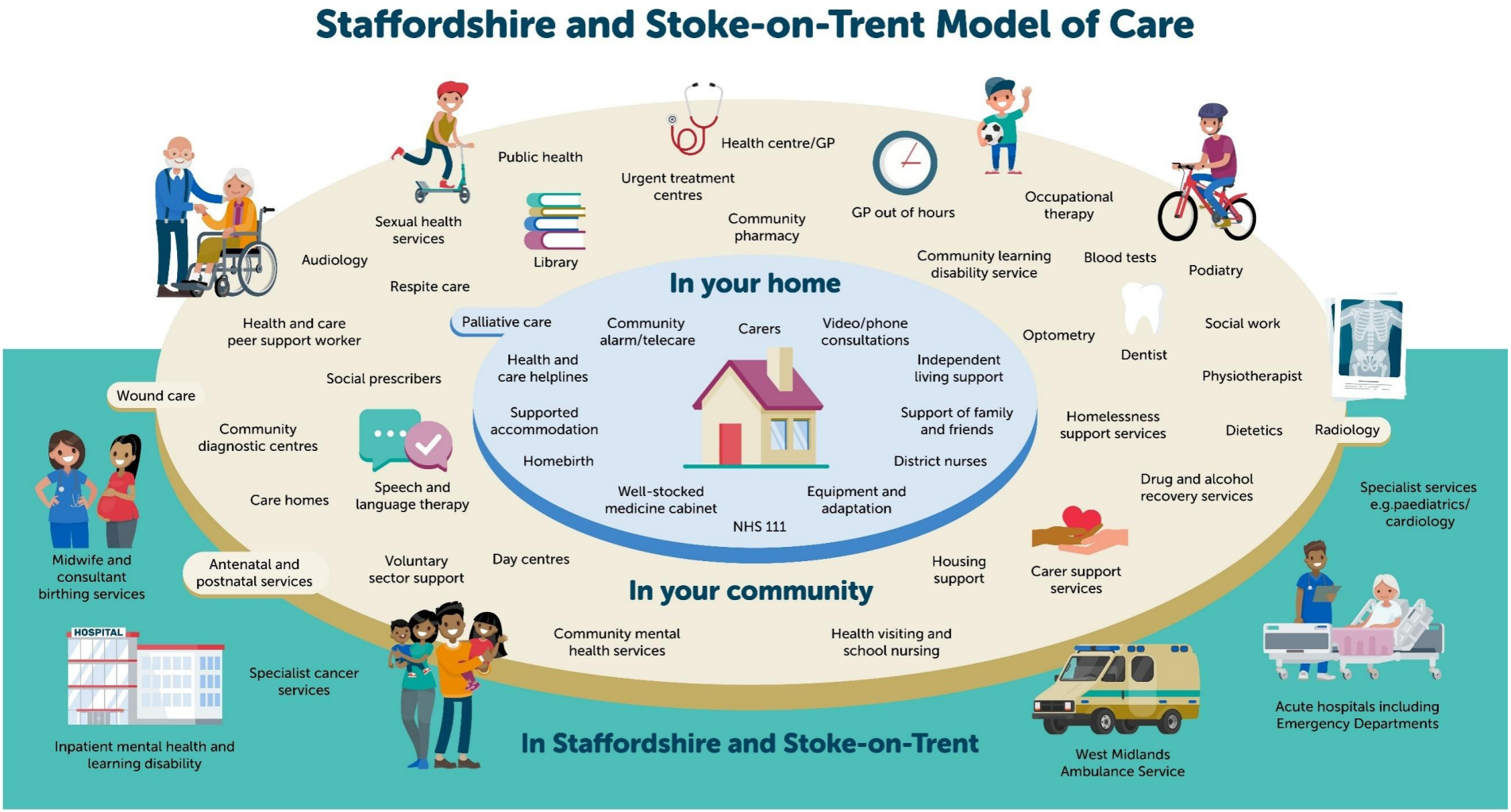
Through 2027/28, these models will scale, supported by strengthened multidisciplinary working, streamlined community access routes through the Integrated Care Coordination Centre, and early rollout of community-based elective pathways in specialties such as ear, nose and throat (ENT), respiratory and gynaecology.

From 2028/29 through to 2030/31, neighbourhood health models will be fully embedded and strengthened, with growing proportions of elective, diagnostic, frailty and rehabilitation care delivered

outside acute hospitals. Home-based cancer treatments, enhanced care home support and expanded community chronic disease pathways will become part of the mainstream offer. Over this period, hospital activity patterns will increasingly reflect the left shift – with more preventative, proactive and community-managed care enabling fewer admissions, shorter stays and greater resilience across out of hospital services. Neighbourhood teams will be supported through devolved budgets, pooled commissioning arrangements and enhanced community capacity to ensure long-term sustainability.

Transformation and new care models

This image illustrates a whole system, integrated model of care for Staffordshire and Stoke-on-Trent. It demonstrates how health, care and community services work together across three levels – your home, your community, and in the Staffordshire and Stoke-on-Trent system.



Our local system will focus on six key elements of neighbourhood health, making sure they reflect the needs of our communities and how services currently work.

- **Population health management –** apply a single, consistent system-wide population health management method to ICB analytics platforms to segment and risk stratify populations, based on complexity and forecasted resource use.
- **Modern general practice –** support with the delivery of the modern general practice model to deliver improvements in access, continuity and overall experience for people and their carers.
- **Standardising community health services –** use the standardising community health services guidance for both adult and children's services.
- **Neighbourhood MDTs –** using the approach outlined in the Fuller Report, ensure MDT coordination of care for population cohorts with complex health, care or social needs who require support from multiple services and organisations.
- **Integrated intermediate care with a 'Home First' approach –** deliver short-term rehabilitation, reablement and recovery services by taking a therapy-led approach.
- **Urgent neighbourhood services –** standardise and scale urgent neighbourhood services for people with an escalating or acute health need, aligned to local demand and front door services.

As part of national NHS plans, new types of contracts are being developed to support neighbourhood-based care. These include options for a single neighbourhood provider, groups of neighbourhoods working together, and new integrated health organisation arrangements. Once further national guidance is released, we will review these options carefully to understand how they can best support our local ambitions for neighbourhood development.

We expect more detailed national guidance on neighbourhood working in 2026. When this is published, we will update our plans to reflect the latest learning both from national early implementer sites and from upcoming changes within local government. This will help us make sure our approach continues to meet the needs of residents and delivers high-quality care in the right place, at the right time.

We will prioritise specific groups within the population where the data shows there is the greatest opportunity to support people to remain independent and reduce avoidable reliance on hospital care or long-term residential and nursing care. This approach will focus on around 2% to 4% of residents and will include:

- Adults with complex physical disabilities or multiple long-term health conditions
- Children and young people who need wider input, including specialist paediatric expertise
- Adults with moderate to severe physical or cognitive frailty, such as dementia
- People of all ages with palliative care or end of life care needs
- People of all ages with high intensity use of emergency departments
- Individuals who are housebound
- Individuals who are homeless.

In 2026/27, we will:

- Strengthen neighbourhood health by creating groups of natural local communities that make sense to residents. These neighbourhoods normally cover around 50,000 people, although some may be smaller, around 25,000 people, where this fits local geography. Primary Care Networks (PCNs) will play a central role, working closely with communities and bringing local services together so that more care can be provided closer to home.
- Build on the work completed over the past 12 months, during which neighbourhood footprints were defined, and early implementer sites for INTs were established.
- Use learning from three pilots – two for adults and one for children and young people – to refine the model and shape a phased rollout to additional neighbourho ods over the next three to five years.

- Bring together the different components of neighbourhood health into a single integrated service offer, informed by national guidance as it becomes available, prioritising prevention, early intervention and personalised support.
- Make the most of the vital roles that community pharmacies, dental practices and optometry services play, including supporting people to stay well, preventing illness and helping manage multiple medicines safely.
- Develop clear shared governance, joint planning, and better use of resources to support moving activity from hospitals into primary care and community services.
- Build a culture where teams work closely together, feel proud of what they do, and support one another. This means giving the time and space to solve problems together and build strong, trusting relationships across primary care, community services, hospitals, social care, and local communities.
- Focus on people with the most complex needs, while also laying the foundations for wider scaling across the system.

In 2027/28 onwards, we will:

- Put these six core elements of neighbourhood health into practice across our area – by making sure local services have the right capacity, and by updating contracts and funding arrangements to support this way of working.
- Aim for full alignment of clinical and operational workforce from community health providers to neighbourhood 'footprints' – working alongside dedicated, named specialist teams from acute and mental health trusts, particularly community mental health teams.
- Achieve full roll out of new care models that bring care closer to home, strengthen prevention and deliver integrated support at neighbourhood level.

Palliative and end of life care

Palliative and end of life care is important to our population. We want to ensure that people who are approaching the end of their lives receive compassionate, high-quality support, and are able to spend their final months, weeks and days in the place that feels right for them, whether that is at home, in a hospice, care home or hospital.

We will continue working with partners to deliver the Staffordshire and Stoke-on-Trent Palliative and End of Life Care Strategy 2025–2028, making sure people have the right support wherever they live and whatever their circumstances. We will also develop new ways of providing palliative and end of life care that reduces the need for hospital-based, crisis responses and instead offer proactive, personalised care in the community through ITNs. These teams work closely with social care, voluntary organisations and community groups to provide holistic, needs-led support.

In 2026/27 and 2027/28, we will:

- Increase the amount of palliative and end of life care delivered in the community
- Embed 24/7 access to advice and support
- Improve coordination between services so that more people can receive care in the place they prefer
- Identify people earlier who are approaching the end of life, ensuring timely assessment and personalised support
- Strengthen integrated MDTs in every neighbourhood to coordinate care across health, social care and the voluntary sector
- Enhance community-based services, including expanding virtual wards and rapid response
- Promote personalised care and advance care planning
- Increase access to information, education and training for professionals, patients, carers and communities

- Review financial allocations to ensure sustainability of our hospice and voluntary sector
- Strengthen partnerships with hospices, VCSE organisations and compassionate communities
- Align this work with the forthcoming national Palliative and End of Life Care Modern Service Framework (expected autumn 2026).

Frailty

Through delivery of the Healthy Ageing and Frailty Strategy 2025–2030, we will:

- Strive to identify people at risk of falling earlier – using risk stratification at scale in primary care, the electronic Frailty Index (eFI) and Clinical Frailty Scale (CFS), and proactive case-finding driven by population data.
- Have a system-wide rollout of Comprehensive Geriatric Assessment (CGA) with 100% acute and community staff trained by 2027.
- Increase access to digital self-management tools and resources, including rolling out proven solutions such as the Steady On Your Feet application which is designed to help older adults improve their balance and reduce risk of falls.
- Strengthen safer prescribing, with around 80% of the frailty cohort to receive annual medication reviews in primary and community settings, increased focus on polypharmacy, deprescribing where appropriate, and reducing falls and events linked to medicines.
- Support primary care to lead on frailty identification and a MDT review model (including pilots in specific PCNs).
- Have a single, integrated falls pathway from prevention to consequence management (including bone health/osteoporosis), underpinned by Steady On Your Feet and best-practice service specifications adopted.
- Develop neighbourhood MDT wraparound for care homes, remote monitoring, virtual wards, and Integrated Care Coordination (ICC) to coordinate timely alternatives to conveyance and admission, and create safer environments for frail and vulnerable residents.
- Proactive identification and management of moderate and severe frailty in primary care – where patients are risk stratified and supported through coordinated multi-provider teams.
- Increase the completion of frailty assessments in primary care – ensuring timely medication reviews, and reducing falls, admissions and hospital conveyances through targeted, neighbourhood-based interventions.

Long-term conditions

Many adults in Staffordshire and Stoke-on-Trent live with a long-term health condition, disability or illness, which can have a significant impact on their quality of life, independence and wellbeing. People in our most deprived communities are affected the most, with far higher levels of illness and earlier deaths. For example, deaths from respiratory disease in people under 75 are almost double those in more affluent areas, and our area has some of the highest emergency hospital admissions in England for chronic obstructive pulmonary disease (COPD) and other respiratory conditions.

Over the next five years, we will base our work on a set of guiding principles that shape how we help people stay well, support them to manage their conditions, and reduce the risk of complications.

We will focus on:

- **Proactive, preventative care** – finding risks early through NHS Health Checks, risk stratification and early identification
- **Personalised support** – developing care plans with each person, including digital tools for self-management where appropriate
- **Joined-up care** – using multidisciplinary teams and neighbourhood models so

support is coordinated and closer to home
- **High-quality clinical care** – making sure treatment follows guidance from the National Institute for Health and Clinical Excellence (NICE) for conditions such as diabetes, respiratory disease and heart disease
- **Safe and effective medicines** – improving medication reviews and reducing risks linked to taking multiple medicines
- **Seasonal resilience** – ensuring people with respiratory conditions have 'winter ready' checks
- **Integrated prevention** – moving towards a whole-system model of chronic disease prevention and management (aligned with best practice).

This integrated model of care links closely with our new neighbourhood-based frailty pathways and our approach to palliative and end of life care. Together, these 'teams of teams' will support people at every stage of their condition, from diagnosis through to ongoing management and specialist care.

Working with partners across the system, we will also review and improve a number of important services that support people with long-term or complex conditions, including:

- A full review of neurological pathways from diagnosis to community rehabilitation
- Commissioning of rehabilitation services for respiratory, cardiac and stroke patients
- Procurement of a new wheelchair services contract
- Recommissioning speech and language services for people living in care homes.

All Age Continuing Care

The 2023 All Age Continuing Care (AACC) improvement programme has already helped improve the quality and safety of care. However, Staffordshire and Stoke-on-Trent still face some of the highest continuing healthcare costs in the country because many people have very complex needs and there are gaps in community support. This can lead to avoidable hospital admissions, longer stays, and greater reliance on bed-based care – which in turn reduces people's independence and increases the level of support they need. These challenges reflect wider pressures across the whole health and care system and underline the importance of working in a more joined-up way so that people can receive the right support at the right time, avoid unnecessary hospital stays and maintain their independence for longer.

We will:

- Continue to develop shared, system-wide policies and processes with our partners, including local councils, to make it easier for people to move smoothly between services and to support more joined-up commissioning across health and social care.
- Design care pathways together with local people, ensuring they are shaped by real, lived experience rather than organisational boundaries, so that support feels coordinated and easier to navigate.
- Expand and embed joint training programmes, such as the shared continuing healthcare training for health and social care staff.
- Develop and widen the use of assistive technology, ensuring it is included as part of standard care pathways so more people can stay independent at home, and fewer need intensive or complex care packages.
- Build our future AACC operating model so it is sustainable, joined up, and designed around people's needs, with clear roles across clinical and non-clinical teams to make best use of everyone's skills and expertise.

Urgent and emergency care

Key to our plan is making sure people can get the right urgent and emergency care (UEC) quickly, while ensuring our hospitals can focus on treating the most seriously ill. To do this, we

will expand and strengthen urgent care services in community settings, so more people can be safely supported closer to home. This will help our providers reduce waiting times in A&E, cut ambulance handover delays and improve people's experience of emergency care.

We will:

- Agree a delivery model in 2026/27 to align demand and capacity across intermediate care using Discharge to Assess (D2A) productivity findings, shift resource to Home First, and enhance stepdown and reablement (including through the Better Care Fund) to improve flow, reduce length of stay and support timely discharge.
- Build on the robust patient engagement already undertaken for our urgent treatment centre (UTC) designation and use its findings to inform and strengthen the further development of our UEC pathways.
- Enable workforce flexibility through workforce sharing agreements and mutual aid processes (built into surge/winter plans).
- Have enhanced reablement services, enabled through the Better Care Fund and closer integration with social care.
- Make every contact count and implement consistent frailty screening at key access points – NHS 111, 999, UTCs, Same Day Emergency Care (SDEC), emergency departments (EDs) and acute front doors.
- Make neighbourhood teams the default for proactive urgent care and admission avoidance during 2026/27 and beyond – delivering anticipatory care planning for high-risk cohorts, such as frailty, multi-morbidity, high intensity users and care homes.
- Use robust data and analytics in the Integrated Care Coordination (ICC) to track utilisation versus demand, expand community pathways, and continuously improve deflection from hospital to community services through 2026/27 and beyond.
- Continue to commission a 24/7 ambulance off-load officer at Royal Stoke University Hospital to support reduced handover delays and improve patient experience throughout 2026/27.

Primary care

Over the next five years, our commissioning ambition for primary care across Staffordshire and Stoke-on-Trent is to create a resilient, equitable, and person-centred system that delivers high-quality care close to home which is outlined within our General Practice Five Year Forward Strategy with an intention to become a wider primary care strategy in 2026/27.

We will measure success and drive improvement by using patient satisfaction data including the Health Insights Survey and 'You and Your GP' feedback, online consultation usage data, workforce data, and the National General Practice Dashboard.

We will:

- Embed integrated neighbourhood working and teams bringing together primary care, community services, social care, voluntary sector partners, and wider healthcare providers (including dentistry, pharmacy, optometry and dentists) to provide proactive, coordinated care tailored to local populations in line with national timescales.
- Work with our partners to update the way care homes are supported.
- Design a new, more effective obesity support pathway, with primary care playing a central role by March 2027.
- Strengthen early detection and management of long-term conditions, with primary care teams contributing to redesigned pathways such as diabetes, cardiovascular and respiratory, supporting earlier diagnosis, improved access to treatment, and reducing avoidable hospital admissions by March 2027.
- Maximise the breadth and accessibility of primary care services across community

pharmacy, optometry, and dentistry. Ensuring increasing access to available services with seamless patient pathways and enhanced community provision throughout 2026/27 and beyond.

- Reduce health inequalities for children with special educational needs and disabilities (SEND) by commissioning a Special Schools Eye Care Service which will improve access and equity of service, support early detection, independence and improve opportunities for greater learning and development (2026/27) by September 2026.
- Introduce the new community dental reforms for adults and children in a way that makes dental care easier to access and more focused on prevention. This means providing more services closer to home, helping people get the right support early, and reducing the need for urgent or avoidable treatment.

Medicines optimisation

With our commissioning arrangements in place with general practice, we have a foundation to build further capacity and capability to support the uptake of medicines-dependent clinical services in primary care. Also, with the expanding role and capability of community pharmacies, we have opportunities to shape the provider market of the future.

This model of care is not simply about shifting services from one sector to another for ease of access and convenience, though these benefits are important. It is about understanding how services can better meet the needs of patients with complexities and addressing differential needs of different communities. Alongside the changes in models of care, it will be important to fully adopt the benefits from the NHS Genomics Medicine Service that will advance the scope for predictive, preventative and personalised treatments.

We will:

- Continue to develop financial controls for medicines spending including the development of an ICB medicines-related cost improvement plan and setting efficiency targets in commissioned services.
- Set budgets within the emerging neighbourhood health services, once established.
- Continue to support medicines-related strategic commissioning via community pharmacy, general practice and other providers including a service specification design incorporating medicines, safety, quality, and efficiency which will lead to improved access to preventative care, acute care and long-term condition management. An increased uptake of new digital solutions will also be considered as part of the service design.
- Continue to build on our experience of working with system partners to develop and modify services, for example the production of effective shared care agreements that enables provision of specialist drugs via primary care. There are number of areas – including diabetes, heart failure and cholesterol lowering – where greater provision can be made in primary care. However, this will require a shift of resources and getting primary and secondary clinicians together to agree the changes to deliver safe and effective interventions for the population to a greater scale.
- Continue to support the development of a Cross Pharmacy and Medicines Optimisation Leadership Group which will consider innovative models for medicines optimisation for the local population.
- Support the development of neighbourhood health services and, once established, ensure medicines use is considered in pathway redesign and the national aspiration for greater community access to care that reduce health inequalities and improve population health outcomes is realised.
- Develop local capacity and capability to fully benefit from the NHS Genomic Medicines Service at neighbourhood health service provision, once established.

Planned care

To support our ambition of providing faster, more convenient planned care, we will be an

active partner in developing local neighbourhood health models. These models will help ensure people can access tests, treatments and follow-up care closer to home wherever it is safe and appropriate to do so.

We will:

- Use community pathways throughout 2026/27 and beyond to manage patients closer to home, with robust triage arrangements prior to onward referral. This will support demand management, as well as embedding advice and guidance to support GPs in referrals for patient treatment.
- Maximise system-wide access to community diagnostic centres to ensure patients receive the diagnostic tests that they need much more quickly in smaller community settings with the third Community Diagnostic Centre (CDC) due to be operational in Hanley, Staffordshire, from April 2026.
- Grow community and home-based anti-cancer treatment capacity – aiming for all appropriate patients to be offered these treatment options by 2030/31.

Mental health, learning disability and autism

We want more people to get the mental health support they need early and close to home, so fewer people reach crisis point or need long stays in hospital. We will transform how mental health care is delivered by developing 24/7 Neighbourhood Mental Health Centres (NMHCs). These hubs will offer local support where people can walk in to get help from a range of professionals and, where needed, access overnight care without having to travel far. They will bring together community mental health teams, crisis services and specialist support into one joined-up offer that is designed around local neighbourhoods. They will also be autism and learning disability friendly, making it easier for people to get the right help in the right place.

Throughout 2026/27, we will:

- Shape each NMHC around the needs of its local population – ensuring services respond to local inequalities and the wider factors that affect people's mental health.
- Identify and reach groups who have previously faced barriers to care.
- Strengthen the links between community services and inpatient care.
- Ensure the number and type of inpatient beds match the needs of local people, helping to reduce long hospital stays and avoid the need for people to be placed far from home.
- Embed the learning from the ICB 3-year Transforming adult mental health inpatient services plan through:
- Learning from Years 1–2 to inform commissioning decisions.
- Embedding end-to-end pathway coherence (from admission to discharge to community).
- Ensuring alignment between population need, bed numbers and pathways – reducing the average length of stay in adult and older adult acute mental health beds and speeding up discharges and minimising barriers to patient flow – ultimately leading to a reduction of inappropriate out-of-area placements and locked rehabilitation inpatient services.
- Continue the commitment of the existing 'Building the Right Support' national plan to reduce reliance on mental health inpatient care for people with a learning disability and autistic people – aiming for a minimum 10% reduction.
- Ensure children and young people with a learning disability, autism or both who are at-risk of entering a mental health hospital are on the Dynamic Support Register (DSR) and are assigned a dedicated keyworker.
- Use DSRs and Care (Education) and Treatment Reviews (C(E)TRs) to identify people at risk of crisis earlier and coordinate proactive support – ensuring awareness and access across primary

care, social care, communities and mental health services.

From 2027/28, we will:

- Move to a new national model for inpatient mental health services – with a strong focus on safety, therapeutic care, and keeping people close to their communities.
- Only commission mental health inpatient services for adults and older adults that align with the NHS Commissioning Framework.

People with autism or a learning disability often experience poor mental health outcomes and may be admitted to hospital when community support could have prevented a crisis. Since March 2015, the overall number of people with autism or a learning disability in a mental health hospital has reduced by 31%, and the number of people with a learning disability (not autism) in a mental health hospital reduced by 59%. However, between March 2017 and July 2025, the number of people in a mental health hospital with autism (not a learning disability) increased by 84%. Of the 2,010 autistic people and people with a learning disability in hospital at the end of July 2025, 50% had stays of more than two years and 30% had a stay of more than five years (Source: Assuring Transformation (AT) NHS England » Update on Learning Disability and Autism Programme).

Demand for autism and ADHD assessments has continued to significantly outstrip service capacity. There is an urgent need to address early determinants of adverse outcomes and reduce waiting times in cost-effective, evidence-supported ways.

Through 2026/27, we will:

- Continue to work to reduce avoidable admissions and long stays by improving early help and expanding the right support in the community.
- Work with schools, councils, GPs and the voluntary sector to create a more joined-up approach that provides earlier, needs-led support and reduces the time people wait for assessments.
- Support a multi-system approach for early diagnosis and support for ADHD and autism. Support for ADHD and neurodivergence should be needs-led and begin early – ideally in preschool or school – and should not rely on or require a clinician-provided diagnosis.
- Embed faster, better diagnostic pathways for autism and ADHD, along with robust 'Waiting Well' programmes that offer targeted support of patients waiting for surgery, supported by early intervention and prevention in partnership with education and local authorities, and the voluntary sector.
- Ensure provision for early years support needs to encompass family outreach and evidence-based parenting interventions appropriate for ADHD, autism and neurodivergence.
- Develop and implement a 'Reform Plan' in response to the SEND White Paper, once published.
- Increase specialist support in schools through partnerships for inclusion of neurodiversity in schools (PINS).
- Expand school interventions to include ADHD and neurodivergence to improve ADHD outcomes delivered via mental health support teams (MHSTs) and PINS.
- Join up schools and ADHD health service providers to co-create school and education policies and practices to enable children with ADHD to thrive.

Children and young people

Staffordshire and Stoke-on-Trent are home to almost 247,000 children and young people (CYP), and this number is expected to grow. While most children grow up safe, happy and well supported, some families face challenges that make it harder for them to thrive, leading to longstanding inequalities and poorer health outcomes.

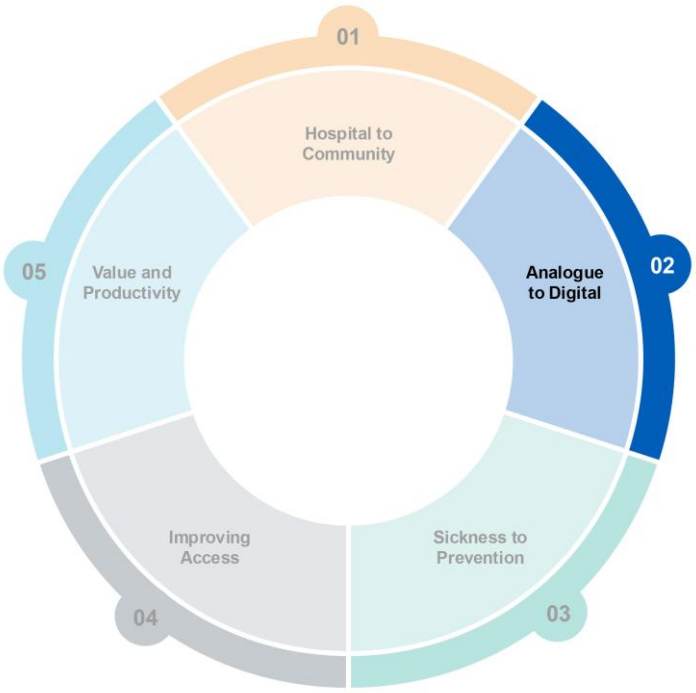
Because CYP make up a third of our population, their wellbeing is central to the future health, prosperity and strength of our communities. Supporting them to grow, learn, stay well and move confidently into adulthood and employment is a vital part of our work to tackle inequalities and improve opportunities for everyone across our area.

Through 2026/27, we will:

- Develop and implement neighbourhood multidisciplinary teams for CYP to support those with complex health and social care needs who need help from multiple services and organisations.
- Shift services towards integrated care – specifically improving pathways for asthma, epilepsy, dietetics, audiology, mental health, oral health, and complications from excess weight (CEW).
- Work with North Staffordshire Combined Healthcare NHS Trust to establish a pilot site to host the multidisciplinary teams in the Bentilee and Ubberley area.
- Build on what we learn from the pilot and apply it over the longer term to help deliver all six core components of Integrated Neighbourhood Teams (INTs). We will work closely with the Families First Partnership programme – which focuses on whole family support and safeguarding. Both approaches promote early help, joined-up working and involving families and communities in shaping their care.
- Develop a strong CYP-centred model that brings health, social care and protection together in one place through shared hubs, roles, information systems and decision making.
- Create clear care pathways for CYP with avoidant or restrictive food intake disorder (ARFID) – including options outside specialist eating disorder services when this is more appropriate. For example, support for children aged 0–5 whose needs may differ. As part of their assessment, the Eating Disorder team will work with the child or young person and their family to decide whether specialist treatment or a shared care approach is the best fit. If it is unclear what support is needed, the case will be discussed by a local multidisciplinary children's team.

Analogue to digital

This section describes how we will modernise health and care by expanding the use of digital technology across pathways and services. Digital tools already support people to manage appointments, monitor their health, receive care at home and stay informed about their treatment. This role will continue to grow as demand and expectations increase, while we also maintain the value and importance of face-to-face care.



Our ambition

The move from analogue to digital is more than just adopting new tools. It is a foundational principle for transforming care delivery, improving patient outcomes, and optimising productivity and efficiency. Digital innovation should guide service design and empower the workforce to work smarter and more collaboratively. When technology is used well, it reduces delays, supports earlier intervention, helps staff spend more time with patients and improves the secure flow of information across teams. However, digital tools will complement, not replace, face-to-face care.

Our ambition is to move from a largely analogue, paper-based system to a modern, digitally enabled health and care service.

- By the end of 2026/27, we expect to see early use of the Digitised Personal Child Health Record (Digital Red Book), pilots for automated transcription, increased NHS App use, early electronic prescribing expansion, stronger digital uptake of Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) and Electronic Palliative Care Coordinating Systems (EPaCCS), and first adult social care data flows into the Shared Care Record.
- By the end of 2027/28, digital capability will have expanded significantly, with the Digital Red Book in routine use, broader home-monitoring technologies, the NHS App established as the main access point, community pharmacy accessing shared data, growing virtual wards and digital UEC platforms, the Integrated Care Coordination Centre (ICC) acting as a single digital entry point, and regular data sharing between adult social care providers.
- By 2029/30–2030/31, we expect to see a Single Patient Record accessed through the NHS App, automated documentation and AI-supported decisions, widespread remote monitoring, real-time data for proactive care, seamless medicines information across settings, a digital-first urgent care model, and universal adoption of digital ReSPECT and EPaCCS.

Transformation and new care models

We will modernise pathways across health and care by expanding the use of digital tools, improving data flow and reducing reliance on paper. The following actions set out how we will improve access, support staff, strengthen safety and ensure services are more joined up and efficient for patients.

We will:

- Digitise the Personal Child Health Record (Digital Red Book) so it can be accessed via our shared care record One Health and Care.
- Introduce tools that reduce the administrative burden, such as automated transcription and documentation support.
- Aim to use digital tools like wearables, which automatically collect the information we need and update our systems with little or no effort from patients.
- Ensure services remain inclusive by providing non-digital routes for those who need or prefer them, and by embedding communication preferences and reasonable adjustment flags (RADJ) across all systems so staff can meet the needs of people with disabilities or additional requirements.
- Work in community locations such as libraries and GP sites to provide training to help people make the most of digital technology.
- Proactively identify patients at risk of digital exclusion and living in digital poverty. Where possible, we will provide access to suitable digital devices to empower them to manage their health and care effectively and improve outcomes.
- Make the NHS App the main digital front door – enabling people to book appointments, order repeat prescriptions, see test results and access their records, supported by digital triage and AI-guided navigation.
- Enable patients to view and manage hospital outpatient appointments via the NHS App, alongside expanded use of digital triage and advice and guidance through the NHS eReferral Service.
- Improve medicines safety and access by expanding electronic prescribing, digital repeat ordering, practice-based messaging and deploying AnalyseRx® to support safer prescribing.
- Enable community pharmacies to access relevant parts of the patient record to deliver safer, more coordinated care.
- Deliver a digital-first urgent and emergency care (UEC) model using virtual wards, remote monitoring and improved streaming so people receive the right care sooner.
- Support a 24/7 Integrated Care Coordination Centre (ICC) using electronic referrals and real-time data to reduce waits and avoid unnecessary ambulance conveyance.
- Deploy digital tools that support real-time management of mental health beds and capacity.
- Strengthen end of life care through the rollout of digital ReSPECT and EPaCCS forms to ensure people’s preferences are clearly recorded and shared with all professionals.
- Expand Docman Connect across hospitals and GP practices to reduce paper and improve communication flow.
- Enable adult social care settings to provide data into the shared care record One Health and Care – including capturing data from wearables.
- Continue to strengthen how information moves between teams, enhancing One Health and Care and preparing for the future National Single Patient Record.

Sickness to prevention

This section explains how we will focus on helping people stay well in the first place. It sets out the programmes we are putting in place to improve health, prevent avoidable disease, and tackle long-standing inequalities. This includes strengthening neighbourhood-based prevention, improving health and housing, boosting health literacy, expanding support for obesity, smoking and alcohol harm, and improving vaccination and screening uptake. It also sets out how we will reshape maternity and neonatal services, improve support for children and young people and ensure people with mental health needs, learning disabilities and autism receive early, coordinated help.

Our ambition

We want to make sure that everyone in Staffordshire and Stoke-on-Trent has a fair opportunity to live a good life. Prevention is everyone's business across the health and care system so we will continue to work with partners to address what is unfair and preventable. We recognise that we need to look beyond health and care services to understand the barriers and opportunities to living a healthier life and are committed to working with partners, people, and communities to address them. Prevention will increasingly be delivered through neighbourhood teams, and each neighbourhood will take responsibility for the health of its population.

Transformation and new care models

Locality Improvement Framework

Staffordshire and Stoke-on-Trent ICB has ring-fenced £1.7 million in recurrent funding over three years from the Health Inequalities budget. Through our Locality Improvement Framework, each of our 12 local areas will design and deliver targeted projects to reduce health inequalities – focusing on the people who need the most support. These projects will be put in place and evaluated over the next one to three years, and we expect to see real, measurable improvements, particularly for groups identified in the Core20PLUS5 approach, supported by strong population health data and analysis.

We will:

- Continue to strengthen cross-sector collaboration and demonstrate measurable improvement in health outcomes for local populations through a targeted Core20PLUS5 approach.

- Offer a unique opportunity for the eight localities in Staffordshire and four in Stoke-on-Trent to submit proposals aligned with their local Core20 priorities, informed by population health management. Each locality can access up to £100,000 in Staffordshire and £125,000 in Stoke-on-Trent annually for a rolling three years.

Worklessness

WorkWell sits alongside locally led interventions such as Get Britain Working, Connect to Work and Trailblazers. It is expected that most people who will benefit from WorkWell over the next one to three years are those whose work is at risk due to health barriers and those recently unemployed with health conditions.

Warmer homes

We are investing in Staffordshire and Stoke-on-Trent's upper tier local authorities (UTLAs) and all 12 local communities to help reduce health inequalities and improve people's health. We know that poor-quality housing can have a major impact on the physical and mental wellbeing of both adults and children, so part of this investment focuses on supporting residents living in cold, damp or unsafe homes to create healthier living conditions.

We will:

- Use the available investment on a phased approach targeting the homes of vulnerable residents in Staffordshire and Stoke-on-Trent with low incomes and health conditions exacerbated by cold conditions and poor housing.

Health literacy

Health literacy is the ability to access, understand, appraise, and use information and services to make informed decisions about health and wellbeing. It involves more than reading leaflets, covering the skills to navigate complex healthcare systems, manage chronic conditions, and communicate personal needs.

Our one to three-year goals for health literacy are to:

- Launch the system-wide health literacy programme – Let's Talk Health.
- Establish the Health Literacy Academy, creating a network of Health Literacy Champions across the system to embed best practice.
- Embed health literacy within locality-level interventions delivered through the Locality Improvement Framework.
- Support workforce development by raising awareness of health literacy principles among frontline staff and building on existing, successful awareness schemes.

Obesity

Locally, we have created the SWITCH programme (Staffordshire and Stoke-on-Trent's Weight-related Interventions Tailored in Care for Health). The programme uses new clinical approaches, digital tools and community support to help people build confidence, understand their health, and make changes that feel achievable and sustainable.

Over the next five years, we will continue to grow the SWITCH programme, including developing local weight management hubs, as part of a wider approach to preventing and treating obesity across Staffordshire and Stoke-on-Trent.

Alcohol

We are working with the Staffordshire and Stoke-on-Trent Drug and Alcohol Partnership to reduce alcohol-related harm across our communities. Together, we have developed a five-year Alcohol Harm Reduction Strategy, supported by a delivery plan now being co-created. The Strategy focuses on five areas – preventing harm across the whole population, providing early support for those at risk, improving treatment and recovery, strengthening community safety, and encouraging healthier attitudes towards alcohol.

Under the Target Prevention and Treatment and Recovery workstreams, we will develop:

- An end-to-end review framed against the prevention model, profiling resource, activity and outcomes.
- A business case for equitable provision of specialist hospital alcohol care teams.
- Screening and brief interventions for alcohol with training and resources to support implementation in target settings (both NHS and community).

Tobacco

The ICB was an early implementer site with four NHS trust providers (MPFT, NSCHT, UHNM and University Hospitals of Derby and Burton NHS Foundation Trust – UHDB) of an offer that all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services. This offer also includes to staff and patient partners within the maternity pathway.

Over the next five years, we will:

- Offer tobacco treatment services in other areas such as outpatients and emergency departments.
- Work with local authorities to ensure that commissioned stop smoking providers offer support to patients following on from being discharged from hospital.
- Meet the 2030 smoke-free ambitions.

Vaccinations, immunisations and screening

Joint working with key partners across provider organisations, local authorities and the VCSE sector is essential to address the requirements for vaccinations, immunisation and screening programmes.

As part of this approach, we will:

- Improve uptake of vaccination and immunisation by using convenient local places for ease of access and offering multiple vaccinations for individuals and their wider family members at the same time, supplemented with targeted outreach to support individuals in underserved populations.
- Maximise digital capabilities of the national programmes.
- Commission responsibly for vaccinations and immunisations together with screening (once responsibility transfers from NHS England to ICBs from April 2027).
- Review and develop screening services that improve uptake by ensuring capacity is delivered in the most appropriate locations and increases accessibility for people.
- Establish system programme governance structures by April 2027 for immunisation and screening.
- Take part in a regional review of how tuberculosis (TB) is managed.
- Undertake a local review of latent TB services.
- Develop local plans by December 2026 to reduce TB incidence through consistent latent TB testing.

Migrant health services

Delivery of migrant health services within community and neighbourhood capacity is key to establishing effective support for this population group.

To achieve this, we will:

- Develop robust and consistent services to support migrants from initial health checks through to management of long-term conditions by March 2027.

Perinatal

Our overarching aim is to provide accessible, safe, and high-quality maternity and neonatal (perinatal) services that meet the needs of women, babies, and families. Nationally, a number of investigations have been carried out and recommendations have been published. These have highlighted that inequalities in outcomes persist across some ethnic and social groups, including outcomes for perinatal mortality, pre-term births, brain injury and maternal deaths.

Perinatal mortality is influenced by factors such as congenital problems, maternal health, smoking in pregnancy, prematurity, low birth weight and quality of obstetric care. The area experiences poorer outcomes in several of these areas – including lower breastfeeding rates, higher premature birth rates and some of the highest infant hospital admission rates nationally. Strengthening the quality and consistency of maternity services is essential to improving these outcomes.

This Five Year Commissioning Plan is informed by the outcomes of previous investigations and recommendations including the Three Year Delivery Plan which is due to end in March 2026. The national maternity inquiry is due to be published in spring 2026, and the action plan will follow in October 2026. Our commissioning intentions will be reviewed once the reports are published.

Our role is to help put strong foundations in place so that maternity and neonatal services across Staffordshire and Stoke-on-Trent are safe, consistent and focused on improving health for all families. As the wider NHS system continues to evolve, the way these services are overseen may change – but our commitment to reducing inequalities and ensuring high-quality care for every woman, birthing person and baby will remain the same.

Ahead of the action plan being finalised, all ICBs and providers are expected to take immediate action to improve care and ensure women are listened to. This includes:

- Implementing best practice resources
- Maternal Care Bundle
- Avoiding brain injury in childbirth
- The national specification for maternity triage services
- The Sands National Bereavement Care Pathway for stillbirth and neonatal death
- Postnatal care guidelines
- The national Maternity and Neonatal Inequalities Data Dashboard
- Participating in the Perinatal Equity and Anti-Discrimination Programme
- The Maternity Outcomes Signal System
- Ensuring a robust system for reporting any clinical incidents, near-misses, or complaints is in place, utilising tools available such as the Perinatal Mortality Review Tool (PMRT), referring to the Maternity and Newborn Safety Investigations (MNSI) for independent investigation where appropriate.

As strategic commissioners, we will:

- Continue to gather service user feedback through surveys and the Maternity and Neonatal Voices Partnership to ensure people and families are at the heart of what we do.
- Commission agreed pathways across providers with minimum standards agreed and robust data and reporting arrangements in place – including monitoring the National Maternity and Neonatal Dashboard against national and local trajectories.
- Ensure alignment between maternity and other services.
- Ensure oversight and continue to manage clinical quality risks in line with National Quality Board guidance – including monitoring outcomes, identifying unwarranted variation, and setting the areas of focus for quality assurance.
- Continue to use the ICB Maternity Escalation Policy to support operational pressures across the system and support the safe arrival of babies in our area.
- Oversee the monitoring of midwifery, obstetric, and neonatal staffing levels against recommended ratios in line with the national framework tool for maternity workforce planning.

Primary care

Primary care plays a central role in shifting the health system from a focus on sickness to a focus on prevention. By identifying risks early, supporting behaviour change, delivering targeted screening and vaccination programmes, and providing proactive, community-based care – primary care helps prevent illness, reduce health inequalities, and improve long-term population outcomes.

This approach will include:

- Maximising undelivered NHS dental activity to reduce inequalities in access, aligned to the Dental Health Equity Audit, with full implementation by March 2027.
- Increasing uptake of early identification and screening programmes, ensuring timely detection of conditions such as cancer, cardiovascular disease, and diabetes.
- Improving uptake of vaccination and immunisation programmes to prevent avoidable illness and reduce demand on urgent and emergency care services.
- Continuing to maximise the additional roles in Primary Care Networks including clinical pharmacists, first contact physiotherapists, care coordinators, health coaches, and social prescribers to deliver preventative care at scale.
- Continuing to support health promotion including smoking cessation, weight management, physical activity, alcohol reduction, and healthy ageing.

Medicines optimisation

The 10 Year Plan has broad ambitions around primary prevention.

We will:

- Build on our success with the lung health check scheme in Stoke-on-Trent and work in collaboration with Stoke-on-Trent City Council to drive uptake of smoking cessation services via community pharmacies to meet their target of reducing smoking rates to 5% of the population by 2030.
- Ensure maximum uptake of human papillomavirus (HPV) vaccinations via community pharmacies in line with the NHS 10 Year Plan, with a national rollout set to begin in 2026. This initiative aims to improve access and increase uptake of the vaccine – particularly among young people who missed their school-based vaccinations – to support the government's target of eliminating cervical cancer by 2040.
- Support the introduction of pharmacogenomics so that pre-emptive genetic testing is routinely included in the over-40s health check in primary care by 2035.

- Scope and implement the availability of weight loss treatments via community pharmacy, as nationally over 1 million people access weight loss treatment privately via community pharmacy.
- In line with the UK Five Year Action Plan for Antimicrobial Resistance 2024-29, we will promote prudent prescribing and use of antibiotics to reduce overall prescribing volume of antibiotics by 10%. We will also increase compliance with the national target for the duration of course of commonly used antibiotics and reduce the prescribing of antibiotics in children aged 0–9 in line with national targets (2026-29).

Planned care, diagnostics and cancer

We know that waiting for treatment can be worrying. We will make it easier for people to stay well and prepare for their procedure.

We will continue to:

- Deliver campaigns to raise awareness of prevention strategies and self-care maintenance – including promoting healthier lifestyle choices to reduce the risk of cancer.
- Support patients to be active participants in their own care and in accessing prevention services through digital technology.
- Provide clear, practical support for people waiting for treatment through 'waiting well' guidance on steps people can take to improve their fitness, mental wellbeing, sleep, weight, mobility and overall health.

Mental health, learning disabilities and autism

Prevention programmes aimed at promoting healthy lifestyles and reducing avoidable morbidity and mortality (for example, through targeted support within screening, immunisation and obesity prevention programmes) must include the needs of people with a learning disability and autistic people.

- **Annual health checks –** We will make sure that people with a learning disability and autistic people are invited for their yearly health check.
- **Health Action Plans (HAPs) –** After each health check, people will be offered a personalised Health Action Plan. This sets out clear, achievable health goals and the support needed to help them stay well, giving individuals and their families a simple plan they can follow throughout the year.
- **Autism and ADHD assessments –** In 2026/27, all ICBs and providers must optimise existing resources to reduce long waits for autism and ADHD assessments and improve the quality of assessments by implementing existing and new guidance, as published.
- **Personalised care plans –** Our aim is to ensure that 95% of people with complex needs – including those with a learning disability and autism – have a co-created care plan by 2027 to support them as active participants in their own care. Plans should include meeting all the neurodiverse needs of each person.
- **Workforce –** Commission providers that ensure the workforce is equipped with the right skills and work in a more integrated way to support people with learning disabilities and autism – including specific mental health support teams in communities.

Children and young people

Prevention starts even before birth – and children and young people are at the heart of this. Early help for children with special educational needs and disabilities (SEND) is a vital form of both secondary and tertiary prevention, helping to identify needs sooner and reduce the risk of future difficulties. Our complications from excess weight (CEW) and Staffordshire and Stoke-on-Trent's Weight-related Interventions Tailored in Care for Health (SWITCH) programmes also play an important role in

preventing harm later in life by supporting children, young people and families with tailored, holistic approaches to healthy weight and wellbeing.

We need to shift from an NHS that focuses mainly on treating illness to one that helps everyone live healthier, happier lives – and this includes children and young people. We are committed to taking a whole population approach to improving children and young people's health, especially as we face growing challenges such as rising obesity rates – with nearly one in five children leaving primary school obese. Our goal is to make it easier for families to find trusted advice, get the right support early, and access treatment quickly when it's needed.

Across 2026/27, we will:

- Improve access to clear, consistent advice to help families make informed choices about healthy living.
- Strengthen local support services, so more children and young people can get help earlier.
- Increase access to treatment for those who need more specialised care.
- Develop new service models – including CEW – to ensure children with obesity-related health conditions receive the right care at the right time.

CEW clinics will be one of our big pieces of work. These clinics take a holistic, whole-person approach – looking at all aspects of a child's health and wellbeing, not just their weight. Families will be able to access a team of specialists who can help with physical health, emotional wellbeing, lifestyle support and any medical conditions that may have developed.

Developing CEW clinics is an important part of our wider Healthy Weights programme. From 2027/28, responsibility for commissioning these services will transfer to local areas.

To prepare for this change, we are:

- Planning how CEW services can be delivered sustainably from 2027/28 – ensuring high-quality support that reflects the needs of families across Staffordshire and Stoke-on-Trent.
- Working with regional partners to understand future demand – including how many families may need support and what level of care will be required.
- Exploring whether a regional model, a local model, or a combination of both would offer the best outcomes for our population.

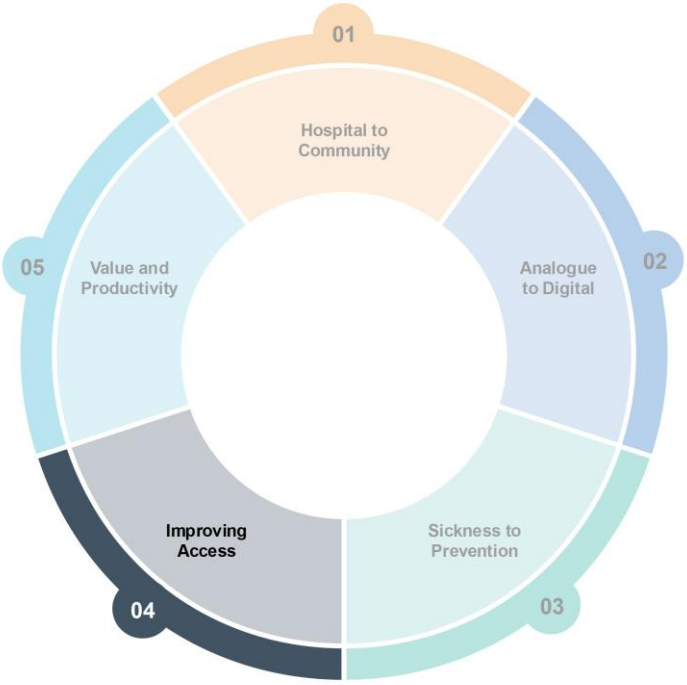
The design of CEW clinics will be based on three core aims:

- Understanding what is driving severe obesity by carrying out a holistic assessment of each child's mental, physical and social needs.
- Treating the health complications linked to severe obesity – making sure children can access other specialist services when needed.
- Providing personalised, family-centred care plans – which may include behavioural coaching, dietary support, mental health input and culturally appropriate interventions to help reduce inequalities.

National early pilot sites have already tested this approach as part of the NHS Long Term Plan ambition to support children with severe obesity-related complications and reduce the need for more invasive interventions. We will build on learning from the regional pilot led by Birmingham Women's and Children's NHS Foundation Trust and review progress at our own local spoke site at Royal Stoke University Hospital – using these insights to shape a high-quality, effective model of care for our area.

Improving access

The section sets out the ambition to ensure timely, equitable and consistent access to high-quality care across all major pathways. These include mental health, children and young people's services, primary care, community services, urgent and emergency care, elective care and cancer. It focuses on reducing long waits, improving digital routes into care, expanding early help, and tackling inequalities for those facing the greatest barriers.



Our ambition

Our overall access ambition is to ensure timely, equitable and consistent access to high-quality care across our pathways of care – meeting or exceeding national requirements by reducing long waits, expanding early help and preventative support, improving digital-enabled access, and tackling inequalities for those with the greatest need.

Transformation and new care models

Urgent and emergency care

We will simplify urgent care access by helping ensure patients are able to access same day urgent care services more easily. This will mean shorter waits for people who require urgent same day care, a better patient experience, and improved care outcomes for all.

During 2026/27, we will:

- Standardise the urgent care front door by embedding urgent treatment centre (UTC) models and strengthening NHS 111 as the default entry point – including bookable arrival times into UTCs and Same Day Emergency Care (SDEC) where appropriate.
- Designate and commission UTCs to national standards to deliver a consistent, front door service for urgent care and reduce avoidable Type 1 (major) ED attendances through better streaming, navigation and choice.
- Support earlier discharge planning, starting at the point of arrival into hospital – with Estimated Discharge Dates recorded and monitored, and improved prioritising discharge of those with "no criteria to reside".
- Continue to strengthen clinical navigation from NHS 111 and 999, primary care and the Integrated Care Coordination (ICC) hub into UTC and SDEC.
- Use digital booking, queue management and clinical decision support to reduce waits and improve experience.

- Continue work to commission a 24/7 single access number and electronic referrals for urgent community services so professionals have a single, simple route to help. The ICC will triage, coordinate and – where clinically safe – manage cases to avoid ED attendance, ambulance conveyance and readmissions.
- Expand capacity outside hospital by growing Urgent Community Response (UCR), virtual wards and SDEC in line with population need – with a clear focus on priority cohorts.

We will strengthen urgent and emergency mental health support to reduce avoidable ED demand and improve outcomes through 2026/27 by:

- Co-locating mental health teams in Type 1 EDs where needs assessments show the greatest impact (2026–29)
- Developing Mental Health Emergency Departments (MHEDs) and Crisis Assessment Centres (CACs), designed to be user-friendly for people with a learning disability or autism. They will provide timely assessment and rapid connection to the right pathway (home treatment, crisis alternatives, community mental health or inpatient care). New MHEDs will provide an appropriate and safe space for Mental Health Act assessments. We will be working to review needs as we work through our capital and estates plans over the five-year planning horizon.
- Using Dynamic Support Registers (DSR) and Care (Education) and Treatment Reviews (C(E)TRs) to identify people at risk of crisis earlier and coordinate proactive support – ensuring awareness and access across primary care, social care, communities and mental health services.
- Building the case for change using clear demand and capacity profiles, map wider crisis pathways, and assess geographic coverage to serve multiple EDs within acceptable travel times.

Planned care, diagnostics and cancer

Our plan will require a significant shift in the way ICBs, trusts and primary care work together to change the way patients access planned care in the future.

Over time, we will innovate care models which will reduce handovers between organisations and reduce wait times for treatment including achievement of national waiting time targets:

- 92% of population first definitive treatment within 18 weeks of referral by March 2029
- 99% of population receive diagnostic test within 18 weeks of referral by March 2029
- 28-day maximum wait for a definitive cancer diagnosis after a referral by March 2029
- 31-day maximum wait from the decision to treat cancer to the start of treatment by March 2029
- 62-day maximum wait from urgent GP referral for cancer to first treatment by March 2029.

We will:

- Continue to work with providers to ensure that capacity and activity plans are informed by robust demand and capacity analysis. This will help us to plan and prioritise resources more effectively so services can meet the needs of our people and improve responsiveness.
- Implement national advice and guidance improvements that will streamline referrals from GPs to Single Points of Access (SPOA) in providers in 2026/27.
- Deliver our five-year System Elective Strategy to get patients the care they need, in the right place, at the right time across Staffordshire and Stoke-on-Trent.

Effective diagnostic services are key to reducing waiting times for elective care services including achievement of the national standard of no more than 14% of patients waiting more than six weeks for a test by 2026/27, reducing this down further to less than 1% by 2028/29.

To support this, we will:

- Continue to develop symptom-based pathways to ensure that all appropriate diagnostics have been undertaken prior to a patient being referred. This will mean that clinical decisions can be made at the first clinical consultation which will support making every contact count.
- Remove tests that provide limited or no clinical value from 2027/28.
- Deliver our five-year Clinical Diagnostic Strategy to expand and modernise diagnostic provision across Staffordshire and Stoke-on-Trent.

The Cancer Strategy is under development, and will focus on earlier diagnosis for cancer, better treatment and improved support aimed to increase cancer survival rates.

To support this, we will:

- Expand straight-to-test pathways, with at least 10 straight-to-test diagnostics operating within community diagnostic centres (CDCs).
- Align our local cancer strategy and cancer action plan to the national plan – ensuring consistency, clarity and a shared approach to improving outcomes in 2026/27.
- Continue to work with the Cancer Alliance on delivery plans to ensure that NHS-wide cancer priorities translate into local action.

Primary care

Central to the broader reforms being delivered nationally and to further strengthen neighbourhood working, there is a continued focus on improving access across primary care. This is critical in managing wider system pressures and improving patient experience.

We will:

- Continue to support GP practices to deliver a Modern General Practice access model to improve patient experience of contact, assessment and allocation to an appropriate healthcare professional or service, improve the working environment for staff, and better align capacity with demand in line with national timescales.
- Use digital pathway tools to improve access – making it easier for patients to get the right care at the right time. Through use of digital tools in terms of local pathways, Advice and Guidance, and shared care records, we will reduce avoidable appointments, improve navigation across primary care, and free up GP capacity – while ensuring access remains inclusive and responsive to patient needs.
- Maximise the breadth and accessibility of primary care services across community pharmacy, optometry, and dentistry (PODs), ensuring seamless patient pathways and enhanced community provision throughout 2026/27 through:
- Pharmacy – Expanding Pharmacy First, blood pressure checks, contraception services and increase Pharmacy First referrals.
- Optometry – Commissioning sight testing in special educational settings to improve equity of access for children and young people with special educational needs and disabilities (SEND) by September 2026.
- Dentistry – Continuing to redistribute under-delivered contracted activity. This will be informed by the outputs of the health equity audit prioritisation areas and in line with our Local Dental Plan. We will also deliver our contribution to the government's commitment to provide an additional 700,000 urgent dental appointments nationally.
- Work closely with general practice in delivering the ambition of 90% same day appointments within general practice for all clinically urgent patients (face-to-face, phone or online) – noting that

this target is still being consulted on nationally. In addition, we will develop winter surge plans to reduce avoidable ED attendances and improve patient experience.
- Introduce ADHD and autism assessments delivered by GPs with a special interest. This will reduce community waiting times (currently more than three years) and increase local capacity – supported by the local mental health service providers.

Medicines optimisation

In recent years, community pharmacies have demonstrated that they can significantly improve primary care access by acting as a first port of call for healthcare – offering services like Pharmacy First (minor ailments), blood pressure checks, and contraception services without an appointment. They reduce pressure on general practice, improve health equity in deprived areas, and support long-term condition management.

In 2026/27, we will:

- Increase community health service capacity through expanding the role and capacity of community pharmacies in line with the nation's ambition of growing from 114,375 consultations (2025 baseline) to 176,284 in 2026/27. As explained above (in the primary care section), these consultations cover treatment of common infections, identification of hypertension, and provision of contraception.
- Introduce a new dermatology service in community pharmacy to expand the service offer through Pharmacy First, which is currently available for the treatment of seven common conditions or infections.
- Build on our success with community pharmacy independent prescribing pilots to develop services that will enable us to target underserved populations for acute care of common conditions, preventative care (including screening), and even better management of long-term conditions.

Mental health

There are an increasing number of people in contact with NHS-funded mental health, learning disability and autism services. To keep up with this demand, the quality of mental health services and the ability to access them – especially for those in crisis and children and young people – must improve to address current unmet needs and reduce the risk of future harm.

Our aim for adult community services is to provide integrated, patient-centred care closer to home. The focus will be on managing long-term conditions, supporting recovery, and promoting independence for people with complex needs (including mental and physical health issues) – by linking with GPs and social care to reduce hospital reliance and improve overall health and wellbeing.

In 2026/27, we will:

- Reduce local inequalities and unwarranted variation in access for children and young people.
- Reduce ill-health related inactivity through access to individual placement and support for people with severe mental illness. We will achieve expansion through a combination of ensuring investment in workforce expansion – ensuring sufficient referral activity and high-quality services through Fidelity reviews.
- Ensure women can access community perinatal mental health services and receive more personalised, equitable, and accessible care. This will include ensuring support extends up to 12 to 24 months postpartum and is also offered to partners – to reduce inequalities. Thematic learning will be informed from patient safety incident response plans and joint maternity and perinatal mental health cases.

- Use ring-fenced funding to support the delivery of effective courses of treatment within NHS Talking Therapies.
- Achieve expansion through a combination of increasing the workforce by 5–7% annually – ensuring sufficient levels and types of referrals and increasing the volume of treatment per person including use of evidence-based digital tools.
- Reduce inequalities by improving access and outcomes of those with protected characteristics, and both younger and older adults.
- Meet waiting time expectations for assessment, and work towards achieving expectations to treatment in-year. The longer a patient has to wait to start treatment, the more likely they will not attend their appointments, drop out of treatment, have poorer clinical outcomes, and a poorer experience overall. We will ensure appropriate measures are taken to reduce waiting times for a second appointment, and where there is a step-up mid-treatment. To support recovery rates, all ICBs should work towards meeting the national targets for Talking Therapies, for 75% of patients to start each course of treatment within 28 days, and for 95% of patients to start each course of treatment within 90 days.

Children and young people

In 2026/27, we will reduce local inequalities and unwarranted variation in access for children and young people (CYP) by:

- Expanding coverage of Mental Health Support Teams in schools and colleges ahead of the ask for full national coverage by 2029. 100% coverage is defined as providing an MHST service to all 5–18-year-old pupils and learners who are on roll within conventional education settings. This includes primary, secondary and post-16 education – including special schools, alternative provision, faith and independent schools and pupil referral units. CYP temporarily absent from education are within scope – along with those categorised as being persistently or severely absent.
- Expanding school interventions to include ADHD and neurodivergence to improve ADHD outcomes delivered via MHSTs and partnerships for inclusion of neurodiversity in schools (PINS) programmes. As school and education policies and practice need to enable children with ADHD to thrive, they require direct links with ADHD health service providers.
- Aiming to meet the national expectation for overall CYP access of at least maintaining the level of access in the August 2025 activity baseline.
- Reducing longest waits for CYP community mental health services by improving productivity. Providers should use their own judgement to find a path to zero 104-week waiters, in the way most clinically appropriate for their local population. The longer-term aim, which will be the focus of planning in future years, is to eliminate 78 and 52-week waits. ICBs and providers should also continue to monitor 78 and 52 week waits, with an ambition to see these reduced alongside.
- Identifying and acting on productivity opportunities including in CYP community mental health services – increasing the number of direct and indirect contacts per whole time equivalent hours worked.

A number of our children and young people are classed as vulnerable, meaning they face increased risks often due to family issues, individual circumstance or societal factors that require specific support from social care, education and health to prevent harm and improve outcomes.

Those who are in care rely on public services to act as responsible, caring ‘corporate parents’ and to make sure their health and wellbeing needs are met. National guidance makes clear that these children often have higher levels of mental health need and must receive timely, appropriate support. Without the right help, these challenges can affect education, relationships and long-term life chances. They can also lead to more crises and high-cost placements.

To change this, we need to move from reacting to problems to providing earlier, trauma-informed support that recognises the impact of abuse, neglect and other adverse experiences. By reinvesting funding released through the West Midlands Child and Adolescent Mental Health Services (CAMHS) Provider Collaborative (Toucan) programme, we will expand access to trauma-informed psychological support, strengthen mental health services for carer experienced children, and embed evidence-based interventions in care settings. This will help prevent crises, reduce placement breakdowns and avoid unnecessary hospital admissions – ultimately improving outcomes for some of the most vulnerable children and young people.

This will be achieved via the delivery of multiple programmes, including:

- Children in care with complex needs two-year pilot
- NHS England's CYP Developmental Service Specification
- Children in care case manager resource attached to Intensive Residential Outreach Care (IROC).

CYP in our care often have complex needs requiring individualised and coordinated arrangements from education, health and children's social care that cannot be met through commissioned provision. To ensure that we are meeting the needs of these individuals, we plan to streamline the joint funding panels for high-needs cases – ensuring panels are timely and effective, and that children and young people receive evidence-based support and therapeutic outcomes.

In 2026/27, we will:

- Develop a single consolidated process with suitable and appropriate decision-making processes and a strong clinical focus, to consider individual health needs. This consolidated process will take into consideration all children with individualised commissioning arrangements – including continuing healthcare, complex CYP panels with local authorities and Education Health Care Plan (EHCP) decisions for funding. This will be service improvement to ensure appropriate alignment of functions, accountability and clinical professional leadership in the decision making of panels.

- There is a strong research base identifying the links between trauma in early years and childhood, and offending behaviours. These vulnerable young people have often not accessed universal health services available to them and a variety of health needs are neglected, impacting on wellbeing, education and community engagement.

In 2026/27, we will:

- Transform the health provision offered to these individuals – enabling vulnerable young people to access assessment and appropriate intervention in a responsive and timely manner.
- Enable a multi-skilled specialist team to provide direct health support and intervention 'in-house' – ensuring that there is 'whole child' approach via tiered levels of support. Services would be responsive to individual need and circumstance, and provided by specialist practitioners with specialist knowledge of youth justice process. This assertive approach and provision of support would offer alternatives to custody.

The Schools SEND White Paper is the government's plan to improve support for children with Special Educational Needs and Disabilities (SEND) in England. Although it has not yet been published, it is expected to focus on giving schools more specialist support through a new model called the 'Team around the School'.

This model aims to:

- Help schools spot children's needs earlier
- Improve how teachers, health professionals and support services work together
- Make mainstream schools and early years settings more inclusive for children with SEND
- Ensure staff have the right support to meet a wide range of needs.

There are already some examples of this kind of joined-up approach, such as:

- **Mental Health Support Teams –** which work directly with schools
- **Partnerships for inclusion of neurodiversity in schools (PINS) –** a national programme that brings specialist help into primary schools
- **Asthma Friendly Schools –** implemented to reduce preventable attacks and emergency admissions.

Once the White Paper is published, we will work with local councils and education providers to design the right support in education settings. A new national framework is also being developed, which aims to improve care for CYP with long-term conditions.

All Age Continuing Care (AACC)

AACC supports some of the most vulnerable people in our communities – including children with complex needs, adults with long-term conditions, and people who need specialist care at home or in residential settings. Our aim is to make sure everyone receives safe, high-quality and compassionate support, in a way that helps them live as independently as possible.

Over the next few years, we will work with local authorities, care providers and community partners to improve the way AACC is planned and delivered.

We will:

- Use technology to make care safer and more reliable by introducing automated appointment reminders, text updates and other simple digital tools that improve communication and reduce missed appointments.
- Streamline the way care packages are arranged by aligning brokerage functions with local councils. This would ensure care is sourced more quickly and consistently, with fair pricing across providers and less time spent on manual processes. The new model will also support complex packages – such as for acquired brain injury and specialist children's continuing care.

Value and productivity

This section explains how we will strengthen value and productivity. It sets out our commitment to ensuring that every pound we spend delivers the greatest possible benefit for local people by reducing waste, and organising services in smarter, more joined-up ways. It outlines how we will streamline processes, cut duplication, shape provider collaborative development, make better use of digital tools, and support freeing up more time for our workforce to focus on delivering high-quality care.

The national 10 Year Plan places productivity and efficiency at the centre of NHS reform, recognising that the NHS cannot continue to operate sustainably without significant improvements in how services are organised, delivered, and supported by technology. National productivity packs developed by NHS England highlight opportunities across areas such as elective care, urgent and emergency care, diagnostics, prescribing and continuing healthcare – and our plan aligns closely with these.

The Strategic Commissioning Framework defines value as “improving outcomes that matter to patients relative to the costs of delivering those outcomes”. This principle underpins our approach to reducing duplication, improving productivity, and ensuring that resources are used wisely to deliver the best possible outcomes for our population.

Our ambition

Our ambition is to create a health and care system where every pound delivers maximum value by streamlining processes, reducing duplication, improving pathways and using digital tools effectively. We aim to manage rising demand, support and equip our workforce, and accelerate the shift towards prevention and community-based care by simplifying how people move through services and reducing delays.

We will strengthen value-based commissioning – ensuring our decisions support prevention, neighbourhood models and reduced dependence on hospital-based care through:

- Utilising a population health management approach to identify opportunities where we can improve outcomes.
- Unifying clinical decision-making and adhering to clinical value-based prioritisation of resources.
- Using behavioural change levers to support frontline staff in delivering care – aligned with agreed evidence-based policies.
- Aligning financial incentives and service design with population outcomes.

This will:

- Reduce unwarranted variation by standardising pathways and sharing best practice – enabling people to receive consistent, high-quality care wherever they live.

- Remove duplication and improve flow, using digital triage, Advice and Guidance, community triage, pathway redesign, UEC modelling and Discharge to Assess (D2A) aligned actions.
- Maximise digital enablers for efficiency – including Docman Connect, NHS App expansion, digital Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) and Electronic Palliative Care Coordinating Systems (EPaCCS), remote monitoring, virtual wards and integrated Electronic Patient Record (EPR) developments.
- Reduce avoidable hospital admissions through stronger neighbourhood-based multidisciplinary teams, early intervention and targeted prevention.

Alongside this, we will continue to enact traditional productivity and efficiency measures to ensure best use of resources to:

- Deliver the ICB-wide efficiency programme – bringing together actions across UEC, planned care, primary care, medicines optimisation, AACC, and community transformation.
- Deliver a financial improvement programme with a minimum of 2% efficiency and productivity target each year.
- Deliver medicines efficiency through biosimilar uptake, AnalyseRx® deployment, robust medicines horizon scanning, and implementation of the Single National Formulary.
- Identify and act on productivity opportunities including CYP community mental health services – increasing the number of direct and indirect contacts per whole time equivalent hours worked.
- Have contracts for providers which are shaped to support the outcomes we want to achieve by setting clear productivity measures to increase the volume and quality of care delivered using existing resources. For example – improving advice and guidance, follow-up ratios, diagnostic hub utilisation, theatre utilisation, length of stay, and day case rates.

We cannot deliver this work in isolation. Many of the changes we need to make rely on strong partnerships across the NHS, local councils, the voluntary and community sector, care providers and our wider system. By working together, we can reduce duplication, share resources more effectively and design solutions that work across whole pathways, not just single organisations.

The following sets out some of the areas where we will need to work with all our partners to support productivity and efficiency.

Urgent and emergency care

Demand for urgent care continues to rise, and this puts pressure on our hospitals, ambulances and community services. To deal with these growing pressures in a planned and proactive way, we need a good understanding of how demand is changing and what this means for our services.

To do this, we will take a series of joined-up actions across the whole system:

- Providers will continuously undertake robust demand and capacity forecasting across all urgent pathways, allowing for accurate modelling to be developed and reviewed. Undertaking accurate modelling for our UEC pathways will support forecasting and better resource alignment to meet local needs. This will support understanding how, with system providers, we move resources to the community to enable the ‘left shift’ and increase appropriate community capacity through multidisciplinary teams and flexible deployment of workforce.
- We will focus on the whole patient journey, not just hospital performance. By improving how people access urgent care, how they move through services, and how they are supported after receiving care – we will deliver better outcomes and a better experience for local people.
- We will deliver these improvements through our UEC Improvement Programme, which brings together a set of linked workstreams designed to strengthen demand management, access, and

patient flow. This work will help improve key measures such as ambulance response capacity and four-hour and 12-hour performance standards.

All Age Continuing Care

The ICB has a statutory duty to ensure that commissioned service complies with the Mental Health Capacity Act 2005 and specifically for patients whose care is fully funded through Continuing Healthcare (CHC) have direct responsibility to apply to the Court of Protection (CoP) for authorisation to deprive individuals of their liberty in community settings. The Court of Protection is a specialist court that makes decisions for people who are unable to make certain decisions for themselves because they lack mental capacity. This might include decisions about their health, wellbeing, care arrangements, or where they live. The court ensures that people's rights are protected, that decisions are made in their best interests, and that any restrictions on their freedom are lawful, appropriate and clearly justified.

We will:

- Develop a joined-up, system-wide approach to Court of Protection processes so that NHS teams, local councils and care providers work to the same standards and follow shared procedures.
- Create shared protocols, pathways and templates so applications are completed consistently, to a high quality, and within the required timeframes.
- Establish a single coordinated approach (and, where appropriate, a lead agency) to reduce duplication, streamline paperwork, and ensure everyone involved understands their role.
- Build a skilled and confident workforce by strengthening training on the Mental Capacity Act and human rights responsibilities – improving legal literacy across the system.
- Support integrated care planning – ensuring decisions about a person's care, capacity and best interests are clearly documented, shared and aligned across agencies.

Planned care

Improving productivity and efficiency across planned care is essential to reducing waiting times, making better use of NHS capacity, and ensuring patients receive timely, high-quality treatment. As demand continues to rise, we must deliver care in smarter, more streamlined ways – removing duplication, cutting unnecessary steps, and using digital tools and modern clinical pathways to work more effectively.

To achieve this, we will:

- Embed new, more efficient models of care by seeking opportunities to commission lead provider models. These models will improve coordination across specialty pathways, enhance patient experience and create the right conditions for innovation – helping the system benefit from economies of scale and improved efficiency.
- Set clear productivity and efficiency standards within provider contracts from 2026. This will include:
- Improving theatre utilisation
- Reducing the number of follow-up appointments
- Increasing the use of Patient Initiated Follow-Up (PIFU)
- Shifting more procedures to day case or outpatient settings
- Using digital tools and redesigned pathways to remove unnecessary steps, reduce delays and support clinicians to work more effectively.

Primary care

By improving digital technology, updating our buildings, and developing our workforce, primary care will be able to meet rising demand, help people manage long-term conditions, and deliver reliable, high-quality care close to home. As primary care providers continue to develop into collaboratives and

neighbourhood teams, Local Enhanced Services (LES) will also need to evolve and adapt to deliver universal services to patients at scale where appropriate to do so.

Primary care will be supported to develop successful networks through the development of GP provider collaboratives to support at-scale delivery of services and to ensure a strong primary care voice within the system. A core aim is for primary care to work in unity with system partners, such as improving estates utilisation and minimising fragmentation.

We will continue to make it easier for services to work well together by simplifying how people move between their GP and hospital care. This includes improving communication, reducing unnecessary paperwork, and cutting down on administrative tasks so that clinicians can spend more time with patients.

Teams from across the system will work together to make referrals simpler and more consistent by streamlining processes, using clearer digital forms, and reducing repeated requests for the same information. Clearer agreements on how care is shared, quicker access to specialist advice, and better support for GPs will help more people be cared for closer to home – with hospital care available when it's needed.

We will also improve the way IT systems connect with each other, promote consistent national standards, and make decision making faster and more efficient. All of this will create a more joined-up, patient-centred experience that reduces delays and helps people get the right care at the right time.

The Primary Care Quality and Contracting Variation Oversight Group will continue to evolve as the single point of monitoring and ensuring the delivery of high-quality services, minimising unwarranted variation and fostering a culture of continuous improvement and shared learning – as well as developing clear action plans in line with national policy. Data sources will include the National General Practice Dashboard, Care Quality Commission (CQC) reports and internal ICB data and intelligence – including a set of intervention levels to focus support and development.

Medicines optimisation

Medicines are one of the largest areas of NHS spend and play a vital role in almost every care pathway. Our focus over the next five years is to ensure that medicines are used safely, effectively and in the most efficient way possible – so that we get the best outcomes for patients while making best use of public money.

We will take a system-wide approach to medicines planning and financial management. This includes developing an ICB-wide medicines efficiency plan (£12.5 million for 2026/27) – setting clear savings and productivity targets and introducing stronger financial controls as neighbourhood health services develop. Our aim is to support financial stability across the local NHS while improving the quality of prescribing and patient care.

National horizon scanning from Specialist Pharmacy Services helps us anticipate future cost pressures and opportunities to make savings. With most of our medicines budget spent in primary care, we will update our commissioning arrangements with general practice to reflect the latest evidence, efficiency opportunities and national policy. We will work closely with pharmacy teams in acute, community and mental health trusts to reduce duplication, share intelligence on high-cost medicines, and maximise value from joint working.

We will continue to strengthen how we review NICE guidance, manage our medicines formulary, and introduce new treatments safely. As national processes change – such as the new NICE appraisal approach and the move to a Single National Formulary – we will update our local systems to match. We will also bring our medicines oversight closer together with wider clinical governance as services change, and build local expertise to safely introduce new areas of care, including genomics.

We will use new national tools, such as 'My NHS GP Tool' and 'My Medicines', to make it easier for people to access services, manage their treatments and reduce medicines waste and harm. We will continue to build on the technology already used locally – such as electronic prescribing, text messaging in GP practices and the NHS App. We will also support community pharmacies to access a single shared patient record so care can be safer, more joined up and based on the most up-to-date information.

In 2026, we have plans to introduce a new digital tool in general practice called AnalyseRx® which will improve the efficiency and productivity of practice-based teams in delivering medicines optimisation services.

Mental health

Across the Midlands, our Mental Health Provider Collaborative has become a major driver of improvement – bringing NHS organisations together to plan and deliver specialist services in a more joined-up and efficient way. By working as a single team instead of separate organisations, the collaborative has already helped reduce the need for people to travel far from home for treatment, cut the use of restrictive practices, and supported quicker, safer discharge.

The collaborative have agreed service line strategies for adult secure, adult eating disorder, CYP mental health, and perinatal mother and baby units. This model has achieved significant improvements in outcomes including a reduction in restrictive practice and out-of-area placements, and reduction in length of stay and improved value, supporting investment in new care models and services across the pathway.

To build on this progress, we will:

- Develop a new commissioning approach ahead of the 2027 contract changes – ensuring services remain sustainable, better aligned with population need and more responsive to changes in demand.
- Strengthen the role of the provider collaborative – ensuring specialist mental health, learning disability and autism services are planned and delivered in a coordinated way across the region.
- Design a more consistent and efficient model for specialist services – including secure care, prison settings, eating disorder services, and CYP mental health (to deliver the CYP Mental Health Developmental Specification in enhancing alternatives to inpatient care), providing intensive support services, and delivering day services and mother and baby units – so people receive the same high standard of care wherever they live.
- Make sure public money delivers maximum impact – reducing duplication, improving productivity and focusing investment on care that improves outcomes and keeps people closer to home.
- Use learning from the collaborative's success to improve quality and safety – including reducing restrictive practices, improving therapeutic care and supporting timely, safe discharge from hospital.
- Work closely with local authorities and national partners to strengthen support for people with the highest level of need – including people with a learning disability or autism.
- Create stronger community alternatives – reducing the need for inpatient care and ensuring more people can access early, preventative support in the least restrictive setting.

Children and young people

Demand for CYP services across Staffordshire and Stoke-on-Trent continues to rise – while current capacity, fragmented commissioning, and national workforce shortages limit the system's ability to meet need. A provider collaborative model offers a strategic route to increase productivity, consolidate scarce specialist workforce, use resources more efficiently, and reduce unwarranted variation across paediatric dietetics and audiology.

Adopting a unified delivery model rather than multiple small, separately commissioned services will enable economies of scale, standardisation of clinical pathways, and more efficient use of clinical time and estate. This will support improvements in throughput, earlier intervention, and a shift from reactive to proactive community-based care.

Adopting provider collaborative models across paediatric dietetics and audiology will generate system-wide benefits, including:

- Reduced unwarranted variation in access, quality, and waiting times.
- Optimised use of workforce, supporting resilience, skill mix, and efficient deployment of scarce paediatric specialists.
- Improved throughput and reduced waiting lists, supporting elective recovery and operational performance trajectories.
- Reduced escalation to hospital care, improving flow and reducing demand for high-cost activity.
- More efficient commissioning, consolidating multiple small contracts into coordinated pathways aligned to outcomes and productivity metrics.
- Improved digital enablement – including shared triage, remote monitoring, and standardised documentation.

Finance

Finance is more than balancing budgets, it is a critical foundation of strategic commissioning and population health improvement. By aligning resources to the areas of greatest need and making sure money is spent wisely, we aim to ensure that every pound spent delivers measurable impact. This section sets out our financial vision, how we will deliver it, and the governance that underpins our approach. This joint plan sets out a unified commissioning finance narrative for Shropshire, Telford and Wrekin and Staffordshire and Stoke-on-Trent over the next five years.

How finance supports the commissioning cycle

Finance is a key enabler across the entire strategic commissioning cycle and underpins the operating model by ensuring resources are aligned to our five big changes and deliver maximum value. During the planning stage, financial analysis and data-driven insights help identify cost drivers, inefficiencies, and opportunities to improve value. Through our procurement activities, finance helps shape contracts and payment mechanisms that incentivise efficiency and shared savings across providers. Finally, in evaluation, financial performance is monitored alongside benefits realisation to ensure investments deliver measurable improvements in health outcomes, productivity, and equity. This integrated approach ensures finance is not just about control, it is a driver of transformation and sustainability.

Delivery of the commissioning plans set out in Section 3 over the period of the plan will require significant changes in how resources are allocated and prioritised, with greater investment moving towards neighbourhood models, proactive care and evidence-based interventions. Our Finance Strategy enables this shift by aligning resources to high-value interventions, strengthening financial controls within neighbourhood health services, and supporting system partners to adopt efficient prescribing practices.

Joint financial vision

Our shared vision is to:

- Return both ICBs to a **sustainable financial position**, no longer reliant on deficit support, by the end of the five-year planning period.
- **Create financial headroom** for commissioning intentions
- Use value-based strategic decision making to guide resource allocation

Context – challenges, opportunities and shared values

The system enters this planning period with significant and longstanding financial deficits. The Medium Term Financial Plan for the ICB sets out a credible route to breakeven by the end of the planning horizon.

We share common cost pressures and opportunities to spend more effectively, which shape our focus, particularly in:

- Urgent and emergency care
- Increasing demand for mental health services which outstrips resource growth
- Productivity and efficiency, for example we have made good progress in areas such as All Age Continuing Care, but there is more we need to do.

Key strategic aims

- **Achieve financial sustainability –** establish a balanced financial position through targeted cost reductions, productivity and efficiency improvements, delivery of transformation programmes, and realignment of resources.

- **Maximise value from investment –** ensure that investment in prevention, community services and digital care grows in line with allocation uplifts. Direct funding towards interventions that improve outcomes, enhance system efficiency and support preventative and community-based care.
- **Enable transformation through strategic investment –** use capital and revenue investment to support service transformation, digital innovation and workforce development, improving quality, efficiency and integration.
- **Embed a culture of financial stewardship –** foster a system-wide approach where all staff take ownership of financial sustainability, ensuring accountability and transparency in financial decision making.
- **Strengthen system-wide collaboration –** work in partnership with local authorities, NHS providers and community organisations to create an integrated approach to financial and healthcare planning.

Governance, assurance and financial rigour

We have strong checks and oversight in place to ensure that every pound spent on local health and care services is used wisely and transparently. Our Finance Committee and Audit Committee regularly review how money is being used, with monthly reports and more detailed quarterly reviews. All of our financial plans follow national rules and standards, and we have robust processes to spot and manage risks such as rising costs or changes in national policy. These measures help us stay on track, make informed decisions, and ensure we can deliver high-quality, sustainable services for our communities.

Oversight and assurance are provided through the ICB Finance Committee, reporting to the ICB Board, including the following areas:

Compliance with national frameworks

Ensuring adherence to the NHS 10 Year Plan, the Medium Term Planning Framework and Financial Framework Business Rules. This includes:

- Delivering in-year capital and revenue resource limits (including Mental Health Investment Standard and Dental ringfence).
- Implementing efficiency and transformation plans to achieve a medium-term breakeven position.

Assurance is supported by monthly finance, efficiency and transformation reports, alongside quarterly thematic deep dives (such as financial updates, Staffordshire and Stoke-on-Trent finance undertakings, and programme-specific reviews such as medicines, continuing healthcare, neighbourhoods and urgent and emergency care).

Management of financial risks

Oversight of strategic and operational financial risks to ensure delivery of financial sustainability and compliance within year limits. Risk management is triangulated across:

- Efficiency and transformation plans
- Workforce considerations
- Operational performance standards
- Quality requirements
- Activity delivery.

Audit Committee oversight

The ICB Audit Committee provides additional assurance to the Board. Its responsibilities include:

- Applying the Well-Led Toolkit, NHS Grip and Control Checklist, and HFMA Financial Sustainability Checklist.
- Monitoring implementation of external and internal audit recommendations and controls assurance.
- Conducting internal audit reviews of efficiency programmes and strategic transformation initiatives – ensuring benefit realisation and embedding lessons learned into future planning cycles.

Financial priorities to support the Five Year Strategic Commissioning Plan

System-wide financial approach

We will continue to manage our finances collectively as a system. Each year, we will refresh and agree the shared principles and behaviours that underpin delivery of our strategic commissioning goals. Local finance groups across Shropshire, Telford and Wrekin and Staffordshire and Stoke-on-Trent will provide oversight, coordination and support to ensure consistent application of these principles.

Contracting approach

Our contracting model will be designed to support the outcomes we want to achieve across Staffordshire and Stoke-on-Trent and Shropshire, Telford and Wrekin. This will include:

- Using gainshare arrangements so partners benefit from shared improvements.
- Introducing year of care and outcomes-based payment models where appropriate.
- Responding to changes in the national NHS Payment Scheme.
- Ensuring a fair and transparent allocation of resources across partners.
- Embedding clear productivity measures, including improvements in:
    - Advice and guidance
    - Follow-up ratios
    - Theatre utilisation
    - Length of stay
    - Day case performance.

Commissioning intentions

Our commissioning intentions will directly reflect the ICB's strategic objectives. Contract discussions will consistently embed the three system shifts – neighbourhood focus, prevention, and digital innovation –alongside our quality and performance standards.

Using a Commissioning for Value framework

Investment decisions will be grounded in evidence and value. A clear Commissioning for Value framework will guide when we invest in new services and when we disinvest or reshape existing resources. This framework will apply to both revenue and capital business cases.

Financial improvement programme

To ensure long-term sustainability, the system will work towards a minimum annual improvement target of 2% efficiency and 2% productivity. This will be delivered through:

- **Strategic commissioning-led transformation programmes –** including neighbourhoods, digital and prevention.
- **Operational improvements –** such as enhanced workforce planning and reduced reliance on temporary staffing.
- **System-wide efficiencies –** including shared services and increased joint working across provider collaboratives.

A joint system approach to capital investment

We will take a system-wide approach to prioritising capital investment – ensuring it supports long-term commissioning intentions. Capital funding will be directed towards:

- Diagnostics – including opportunities for new community diagnostic centres
- Elective recovery and urgent and emergency care
- Mental health and learning disability services
- Community and primary care infrastructure.

Capital planning will be fully integrated into the commissioning process and aligned with national guidance, including the Medium Term Financial Framework and NHS England capital priorities. All schemes will go through a system-wide prioritisation process to ensure alignment with commissioning intentions and constitutional standards. Assurance will include gateway approvals, clinical safety and other appropriate

sign-offs e.g digital technology assessment criteria compliance, and quarterly benefits reporting. This approach ensures transparency, value for money, and delivery of strategic objectives.

Procurement approach

Our procurement activity will ensure best value for our population and full compliance with national rules and Standing Financial Instructions.

We will:

- Ensure fairness, transparency and strong governance.
- Embed sustainability principles, including a minimum 10% weighting for net zero and social value.
- Require alignment with the NHS Net Zero Supplier Roadmap.
- Include sustainability and social value requirements within commissioning specifications.
- Publish annual forward procurement plans aligned to commissioning portfolios.

Investment

As part of our role as a strategic commissioner, we will apply a clear and transparent prioritisation framework to guide how we invest resources over the next five years. This framework will support the ICB, and where appropriate our wider system partners, in making well-informed decisions about revenue investment (over three years) and capital investment (over four years).

The framework provides an agreed set of criteria so that every proposal can be assessed consistently and fairly. Each investment case will clearly set out why the change is needed, how it supports our five major changes, how it contributes to national standards and its impact on equality, quality and safety. Financial implications, contractual requirements, risks and mitigations are also considered. It is supported by a multidisciplinary team including clinical, quality, data, contracting and finance experts, ensuring the process is robust and reflects a range of perspectives.

Risks and mitigations

All financial risks and mitigations will be monitored through the ICB Finance Committee and reported to the ICB Board via the risk register and Board Assurance Framework. This ensures robust oversight, timely escalation and effective mitigation of financial risks across the system.

People and workforce

This section sets out how we will develop, support, and sustain the workforce needed to deliver high-quality health and care services across Staffordshire and Stoke-on-Trent. It highlights the central role of workforce intelligence in the commissioning cycle, the importance of supporting our staff's wellbeing and development, and the actions we will take to strengthen leadership, capability, and collaboration.

Staffordshire and Stoke-on-Trent ICB and Shropshire, Telford and Wrekin ICB both face significant challenges – extreme financial pressures, rising demand in acute services, workforce burnout, sickness absence, and industrial action. These pressures are compounded by nationally driven NHS reforms, clustering arrangements, and new financial allocations. Despite this, the resilience and commitment of staff remains a strength – supported by strong partnership working across health, social care, local authorities, and the voluntary sector. Looking ahead, the National Long Term Workforce Plan (expected summer 2026) will reset workforce ambitions, focusing on retention, wellbeing, skills, and productivity to enable sustainable, community-based, digital-first care models.

Our clustered ICB must transition from operational delivery to strategic leadership – convening partners, setting commissioning intentions, and managing demand through evidence-based planning. This shift requires workforce realignment, new capabilities, and cultural transformation.

The role of workforce in the strategic commissioning cycle

The workforce – our NHS people – are the primary means through which patients receive care and represents the largest cost driver (approximately 70%). Having the right workforce data available, covering experience and wellbeing, stability, supply, and future pipeline throughout the commissioning cycle is essential to ensuring safe, equitable, and sustainable services.

Given the scale of change signalled within our commissioning intentions, the future health and care landscape will require a workforce that is agile, and flexible, under the ethos of 'right staff, right skills, right place' (National Quality Board, 2016). Workforce considerations must sit at the heart of our strategic commissioning approach.

As system leader and convener, the ICB plays a critical role in commissioning a strategically aligned, future-ready workforce, realigning capacity across sectors, directing investment in digital capability, and shaping deployment models that meet population health needs. This includes:

- Commissioning for socio-economic impact through skills pipelines, apprenticeships, and employment pathways.
- Developing integrated neighbourhood and CYP workforce models in partnership with local authorities and providers.
- Embedding proactive, prevention-focused care through community-centred, home-first approaches.

We must also ensure urgent care workforce models balance generalist and specialist roles, and that sufficient capability is commissioned to support wellbeing and self-management.

Enabling change and transformation

Our approach will combine system leadership, organisational development, and targeted workforce planning, alongside building internal ICB capability and looking after our workforce, as follows.

System convening

- Strengthening partnerships and collaboration across NHS, primary care, local authorities, social care, and VCSE sectors to co-design solutions.

System and organisational development

- Commissioning multi-partner workforce strategy and plans, to support neighbourhood health and care models, and associated strategic risk management.
- Implement organisational design, organisational development programmes, and cultural transformation to support transition across the system and within the ICB.

Strategic workforce planning

Strategic workforce leadership, workforce expertise and insights – to enable outcomes-based commissioning of new care and service models, and contract management.

Socio-economic and anchor model

Commissioning for reductions in health inequalities through workforce and recruitment – including local skills supply, apprenticeships, and routes into health and care careers.

- Enabling implementation of the Get Britain Working White Paper and Work Well programmes.
- Strengthening well-established anchor employer approaches across the cluster and system.

Internal ICB competency and capability

Executive and board development will be key, alongside fostering an inclusive culture that champions education, wellbeing, and equality. Together, these actions will create a skilled, resilient, and agile workforce aligned to the ICB's strategic objectives. Building strategic commissioning capability across leadership, analytics, market shaping, and population health management, guided by NHS England's Strategic Commissioning Development Programme.

Looking after our ICB workforce

Prioritising staff health, engagement, and inclusion is essential to reducing burnout, improving retention, and fostering a positive culture. By creating an environment where staff feel supported, heard, and valued – we will strengthen resilience, improve service user outcomes, and enable sustainable transformation. This is of particular importance during reform and transition, as our workforce navigate the challenges associated with clustering and merging the two ICBs.

Our focus includes:

Health and wellbeing

- Building on physical and mental health support provision and offers.
- Promoting flexible working arrangements to support work-life balance.
- Encouraging regular wellbeing check-ins and proactive interventions.

Engagement and voice

Create opportunities for staff to shape decisions through forums and feedback mechanisms.
Recognise and celebrate achievements to build morale and motivation.
Ensure transparent communication about organisational ambition and changes.

Inclusion and belonging

Further embed equality, diversity, and inclusion in all workforce policies and practices.
Robust training and development offer to strengthen and support inclusive leadership.
Foster a culture where every individual feels valued and respected.

Retention and development

- Invest in career pathways and continuous professional development.
- Support succession planning and talent management.
- Address workload pressures through workforce planning and resource allocation.

Enablers

Delivering our strategic commissioning plan depends on a set of enablers that make change possible and support every stage of the commissioning cycle (Planning, Procuring, Evaluation). This section summarises the core enablers and statutory duties that underpin delivery of our Five Year Strategic Commissioning Plan – ensuring we have the foundations, intelligence and assurance required to drive transformation across the system.

It covers population health intelligence, digital and data, and how estates and facilities enable neighbourhood-based, flexible and sustainable models of delivery. It also outlines the wider duties we must meet as an ICB – including our commitments to involvement, sustainability and the Net Zero Green Plan, equality, diversity and health inequalities, research, innovation and improvement, safeguarding and protecting vulnerable people, and emergency preparedness, response and resilience.

Population health intelligence

To improve health and reduce inequalities, we need a clear and detailed understanding of the needs of our population. Population Health Intelligence helps us do this.

By bringing together information from across health and care, we can see:

- Who is most at risk
- Which services people use
- Where inequalities exist
- Where early help will have the greatest impact.

This insight guides our decisions at every stage of the plan. It helps us design services based on evidence, focus support on the communities who need it most, and invest in prevention so that people stay healthier for longer.

Population health intelligence is not a standalone activity – it is considered across all elements of our plan. It will shape how neighbourhood teams work, how we organise services at place and system level, how we prioritise resources, and how we measure progress.

This diagram explains the key ingredients needed for a health and care system to improve the health of its population. At the centre is population health management, which means understanding the needs of local people and planning services that keep them healthier for longer. Surrounding this are four areas that all need to work together.

Infrastructure

Core building blocks for the system to be able to manage population health and wellbeing:

- Organisation and human factors
- Digital infrastructure and maturity
- IG processes
- System vision.

Intelligence

Opportunities to improve quality, efficiency and equity of care gathered from data for improved decision-making:

- Advanced analytical tools
- Analysis and actionable insight
- Alignment of muti-disciplinary analytical and improvement teams
- Development of a cross-system ICS Intelligence function.

Incentives

Creating the environment that supports and rewards integrated care models that address population need rather than organisation objectives:

- Population health contracting and payment models
- Workforce development and modelling
- Enabling governance.

Intervention

Models of care aiming to reduce inequalities and improve quality and efficiency for care through proactive, patient-centred care:

- Care model design and delivery
- Monitoring and evaluation of patient outcomes and impact of intervention to feed into continuous improvement cycle
- Person-centred care
- Community wellbeing voluntary and third sector.

Digital and data

Digital technology and good use of data are essential to providing high-quality, joined-up care. But this is about more than having the right IT systems, it's about building a culture where staff have the skills and confidence to use information well and make informed decisions that improve services.

We will:

- Expand the Shared Care Record, integrate it with the NHS App, and deploy the Federated Data Platform to provide real-time, linked datasets across health and care.
- Roll out national data platforms.
- Establish robust data sharing agreements and governance frameworks to protect privacy and enable safe, appropriate use of linked datasets.
- Build analytical capability within the ICB, including health economists, analysts and data scientists, to interpret complex data and generate actionable insights.
- Develop outcome dashboards and predictive tools to support commissioning decisions and monitor progress in real time.
- Improve forecasting for urgent and emergency care using real-time data and better modelling – helping us understand pressure points across hospitals, community teams, social care, pharmacies and urgent community response services.
- Use tools such as Pathfinder and One Health and Care to support system-wide insight.
- Deliver the data infrastructure needed and agree a data architecture that is fit for purpose and mobilise a plan to deliver it.
- Provide training and support for neighbourhood teams and provider collaboratives to embed digital tools into everyday practice.
- Automate low-value, repetitive tasks and scale approved digital therapeutics to empower patients and free up clinical capacity for more complex care.
- Research and, where feasible, develop AI solutions to support Advice and Guidance and Patient Initiated Follow Up (PIFU).
- Ensure all systems are cyber-secure, resilient and compliant with national standards.
- Enable at least 95% of appointments – after appropriate triage – to be available via the NHS App.
- Use a 'digital by default' approach to support targeted, preventative interventions.
- Support major acute providers to gain approval for NHS business case investment in modern digital infrastructure and ensure all providers transition towards an integrated Electronic Patient Record (EPR) service.

The Digital Transformation Programme follows our 12 digital initiatives:

1. Digitise	2. Connect	3. Transform
Electronic Patient Record Level up access to electronic records & converge on fewer EPR products across the system	**One Health & Care** Digital One Health & Care, sharing data across NHS and local government organisations, and supporting collaboration at a system level.	**Citizen Digital inclusion** Offering greater digital choice for how citizens can access & manage health and care services
Cyber Security & support Ensuring that the ICS Partners' cyber & support approach is robust and serves to uniformly protect the entire system	**Development of data access & BI** Comprehensive, system-level information asset management (aka Corporate DW) to drive evidence-based decision making and service improvement.	**Remote Monitoring & Virtual Wards** Expand technology use to support treatment at home and prevent health issues escalating in vulnerable or at-risk groups.
Infrastructure Convergence Converge hardware and software to reduce variation, moving towards common networks/wireless/connectivity across the ICS	**Population Health Management** Implement PHM to understand the population and thereby enable interventions to address issues that may relate to aspects such as diversity and/or inequality of service provision.	**Automation [RPA]** Expand the adoption to intelligently automate manual, time-intensive and repetitive tasks, reducing duplication and error
Digital Learning An individual budget to upskill staff and individuals to use digital in a way that is aligned to predefined skills pathways		**Artificial Intelligence [AI]** Develop usage of AI to support staff in decision making, diagnosis and completing complex tasks
Digitise Adult Social Care Improving digital maturity of Adult Social Care throughout the ICS		

Collaborative ways of working and model for digital

Putting in place the right Operating Model, Standards and tools to foster collaboration

Estates and facilities

Modern, flexible estates are essential to delivering integrated care and supporting the shift from hospital-based services to neighbourhood and community-led models. Our vision is for a networked, right-sized estate that enables multidisciplinary working, digital-first pathways, and sustainable service delivery. These changes will support the 'left shift' from hospital to community – making care more accessible and proactive. They will also help us meet net zero ambitions by reducing carbon emissions through energy-efficient design and greener clinical pathways.

We will:

- Align estates planning with commissioning intentions and the commissioning cycle.
- Prioritise schemes that expand community and primary care capacity, support diagnostics and elective recovery, and enable urgent care resilience.
- Ensure estates upgrades align with digital infrastructure rollouts – including Shared Care Records.
- Embed sustainability principles in all projects, supported by our Green Plan.
- Work collaboratively with partners to deliver co-located services and neighbourhood models.

Other wider enablers and our statutory duties

Delivering our strategic commissioning plan depends on a broader set of system enablers that ensure we meet our statutory duties as an ICB. These enablers underpin every stage of the commissioning cycle, planning, procuring and evaluation and ensure that services are safe, sustainable, inclusive and effective.

Involvement

NHS commissioning organisations are legally required to involve people who use services in commissioning decisions under the NHS Act 2006. This duty includes involving the public in the planning of services. It also includes involving them when developing and considering proposals for service change.

Public involvement is necessary when decisions could affect the range or manner of services delivered. Genuine involvement goes beyond meeting legal duties. It involves two-way, inclusive conversations with diverse communities. These conversations build a deeper understanding of population needs. They also help identify inequalities and underserved groups early.

Staffordshire and Stoke-on-Trent ICB and Shropshire, Telford and Wrekin ICB both embed engagement throughout governance structures. Staff across both organisations contribute to engagement through their roles and local insight. The ICBs work collaboratively across ICSs to ensure coordinated engagement and decision making that reflects local people's experiences.

The ICBs also prioritise working with the VCSE sector to reach underserved communities. The VCSE sector also helps bring lived experience directly into service design and delivery. In Staffordshire and Stoke-on-Trent, the VCSE Healthy Communities Alliance provides the mechanism for this partnership. The ICB supports its continued development within the ICS.

Neighbourhood-level working is essential to understand local health contexts and inequalities. Strong community involvement supports population health management through better insight. Collaborative relationships with communities help shape care that delivers the best value and meets national expectations. Insight from engagement informs every stage of the commissioning cycle, guiding evidence-based decisions and helping to reduce health inequalities.

Sustainability and Green Plan (Net Zero NHS)

A sustainable, low-carbon health and care system is a core enabler of our Strategic Plan – helping us meet national NHS Net Zero duties while improving population health, reducing costs and increasing long-term resilience.

We will embed the ICB Green Plan across all commissioning and transformation programmes including the rollout of the sustainable impact assessment (SIA), prioritise low-carbon clinical pathways, and ensure estates developments meet modern sustainability standards. System emissions will be reduced through greener travel, medicines, waste and supply chains, supported by expanded digital-first pathways that cut unnecessary journeys.

Working with providers, we will develop and monitor decarbonisation plans and strengthen climate adaptation and resilience measures to prepare for extreme weather and future environmental risks.

Equality, diversity and health inequalities duties

Equality, diversity and inclusion are essential to how we plan and commission health and care services as part of our strategic commissioning role and the commissioning cycle. We want everyone to be able to access good-quality care – and we use data, local insight and lived experience to understand what different communities need. This means working with people, not just planning for them, by involving patients, carers and community groups in shaping services and making sure diverse voices are heard.

Our workforce also needs to reflect the communities we serve, with inclusive leadership and decision making. To support this, we use Equality and Health Inequalities Impact Assessments to check for any unintended consequences, identify risks, and ensure decisions are fair and transparent whenever services are introduced, changed or redesigned.

Research, innovation and improvement

Research, innovation and improvement are key to how we develop better, more effective health and care services, and the ICB has a duty to promote and support this work. We will do this by strengthening research activity across provider collaboratives and clinical networks, adopting proven innovations through national pathways, and using rapid evaluation and improvement methods to test, learn and scale new models of care.

We will also expand the safe and evidence-based use of digital tools and AI to enhance care, improve outcomes and support clinical decision making. A Research and Innovation Strategy has been produced and agreed through the Staffordshire and Stoke-on-Trent, Shropshire, Telford and Wrekin Health and Care Research Partnership (SSHERPa).

Safeguarding and responsibilities for vulnerable people

The safeguarding of children, young people and adults who are at risk is a fundamental obligation for everyone who works in the NHS and its partner agencies. All commissioned services will be required to be compliant with their statutory safeguarding responsibilities and duties, ensuring high standards and

maintaining appropriate training and supervision, supported by system-wide learning and intelligence to identify risks early.

We will also strengthen support for people with complex needs, including those with learning disabilities and autism, to ensure they receive safe, appropriate, effective and person-centred care.

The Children Wellbeing and Schools Bill was introduced on 17 December 2024 and emphasises prevention and early intervention, driving the need for integrated safeguarding responses. This change is formed of two key elements:

- **Families First –** This is the re-introduction of early help support within communities, partnering with non-profit organisations and charities along with health and local authority early help services to meet the needs of children and their families – without any form of statutory intervention. This is being delivered via the family hub model or equivalent within Staffordshire and Stoke-on-Trent.
- **Multi-Agency Child Protection Teams (MACPT) –** Integrated Front Door (IFD) models are being developed to deliver on this change in legislation in both Staffordshire and Stoke-on-Trent. This involves the co-location of children's services, police, housing, probation and health.

In order to deliver safe, high-quality care and engage and support the implementation of child safeguarding multi-agency reforms, we will ensure robust partner arrangements are in place to identify the need for the earliest intervention in order to protect children, young people and adults in accordance with the Children Act (1989 and 2004), Working Together to Safeguard Children (2023) and the Care Act (2014).

Emergency preparedness, response and resilience (EPRR)

The ICB is committed to keeping our population safe by ensuring strong EPRR across the health and care system. We work closely with our NHS providers and local partners – including local authorities, police, fire services and the Local Resilience Forum – to plan for major incidents and manage system pressures.

This includes making sure all providers meet national EPRR standards, maintaining robust business continuity, and ensuring effective surge planning and winter resilience arrangements are in place. By using real-time data and clear escalation processes, we can respond quickly and in a coordinated way to protect patients and maintain essential services.

Risks and mitigations

All major plans carry risks. These may include workforce challenges, financial pressures, digital readiness, inequalities, rising demand, or difficulties in changing how services are delivered. Risks have been identified through the development of the plan by our portfolio and enabling leads.

Each risk has been assessed using a standardised methodology that evaluates both likelihood and impact. This ensures a transparent and consistent understanding of risk severity and supports proportionate and targeted mitigation planning and reporting. Risks are owned by Executive Portfolio Leads and monitored through established ICB committees and aligned risk management processes.

A detailed Risk Register and Board Assurance Framework are maintained internally as part of the ICB's formal governance and are subject to routine oversight. This document provides a strategic level overview rather than the full register developed to support this plan.

Strategic risks

Delivering the ambitions set out in the 10 Year Plan and this five-year commissioning plan requires coordinated action across multiple portfolios, partners, and delivery platforms.

Financial sustainability and the ability to invest

We operate within the financial boundaries of our allocations, with pressures driven by rising demand, inflationary costs, and increasing acuity. Revenue and capital plans carry risk from slippage, cost escalation and uncertainty in national policy and allocations. At the same time, new models of care set out in the 10 Year Plan are not supported by new investment.

Digital readiness, interoperability, cyber security and digital inclusion

Progress towards a digitally-enabled system is being shaped by variation in digital maturity, clinical system limitations, and interoperability challenges that restrict the flow of information across care settings. At the same time, the move to remote monitoring, patient-facing apps and digitally-supported pathways brings a significant digital exclusion risk.

Demand, capacity and system flow across pathways

Increasing demand for urgent care, elective procedures, primary care, community services and specialist pathways continues to outstrip available capacity. Workforce shortages, estates constraints and variation in pathway maturity limit the ability to shift care from hospital to community settings. These pressures affect performance across urgent and emergency care, elective recovery, and long-term condition management.

Delivery of strategic change, partnership alignment and reducing inequalities

The scale of transformation outlined in our plan depends on strong system leadership, coordinated commissioning, aligned incentives and shared delivery across all partners. Risks arise where clinical leadership is limited, where capacity for redesign is constrained, or where organisational reform (including the ICB merger and local government changes) creates uncertainty.

Workforce capacity, capability and cultural readiness

Workforce challenges remain one of the most significant constraints for all ICS partners. Rising demand, sickness, burnout and industrial action continue to impact our teams. In parallel, cultural and organisational development across the system is maturing but needs to be progressed.

How risks will be managed across the cluster

Risk oversight will evolve to be consistent across both ICBs and aligned to maturing joint working arrangements and the future merger.

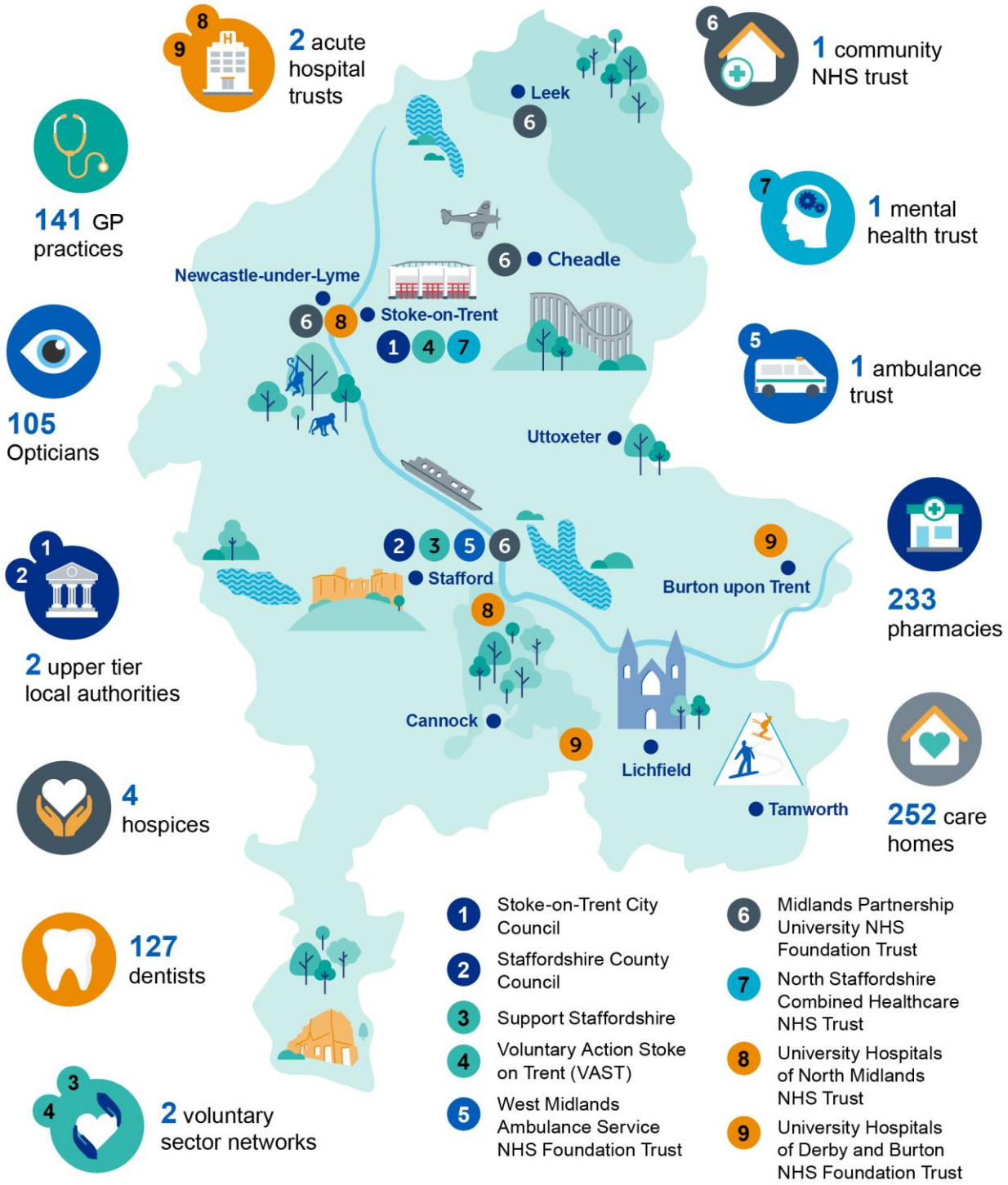
This will ensure a coherent and streamlined approach to identifying, escalating, and managing risk across the cluster:

- **Finance Committee –** risks relating to financial balance, efficiencies, contracting, and capital.
- **Quality Committee –** risks relating to quality, safety, inequalities, and patient experience.
- **Audit Committee –** risks relating to governance, controls, compliance, and internal audit assurance.
- **Strategic Commissioning Committee –** risk ownership aligned to commissioning cycle stages and delivery accountability.

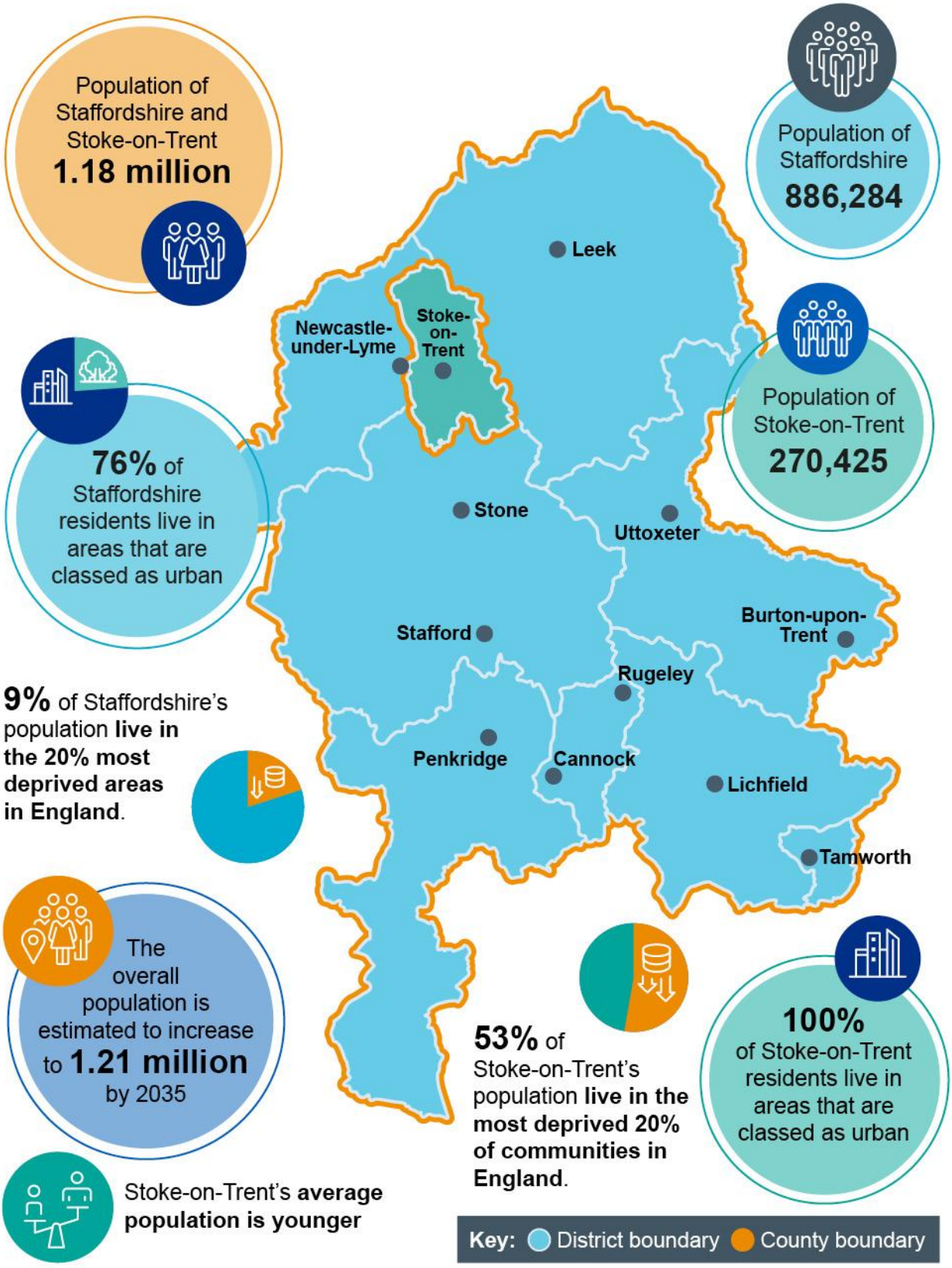
As cluster working progresses, a harmonised Risk Register and aligned Board Assurance Framework will ensure that system risks are clearly understood, consistently assessed, and collectively managed across both ICBs.

Appendix 1 – Our system explained

The Staffordshire and Stoke-on-Trent Integrated Care System (ICS) brings together partners who are responsible for planning and delivering health and care and for improving the lives of people who live and work in our area. The ICS is the geographical area in which health and care organisations work together.



Appendix 2 – Staffordshire and Stoke-on-Trent population



Appendix 3 – Integrated Strategic Needs Assessment (ISNA),

You can download this document on the ICB website.