

NHS STW/SSOT Integrated Care Board

PUBLIC

Agenda Papers

MEETING
26 March 2026 13:30

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20 March 2026

Shared Agenda for Meetings in common of:

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

Integrated Care Board

Thursday, 26 March 2026 / 1:30pm

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

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

	Agenda Item	Lead	Purpose	Format	Time
OPENING MATTERS					
(1)	Welcome and Apologies	Chair	I	Verbal	1:30
(2)	Declarations of Interest: To declare any new interests or existing interests that conflict with an agenda item	Chair	I	Verbal	
(3)	Minutes from previous meeting	Chair	A	Enc.01 Enc.02	
(4)	Matters Arising / Actions from previous meeting	Chair	I/D	Enc.03	
(5)	Questions from members of the public	Chair	I	Verbal	
STRATEGIC DEVELOPMENT AND OVERSIGHT					
(A)	ICB Cluster:				
(6)	Chair's Report	Chair	I/D	Enc.04	1:40
(7)	Chief Executive Report	Simon Whitehouse	I/D	Enc.05	1:50
(8)	Patient Story - CAMHS: Logan's story	Vanessa Whatley	I/D	Enc.06	2:00
(9)	Updated NHSE ICB Collaboration Agreement and Joint Working Agreement	Dr Lorna Clarson	A	Enc.07	2:30
(10)	Involvement Update	Mish Irvine	I/D	Verbal	2:40
(11)	5 Year Strategic Commissioning Plans	Claire Skidmore	I/D	Enc.08	2:50
BREAK 10 MINUTES					3:10

GOVERNANCE AND PERFORMANCE					
(12)	Integrated Performance Report	Claire Skidmore	ToF	Enc.09	3:20
(13)	Transition Committee Update Report	Simon Whitehouse	A	Enc.10	3:40
(14)	'Triple A' Board Committee Highlights Reports				3:50
	a) In Common: Finance and Performance Committee Audit Committee Remuneration Committee Strategic Commissioning & Transformation Committee	Mike Lawton Roger Dunshea Shokat Lal Mike Lawton	A A A A	Enc.11 Enc.12 Enc.13 Enc.14	
	b) STW: Quality and Performance Committee Shropshire Integrated Place Partnership Telford and Wrekin Integrated Place Partnership People, Culture and Inclusion Committee	Cheryl Etches Tanya Miles David Sidaway Mish Irvine	A ToF A A	Enc.15 Enc.16 Enc.17 Enc.18	
	c) SSOT: Quality and Safety Committee Staffordshire & Stoke-on-Trent Health and Care Senate Finance Committee	Siobhan Heafield Rachel Gallyot Mike Lawton	A A A	Enc.19 Enc.20 Enc.21	
(15)	ICB Cluster - Joint SBAF and Risk Register Report	Mish Irvine	S/D/I	Enc.22	4:05
(16)	Any Other Business – notified in advance to Chair	Chair	D	Verbal	4:30
(17)	Review of new or amended risks following discussions in the meeting	Chair	D/A	Verbal	
(18)	Meeting Effectiveness: - Have we upheld the behaviours agreed in the Leadership Compact? - Has there been any learning and how we can improve going forward?	Chair	S	Verbal	
Date and time of next meeting: Thursday, 30 th April 2026 at 1:30pm					

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

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

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

Thursday, 29 January 2026 at 1.30pm
Utttoxeter Suite, Stafford Education & Enterprise Park, Weston Road, Stafford, ST18 0BF

Present:

Ian Green OBE (IG)	Chair (Meeting Chair), NHS STW & NHS SSOT
Simon Whitehouse (SW)	Chief Executive Officer, NHS STW & NHS SSOT
Claire Skidmore (CS)	Deputy Chief Executive Officer and Chief Finance Officer, NHS STW & NHS SSOT
Cheryl Etches OBE (CE)	Non-Executive Director, NHS STW
Prof. Trevor McMillan OBE (TM)	Non-Executive Director, NHS STW
Roger Dunshea (RD)	Non-Executive Director, NHS STW (Virtually)
Siobhan Heafield (SH)	Non-Executive Member, NHS SSOT
Shokat Lal (SL)	Non-Executive Member, NHS SSOT
Mike Lawton (ML)	Non-Executive Member, NHS SSOT
Vanessa Whatley (VW)	Interim Chief Nursing Officer, NHS STW
Heather Johnstone (HJ)	Interim Chief Nursing Officer, NHS SSOT
Phil Smith (PS)	Interim Chief Delivery Officer, NHS STW & Chief Delivery Officer, NHS SSOT
Dr. Lorna Clarson (LC)	Chief Officer of Strategy and Improving Outcomes, NHS STW & NHS SSOT
Dr Rachel Gallyot (RG)	Interim Chief Medical Officer, NHS STW & NHS SSOT
Joanne Williams (JW)	Trust Partner Member and Chief Executive Officer, The Shrewsbury and Telford Hospital NHS Trust and Shropshire Community Health NHS Trust
Stacey Keegan (SK)	Trust Partner Member and Chief Executive Officer, The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Dr Buki Adeyemo (BA)	Trust Partner Member and Chief Executive, North Staffordshire Combined Healthcare NHS Trust
Simon Constable (SC)	Trust Partner Member and Chief Executive, University Hospitals of North Midlands
Dr. Ian Chan (IC)	Primary Care Partner member, NHS STW
Dr Joanna Chan (JC)	Primary Care Partner Member, NHS SSOT
David Sidaway (DS)	Local Authority Partner Member and Chief Executive Officer, Telford and Wrekin Council (Virtually)
Patrick Flaherty (PF)	Local Authority Partner Member and Chief Executive, Staffordshire County Council

In Attendance:

Mish Irvine (MI)	Chief of Staff, NHS STW & NHS SSOT
Claire Finn (CF)	Financial Recovery Director, NHS STW & SSOT
Dr Paul Edmonson-Jones (PEJ)	Transition Director, NHS SSOT
Liz Lockett (LL)	Chief Nurse, Midlands Partnership University NHS Foundation Trust
Dr Tony Ahmed (TA)	GP Partner (Dental), NHS SSOT
Tanya Miles (TMS)	Interim Chief Executive Officer, Shropshire Council (Virtually)
Andrew Morgan (AM)	Chair in Common, Shropshire Community Health NHS Trust and Shrewsbury & Telford Hospital NHS Trust

Jacqueline Small (JS)	Chair, Midlands Partnership University NHS Foundation Trust (Virtually)
Melissa Michael (MM)	Senior Statutory Grants Officer, SSAFA (Virtually)
Terry Gee (TG)	Healthwatch, Telford and Wrekin (Virtually)
Jan Suckling (JSG)	Lead Engagement Officer, Healthwatch Telford and Wrekin
Lynn Cawley (LCY)	Healthwatch Shropshire
Clare Trenchard (CT)	Healthwatch Stoke-on-Trent
Dr. Charlotte Hart (CH)	Joint Chair of GP Board, STW
Paul Winter (PW)	Associate Director of Corporate Governance, NHS SSOT
Claire Colcombe (CC)	Board Secretary, NHS STW

Apologies:

Dr Niti Pall	Non-Executive Member, NHS STW
Neil Carr (OBE)	Trust Partner Member and Chief Executive Officer, Midlands Partnership University NHS Foundation Trust
Jon Rouse (CBE)	Local Authority Partner Member and Chief Executive Officer, Stoke-on-Trent City Council
Dave Bennett	Associate Non-Executive Director, NHS STW
Julie Houlder	Non-Executive Member, NHS SSOT

Minute No. ICB-26-01.001a – Welcome & Apologies

- 001a.1 IA welcomed all attendees to the meeting and noted that this was a meeting held in public. Members of the public were invited to observe the proceedings, and IA emphasised the Boards' commitment to openness and transparency. An opportunity had been provided for the public to submit questions in advance. Six questions were received, and written responses will be provided following the meeting. These responses will also be published on both ICB websites. As the meeting is held in common between two ICBs, IA highlighted that each ICB currently operates different approaches to handling public questions. Time will be taken as joint working develops to determine the most appropriate and consistent approach for future meetings held in common.
- 001a.2 Apologies were received and noted. Julie Houlder and Dr. Niti Pall were unable to attend, and this meeting would have been their last meeting for their respective ICBs, and IA thanked them both for their valuable contributions. Members were asked if any further apologies needed to be recorded but none were raised.
- 001a.3 IA reminded colleagues joining online that if they were members of the ICB Boards, they were welcome to contribute to the meeting. Those wishing to speak were asked to raise a hand to signal their intention. All participants were requested to remain muted when not speaking to ensure the smooth running of the meeting.

Minute No. ICB-26-01-001b – Leadership Compact

- 001b.1 IA reminded members of the Leadership Compact included within the meeting papers. It was noted that the Compact is currently a document owned by the Staffordshire and Stoke-on-Trent Integrated Care Board. However, IA expressed the expectation that colleagues from Shropshire, Telford and Wrekin Integrated Care Board would recognise the Leadership Compact as setting out the principles and standards of conduct by which meetings should be undertaken. IA requested that the Leadership Compact be adopted consistently across both Integrated Care Boards to support alignment and shared ways of working as the joint meeting arrangements develop.

Action – Leadership Compact to be adopted consistently across both Integrated Care Boards to support alignment and shared ways of working as the joint meeting arrangements develop - SW/MI

Minute No. ICB-26-01-002 – Members’ Declarations of Interests

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

[NHS Shropshire, Telford and Wrekin ICB - Register of Interest - January 2026](#)

[NHS Staffordshire, Stoke-on-Trent ICB - Register of Interest - January 2026](#)

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

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

Minute No. ICB-29-01.003 – Minutes of the previous meetings held on: STW – 26 November 2025 and SSoT – 20 November 2025

003.1 IA introduced the minutes of the previous meetings for approval. The minutes of the Shropshire, Telford and Wrekin ICB meeting held on 26 November 2025 were reviewed, and members were asked to confirm any issues relating to accuracy. No amendments were raised, and the minutes were approved as an accurate record of the proceedings.

003.2 The minutes of the Staffordshire and Stoke-on-Trent ICB meeting held on 20 November 2025 were then considered. These had been circulated in advance, and no corrections were requested. The minutes were therefore approved as a correct record.

RESOLVE: The NHS Shropshire, Telford and Wrekin Integrated Care Board and NHS Staffordshire, Stoke-on-Trent Integrated Care Board **APPROVED** the minutes of the previous meetings held on 26 November 2025 and 20 November 2025.

Minute No. ICB 29-01.004 – Matters arising and action list from previous meetings

004.1 IA introduced the matters arising and reviewed the outstanding actions from previous meetings. The actions relating to the Shropshire, Telford and Wrekin ICB were considered first.

- Minute No. ICB 25-09.207 – Update on Quality Oversight of Primary Care – Completed and agreed to close.
- Minute No. ICB 25-09.208 – Infrastructure Strategy – Completed and agreed to close.
- Minute No. ICB 25-09.214 – LeDeR Annual Report 2024/25 including Learning Disability Mortality Review Annual Report – Confirmed that an update will be included within the Annual Report for 25/26 - 23/10/2025 – Agreed to close.

004.2 Three actions arising from the previous Staffordshire and Stoke-on-Trent meeting were also reviewed. All three actions had been completed, and the recommendation to close each of them was accepted. No further matters arising or additional actions were identified for discussion. Members confirmed that all items marked for closure could be formally closed.

RESOLVE: The NHS Shropshire, Telford and Wrekin Integrated Care Board and NHS Staffordshire, Stoke-on-Trent Integrated Care Board **NOTED** the updates provided to the action list.

Minute No. ICB 29-01.005 – Questions from Members of the Public

- 005.1 IA noted that six questions had been submitted by members of the public in advance of the meeting. Written responses to these questions will be prepared following the meeting and published on both ICB websites. Until a unified approach is established for managing public questions across the two ICBs operating in common, the current STW ICB Board arrangements will be used.

RESOLVE: The NHS Shropshire, Telford and Wrekin Integrated Care Board and NHS Staffordshire, Stoke-on-Trent Integrated Care Board **NOTED** that six questions had been received from the members of the public.

Minute No. ICB 29-01.006 – ICB Cluster Chair's Report

- 006.1 IA presented the report and confirmed that the paper was taken as read. IA reported one item of note relating to an urgent decision taken by the Staffordshire and Stoke-on-Trent ICB Board. This decision had been progressed in full accordance with the required governance processes, including appropriate consultation and submission through the necessary approval channels.
- 006.2 The Board was asked to ratify the prior Urgent Decision taken by IA on 15th January 2026, and to be assured that all ICB governance had been properly followed in doing this.
- 006.3 Members were invited to highlight any specific matters requiring the Board's attention. No matters were highlighted.

RESOLVE: The NHS Shropshire, Telford and Wrekin Integrated Care Board **RATIFIED** the prior Urgent Decision taken by the IA on 15th January 2026, and to were **ASSURED** that all ICB governance had been properly followed in doing this.

Minute No. ICB 29-01.007 – ICB Cluster Chief Executive (CEO) Report

- 007.1 SW presented the report, noting that all papers were taken as read. He highlighted key areas of activity, beginning with progress on the Integrated Care Board governance reset programme. The first phase of the voluntary redundancy programme was nearing completion, and full consultation was now underway with the senior leadership team following the completion of the Executive structure process prior to Christmas. Work would continue to develop the operating model and committee structures, with updates to be discussed later on the agenda. The Board's attention was drawn to an NHS England (NHSE) checkpoint meeting held recently, with an update provided in the report. The Board was also informed of the Board Assurance Statement that was required to be submitted to NHSE. SW acknowledged that some Board members, particularly Non-Executives Members, might be less closely involved in aspects of the governance transition and emphasised the need to carefully manage how the Board reaches collective assurance. To address this, all Non-Executive members were now invited to the Joint Transition Committee.
- 007.2 SW updated the Board on recent meetings, including Chief Executive sessions held across both Staffordshire & Stoke-on-Trent and Shropshire, Telford and Wrekin. He attended the topping-out ceremony for the Hospital Transformation Programme at the Royal Shrewsbury Hospital, led by AM and JW. He also welcomed the visit of Chief Medical Officer Professor Sir Chris Whitty to Shropshire, whose forthcoming national report will focus on rural health; the visit included discussions on rurality and associated challenges. SW recognised recent honours awarded to several colleagues: Jill Boast

(MBE) (Primary Care Senior Nursing), Ann Marie Riley (OBE), and Kate Taylor Whittenham (MBE). He thanked all teams and partners for their continued efforts in managing winter pressures, noting that further detail on urgent and emergency care was provided later in the papers.

- 007.2 The Board was asked to receive the report and be assured that the leadership team are working on each topic as detailed.
- 007.3 In response to IA's request for further context on the forthcoming Board Assurance Statement, SW outlined the areas requiring Board consideration. These included the Integrated Care Board's (ICB) progress against the operating model in response to the nationally published model blueprint and good practice guidance; development of a sustainable and affordable operating model; progress through the phased organisational change process; and readiness to deliver an effective strategic commissioning function. He noted that while full implementation would continue into 2026/27, the ICB had a clear glide path and governance structure to support delivery.
- 007.4 A query was raised regarding the dental care incentive scheme, noting that only 50% of practices in Shropshire had taken up the scheme. SW invited further detail from senior colleagues, who explained that, although the uptake figure appeared low, the urgent dental care provision was geographically well-distributed, ensuring access across the population. Good feedback had been received, and contractual changes due from 1 April 2026 were expected to strengthen the offer. Work to improve access remained ongoing.
- 007.5 A representative from Healthwatch raised several questions regarding mental health services, noting that mental health had been identified as the top priority for residents in their annual survey. Questions focused on the scope for learning transfer from all-age autism and ADHD review, the coverage of the NBFT-commissioned E-service, access issues for children removed from school, and concerns about potential keyword filtering within the mental health text messaging service. SW welcomed the feedback and confirmed that further detail on the text service would be reviewed and responded to; learning from one area should be shared across both ICBs where appropriate; and clarification would be sought regarding E-service availability across Staffordshire and Stoke-on-Trent. The relevant teams would provide follow-up responses.
- 007.6 IA thanked SW for the report and reminded contributors to introduce themselves when speaking.

ACTION: *Responses required from relevant teams relating to further detail on the text service and clarification on E-service availability across Staffordshire and Stoke-on-Trent - SW*

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

Minute No. ICB 29-01.008 – Residents/Community Story – NHS Staffordshire, Stoke on Trent – End of Life Care

- 008.1 IA introduced the resident story item, noting the value of beginning the meeting with a reflection on lived experience. HJ presented a powerful patient story concerning end-of-life care within the Staffordshire and Stoke-on-Trent area. She expressed sincere thanks to the resident who had generously shared the story of his late wife. HJ explained that although the wife was a Staffordshire and Stoke-on-Trent resident, the

issues highlighted were relevant to patients and carers across the country. A short video was shared summarising the wife's five-year experience of frontotemporal dementia and the repeated crises her family faced because of fragmented care, poor continuity, rushed discharges, and limited coordination across services. The video concluded by emphasising the profound impact of system failings and the importance of learning to prevent future experiences of this nature.

- 008.2 Following the video, HJ reflected on the need for the cluster to consider how learning from this experience could support improvements in system processes, joined-up working, and patient-centred care.
- 008.3 IA reiterated its importance as a catalyst for collective learning. He emphasised the need for the system to move away from organisationally focused pathways towards care that is genuinely built around individuals and their families.
- 008.4 Reflections highlighted that longstanding challenges in end-of-life care continue to affect families, and there was agreement that improvements must be clearly felt by those using services. The discussion stressed the importance of keeping patients and families at the centre of decision-making, particularly at critical moments where there is no opportunity for a second chance. It was noted that the experience shared reflected wider system challenges, reinforcing the need for stronger community-based care and more effective shared care records to support complex needs at neighbourhood level. Queries were raised about where system-wide conversations on improving end-of-life pathways should take place, and it was confirmed that this work sits within neighbourhood and place-based development, requiring close collaboration across primary care, community services, local authorities and the voluntary sector. While some progress has been made, further work is needed to deliver visible improvements for residents.
- 008.5 Further reflections highlighted the essential role of families and carers. The Board was reminded that carers often felt excluded from key decisions, with examples given of family members not being involved in creating Respect forms. It was stressed that training and awareness should be embedded across all staff groups by the relevant agency.
- 008.6 SW confirmed that end-of-life care and neighbourhood development had been discussed at the recent Board strategy session, though no public-facing document was yet available. He proposed bringing forward an update to a future public Board meeting to support visibility and collective input.
- 008.7 IA concluded the item by requesting that Heather formally convey the Board's thanks to the resident for sharing the story and for his contribution to learning across the system.

ACTION: *Provide an update on end-of-life care and neighbourhood development at a future public Board meeting - SW*

Minute No. ICB 29-01.009 - SBAF

- 009.1 MI presented the report and noted that substantial detail had been included within the papers. Both ICBs had made full updates, and progress was clearly documented. Overall, she reported that risk positions remained relatively static, with high-level risks continuing to feature prominently. There were, however, no identified gaps in control measures at this stage.

- 009.2 MI advised that, for the purposes of the current meeting, risk reports from the two ICBs continued to reflect distinct approaches to risk management. Looking ahead, work would begin to harmonise the two frameworks, including the respective risk registers with the aim of drawing together the strengths of both systems. This harmonisation would support the development of a consolidated SBAF for the Cluster Board, enabling future meetings to receive a single integrated report rather than separate linked documents. She noted that timing would be important, given the need to first align risk strategies and to take into account the internal audit currently in progress. Subject to this, the intention was to bring forward an integrated SBAF to the next meeting.
- 009.3 IA welcomed this approach, noting that there were clear common themes across both ICBs' risks. He emphasised that once shared risks were identified, they should directly inform the Board's agenda planning and the focus of the Cluster Board's scrutiny. This would ensure that the Board maintained oversight of the key strategic risks facing the system and monitored progress in mitigating them.
- 009.4 The Board was asked to consider whether the risk levels and assurance assessments are an accurate reflection of the position and discuss and confirm the adequacy of those controls and assessments.
- 009.4 During discussion there were comments on the importance of the SBAF, noting that while risk documentation could appear technical or dry, it played a vital role in showing where responsibilities lay, how committees linked together, and how assurance was provided across the system. The work undertaken to prepare and present the reports was commended.
- 009.5 There were no further questions.

ACTION: *Bring an integrated SBAF to a future meeting – MI*

RESOLVE: **The NHS Shropshire, Telford and Wrekin Integrated Care Board and NHS Staffordshire, Stoke-on-Trent Integrated Care Board CONSIDERED whether the risk levels and assurance assessments are an accurate reflection of the position and DISCUSSED and CONFIRMED the adequacy of those controls and assessments.**

Minute No. ICB 29-01.010 – Short and Medium Term Planning

- 010.1 CS provided an update on progress with the planning process. She noted that NHS organisations were now fully engaged in the national planning cycle and that a series of committees and Boards would convene to agree the forthcoming year's plans. The update summarised progress since the initial draft submissions in December and outlined the next steps leading up to the final submission and associated Board assurance requirements.
- 010.2 CS reported that a third-year financial allocation had now been issued, supplementing the two-year allocation received prior to Christmas. Consequently, all financial plans were being developed on a three-year basis. Work continued on revenue and capital planning, alongside activity and performance plans, to ensure alignment with system priorities and the delivery ambitions for future years. Significant focus remained on triangulating finance, activity, and workforce plans to ensure consistency and robustness, particularly within provider organisations.
- 010.3 In addition to the technical submissions made before Christmas, work was also progressing on the ICB's five-year commissioning plan, accompanied by provider delivery plans. CS confirmed positive progress across both ICBs and emphasised that

current efforts were centred on optimising resources to support performance recovery, constitutional standards, and broader system objectives. Although the timeframe was challenging, she expressed confidence that all partners would meet the submission deadlines.

- 010.4 Boards would be required to sign off Board Assurance Statements confirming confidence in the plans and their deliverability. Further detail would be discussed later in the private session of the meeting, recognising that some elements could not yet be discussed publicly as plans had not been validated or agreed by NHS England. A further meeting would be scheduled before the submission deadline to provide an update and seek final approval.
- 010.5 The Board was asked to note the 17th December submission; note the development of a 5-Year Strategic Commissioning Plan and note the next steps required to meet the final submission deadline of the 12th of February.
- 010.6 IA asked two questions, the first concerning the level of alignment between provider plans and ICB plans, and the second on feedback received from NHS England following the initial draft submission. CS reported that close joint working had significantly reduced the risk of misalignment. While some differences were identified, these were expected for this stage of the process and were already being worked through. No material issues had been escalated, and both ICB teams confirmed that the areas of variance were known and actively managed. Regarding NHS England feedback, Mrs Skidmore confirmed that comments had largely been practical in nature. The overarching expectation remained that both ICBs would deliver a break-even position (with deficit support) and meet required performance standards. Regular updates continued with NHS England to ensure shared understanding of progress, ambition, and the narrative underpinning the three-year plan.
- 010.7 IA noted the report and confirmed that further discussion would take place later in the private session.

ACTION: *Schedule further meeting for an update and final approval of the Board Assurance Statement ahead of submitting to NHSE - CS*

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

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

Minute No. ICB 29-01.011 – Winter Plan Delivery Update

- 011.1 PS introduced the paper and took it as read. PS summarised the progress in implementing the winter plans approved by both ICB Boards in autumn. He reported that winter pressures had begun earlier than expected, with flu and RSV activity approximately four weeks ahead of national projections. This created operational challenges at the end of November and into early December. The period was further affected by junior doctor industrial action in the run-up to Christmas, adding strain to patient flow and delivery of planned schemes.
- 011.2 Despite these pressures, PS highlighted significant achievements across the system. Acute bed occupancy heading into Christmas was notably improved, standing at 78% at UHNM and 82% at SaTH. This created essential capacity as the system moved into

the New Year. Both systems experienced challenges with discharge profiles over Christmas and New Year, combined with increased acuity typical of the season.

- 011.3 PS commended the mobilisation of winter schemes across the cluster, including the introduction of 56 additional acute beds at UHNM, 40 assessment beds at SaTH, 40 extra community beds in Staffordshire & Stoke-on-Trent, enhanced integrated coordination, extended Urgent Community Response (UCR) hours, and rapid access to domiciliary care. Referral volumes to the integrated single point of access in Staffordshire were at their highest levels to date, signalling strong system engagement.
- 011.4 He noted that while performance remained below desired levels, A&E four-hour performance at 64% (UH&M) and 53% (SaTH), and Category 2 ambulance response times at 43 minutes (SSoT) and 40 minutes (STW), these represented meaningful improvements on the previous year. PS highlighted innovative developments such as the newly launched X-ray car pilot at UHNM and MPFT, and ongoing work on ambulance release-to-respond times to return to the 45-minute standard. Learning events were planned for post-Easter, with findings to be reported through committees and the Board.
- 011.5 The Board was asked to note the update.
- 011.6 SC reported that winter pressures continued but system resilience and joint working had improved significantly. Support from national UEC improvement teams was positively influencing clinical flow and ambulance release times, with early signs of sustained improvement.
- 011.7 JW confirmed similar experiences in Shropshire, Telford and Wrekin. Winter planning had commenced unusually early in February 2025, resulting in increased bed capacity and strengthened community response. She noted that the system had not declared any critical incidents this winter, a marked improvement from previous years, while acknowledging the impact on increasingly fatigued staff.
- 011.8 IA thanked both CEOs and emphasised the importance of recognising the sustained hard work of frontline teams. He reiterated the need to capture and apply learning throughout the year.
- 011.7 SW commended the strongest level of partnership working seen in recent years across primary care, community services, mental health, local authorities, and the voluntary sector in both ICB areas. He noted significant progress in Staffordshire & Stoke-on-Trent since his previous tenure.
- 011.8 JC confirmed high pressures in general practice but highlighted successful schemes such as same-day service models, which had improved access, patient satisfaction, and winter capacity.
- 011.9 RG stressed the impact of improved vaccination uptake and the importance of maintaining this focus annually.
- 011.10 CE sought assurance regarding harm reviews related to delays in care. VW confirmed that harm reviews were closely monitored, showing that harm remained rare; delays in care were more common but were systematically assessed and fed into continuous improvement processes. Quality planning remained a central element of winter preparedness.

- 011.11 The Board noted the contribution of services outside the immediate cluster footprint, with assurance provided that quality and safety oversight extended to partner systems delivering care to local residents. Appreciation was expressed to the communications team for simplifying winter messaging for the public.
- 011.12 IA thanked all contributors and noted the progress achieved, while recognising that performance levels remained below expectation and would require continued focus. He emphasised the need to maintain system learning throughout the year and ensure ongoing improvements in winter resilience.

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

Minute No. ICB 29-01.012 – NHS Reset – Proposed Governance Changes

- 012.1 MI summarised the extensive work undertaken to support closer working between the two ICBs and to progress the cluster operating model. The report set out four key areas of development:
1. Appointments to Both Boards
MI confirmed the appointment of designated individuals to serve across both Integrated Care Boards (ICB), congratulating colleagues named in the paper. This marks a further step towards more integrated leadership arrangements across the cluster.
 2. Committees in Common and Governance Streamlining
Work was underway to move to committees in common across the two ICBs, with the aim of establishing more streamlined and aligned governance processes. MI advised that while committees-in-common were the immediate approach, there was a preference to progress towards full joint committee status from 1 April 2026, subject to further work and approval.
 3. Future Merger of the Two ICBs
The Board noted NHS England's expectation that the two ICBs should merge in due course. Both Boards confirmed their intention that the existing ICBs be dissolved and replaced with a single ICB from April 2027. This commitment was recognised as an important step in enabling long-term alignment of functions, strategy, and resources.
 4. Proposed Changes to ICB Board Membership
MI highlighted proposed amendments to the ICBs' constitutions which included a reduction in the number of partner members, participants, and observers attending the Board. She acknowledged potential conflicts of interest given the impact on current attendees and noted that further discussion would take place in the private session. The Board was asked to consider and approve the proposed constitutional amendments to support these changes.
- 012.2 Additional actions were outlined, including the commitment for the Staffordshire & Stoke-on-Trent ICB to develop strengthened place-based boards, and the requirement for both ICBs to approve the constitutional updates prior to submission to NHS England.
- 012.3 The Boards of NHS STW and NHS SSOT were asked to:

- To NOTE the appointments of Non-Executive Members to the Boards of NHS STW and NHS SSOT as set out in section 2.1. and APPROVE appointment to the Deputy IA and Senior Independent Director role.
- To NOTE the post-November 'early adopter' developments and new external factors, and to SUPPORT the original proposal made for all Committees to adopt full Joint Committee status effective 1st April 2026.
- To NOTE the expectation of merger of the two ICBs by NHS England and SUPPORT the direction of travel towards merger and CONFIRM the desire of both Boards that the two existing ICBs be dissolved and a single ICB created in April 2027, to cover the wider geographical areas of Shropshire, Telford and Wrekin, Staffordshire and Stoke on Trent.
- To CONSIDER and APPROVE the proposal to amend the ICBs' Constitutions to reduce the number of Partner Board Members, Participants and Observers as set out above in section 2.2 in this report, for onward recommendation to NHS England for ratification.
- To APPROVE the proposed changes to the ICBs Constitutions outlined in appendix 1, for onward recommendation to NHS England for ratification.

The Board of NHS SSOT was also asked to:

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

012.4 IA reflected on discussions held before Christmas and within development sessions, noting a clear direction of travel toward a merged organisation and the need for the cluster to operate increasingly as a single entity. He emphasised that while governance must become more streamlined, there must also be strong and visible engagement with providers and system partners. Development sessions would be used more effectively to ensure wide-ranging involvement in shaping future strategy and to retain the richness of provider and stakeholder insight.

012.5 SW added that the shift towards a strategic commissioning model required reconfiguration of Board membership to reflect future responsibilities and to minimise conflicts of interest. However, it was equally important that strong partnership working, and system development were maintained through other engagement mechanisms, even if not formally through Board attendance.

012.6 Board members and observers were invited to comment.

- AM expressed full understanding of the need to reduce Board size, recognising that the current number of attendees was no longer sustainable. He emphasised that provider involvement remained critical to successful system delivery but accepted this did not need to take place through membership of the Board.
- Healthwatch representatives expressed their appreciation for being included at Board meetings to bring the public voice. They raised concerns about how the Board would continue to demonstrate transparency and engagement with the public if Healthwatch were no longer present at the table. They encouraged the development of mechanisms to ensure the patient voice continued to shape decision-making, including the potential for shared work across the cluster and ongoing visibility of Healthwatch reports within public forums.

012.7 IA and MI acknowledged the importance of public and patient voice and confirmed that work was underway to review governance routes for engagement across both ICBs.

The Board agreed that proposals on this should be brought back to the next meeting in common, in March.

- 012.8 DS noted the need to protect effective commissioning relationships between the NHS and councils, emphasising the importance of coherent joint commissioning. IA agreed, highlighting the role of strengthened place-based boards in enabling more integrated planning and delivery.
- 012.9 IA concluded the item by congratulating Michael Lawton, Non-executive Director on his appointment as Deputy Chair and announced a short adjournment before the next session.

Action: Bring forward proposals to the next Board meeting in common, on how the public voice, including Healthwatch, will continue to be integrated into decision-making processes - MI

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

- **NOTED** the appointments of Non-Executive Members to the Boards of NHS STW and NHS SSOT as set out in section 2.1. and **APPROVED** the appointment to the Deputy IA and Senior Independent Director role.
- **NOTED** the post-November ‘early adopter’ developments and new external factors, and **SUPPORTED** the original proposal made for all Committees to adopt full Joint Committee status effective 1st April 2026.
- **NOTED** the expectation of merger of the two ICBs by NHS England and **SUPPORTED** the direction of travel towards merger and **CONFIRMED** the desire of both Boards that the two existing ICBs be dissolved and a single ICB created in April 2027, to cover the wider geographical areas of Shropshire, Telford and Wrekin, Staffordshire and Stoke on Trent.
- **CONSIDERED** and **APPROVED** the proposal to amend the ICBs’ Constitutions to reduce the number of Partner Board Members, Participants and Observers as set out in section 2.2 in the report, for onward recommendation to NHS England for ratification.
- **APPROVED** the proposed changes to the ICBs Constitutions outlined in appendix 1, for onward recommendation to NHS England for ratification.

NHS Staffordshire, Stoke-on-Trent Integrated Care Board:

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

Minute No. ICB 29-01.013 – NHS STW Integrated Care System Performance Report and Board Committee Chair Reports

- 013.1 The Board received the Integrated Care System Performance Report as read, with key areas of progress and ongoing concern highlighted.
- 013.2 The Board was asked to note and discuss the contents of the report.
- 013.3 Significant improvements in performance across the ICB was noted, with a particular focus on cancer services. The Board acknowledged exceptional progress against the Faster Diagnosis Standard: in March 2025, Shropshire, Telford and Wrekin ranked

42nd out of 42 ICBs nationally, but through sustained effort over the past year, the system had recently ranked first. Members commended the work of clinical and operational teams in delivering this transformation.

- 013.2 While urgent and emergency care performance had been discussed earlier under the winter item, the Board noted again that all planned bed reconfigurations and expansions were now complete. Their impact, as reported by providers, was being observed through improved patient flow and resilience. However, challenges remained. Ambulance handover delays continued to require attention, with new plans in place to support improvement from February. The Board also discussed the continued high use of adult out-of-area mental health placements. This remained a priority area for the five-year plan, with work underway with MPFT to secure capital funding for additional local capacity for the benefit of patients and financial sustainability.
- 013.3 From a quality perspective, VW reported that infection control continued to pose challenges, particularly linked to pressures within the urgent and emergency care pathway. The system remained over trajectory for C. difficile, although there had been significant improvements in antimicrobial stewardship. Positively, maternity services continued to show sustained improvement. Booking appointments before 10 weeks had been consistently achieved, and maternal smoking rates remained below 6%, improving outcomes for mothers and babies. The Board also welcomed assurance that no inadequately rated organisations were currently recorded across Shropshire, Telford and Wrekin by the Care Quality Commission (CQC), including within primary care.
- 013.4 Further comments were made concerning elective recovery. NHS England had released additional Q4 resources as part of the elective “Sprint” initiative. The Board noted that these would support targeted recovery efforts, including in organisations such as the Robert Jones and Agnes Hunt Orthopaedic Hospital, where clinically complex long-wait patients remained. The Board also welcomed confirmation that a National Cancer Plan, forming part of the wider NHS 10-year plan, would soon be published and would help shape strategic priorities.
- 013.5 CS reported on the financial performance at Month 9 (end of Q3). The system had been awarded full-year deficit support funding based on meeting plan expectations and demonstrating confidence in delivering the year-end forecast. The ICB remained on track to deliver the planned position, with any year-to-date variance considered manageable and recoverable. Capital expenditure remained on course, including approval of carry-forward arrangements to support continued progress on the Hospital Transformation Programme. A cost improvement programme of over £41 million was expected to be delivered reflecting sustained organisational effort. Providers also reported strong progress on their respective CIP programmes.

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

- 013.6 The Board then received the following Shropshire, Telford and Wrekin Committee IA reports:

Quality and Performance Committee

VW introduced the report and highlighted that the Child Death Policy had been approved on behalf of the Board, and the Shropshire, Telford & Wrekin Child Death Overview Panel Annual Report (2024/25) had been accepted, with publication planned. The report showed a 20% reduction in child deaths and identified important learning for

future action. Two extreme risks were noted, urgent and emergency care, and diabetes, both of which had active mitigation plans overseen closely by the Committee.

The Board endorsed the report.

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

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

Finance Committee

DB introduced the report which was taken as read. It was noted that the Month 9 position reviewed at Committee aligned with the update presented to the Board.

The Board was asked to note the contents of the paper.

No further comments were raised.

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

Strategic Commissioning and Productivity Committee

LC introduced the paper. The report was taken as read.

The Board was asked to note the information within the report.

No additional points or questions were raised.

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

Strategy and Prevention Committee

LC introduced the paper. The report was taken as read. LC highlighted the recent presentation on Smoke Free Telford & Wrekin, which demonstrated the potential to improve outcomes for mothers and babies.

The Board was asked to note the information within the report.

The work was strongly supported by the Committee, and no further questions were raised.

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

Shropshire Integrated Place Partnership Committee

IA introduced the paper. The report was taken as read and no questions were raised.

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

Telford & Wrekin Integrated Place Partnership Committee

DS introduced the report. DS provided an update, noting significant focus on young people's mental health support, including a recent workshop ahead of a new contract commencing 1 April 2026. The Committee continued to scrutinise waiting times, mental health support in schools, and improvements to local pathways. The Board was informed of progress towards the statutory plan required by March to improve Good Level of Development outcomes for children, with strong partnership working in place across health, education, SEND, and the voluntary sector.

DS also reaffirmed the Committee's commitment to progressing neighbourhood working as part of the 10-year plan. It was stressed that real impact required shifting resources closer to local areas and ensuring continued collaboration across NHS, local authority, and voluntary sector partners.

The Board was asked to note the:

- System pressures in CYP mental health remain high; upcoming January updates are critical for assurance
- Early Years GLD improvement is now a nationally driven priority requiring multi-agency response and alignment with wider priorities by March 2026.
- TWIPP are well positioned to transform and accelerate neighbourhood health plans and in January will be able to share achievements from the devolved ICB prevention budget with a view to securing additional funding for 2026/27.

SW confirmed that place-based boards would remain critical to delivering neighbourhood-level improvements and that governance arrangements would be strengthened across both Integrated Care Boards. Members highlighted the need for shared learning between place areas and strong involvement of the voluntary and community sector.

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

- **System pressures in CYP mental health remain high; upcoming January updates are critical for assurance**
- **Early Years GLD improvement is now a nationally driven priority requiring multi-agency response and alignment with wider priorities by March 2026.**
- **TWIPP are well positioned to transform and accelerate neighbourhood health plans and in January will be able to share achievements from the devolved ICB prevention budget with a view to securing additional funding for 2026/27.**

System Transformation and Digital Group

AM introduced the report which was taken as read. Mr. Morgan reported that the November 2025 and January 2026 meetings had focused on simplifying the transformation narrative, clarifying leadership responsibilities, and ensuring that transformation activity was practical and deliverable. Strong emphasis remained on neighbourhood health implementation and the wider transformation schemes referenced in earlier performance updates.

The Board was asked to note updates within the highlight reports.

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

Minute No. ICB 29-01.014 – NHS SSOT Integrated Care System Performance Report and Board Committee IA Reports

- 014.1 CS introduced the paper which was taken as read. Key performance headlines were highlighted. Referral to Treatment (RTT) performance remained challenging, particularly for patients waiting over 65 weeks. Three specialties at UHNM were identified as continuing to experience the greatest pressures. Mental health out-of-area placements had decreased significantly from 28 to 21, which was welcomed as a positive development for both patients and their families. CS also highlighted successful delivery of the Oliver McGowan Mandatory Training (Tier 2), where performance exceeded target for the first time this year.
- 014.2 The Board was asked to:
- Acknowledge the performance overview
 - Acknowledge the financial position.
- 014.3 It was noted that elective recovery had been more challenging over the Christmas and New Year period due to deliberate operational decisions made to protect patient flow and safety. As a result, UHNM faced a larger recovery position for year-end; however, plans were in development using both internal and external capacity to mitigate this. Assurance was also provided that recent increases in stroke activity and acuity were being explored.
- 014.3 There were no further questions on performance.
- 014.4 The Board received the Month 9 financial position. The Finance Committee had met the previous day and confirmed that the Month 9 results aligned with earlier reporting. The system remained on track to deliver its financial plan. Confirmation had been received of full-year deficit support funding, enabling the system to plan for breakeven with confidence. A small element of residual risk remained, but the Board was assured that this was clearly understood and being actively managed by provider organisations. Capital expenditure remained on track, and no additional issues were reported.
- 014.5 ML reinforced this positive position.

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

- **ACKNOWLEDGED** the performance overview
- **ACKNOWLEDGED** the financial position

- 014.6 The Board then received the following Staffordshire, Stoke-on-Trent Committee IA reports:

Finance and Performance Committee

ML introduced the paper and took them are read. ML emphasised the scale of improvement achieved since the financial targets were set in March of the previous year. At that time, the challenge had appeared insurmountable, but through sustained system collaboration, the Integrated Care Board was now forecasting balance. IA expressed gratitude to all system partners and, in particular, commended CF for her leadership and coordination. Recognition was also given to Integrated Care Board staff for maintaining focus and professionalism during a period of organisational uncertainty.

No further comments were made.

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

Quality and Safety Committee

SH introduced the paper and took it as read. She highlighted two key areas:

1. Right Care, Right Person (RCRP)

The Committee reviewed four incidents related to local RCRP implementation. A full thematic review had been completed, and learning actions implemented across providers. No further incidents had occurred since March 2025. To provide additional assurance, an independent external review was commissioned from another Integrated Care Board and has since been well received, including commendation from the regional team, who intend to present it to the Regional Policy Committee. This was noted as positive cultural progress in relation to risk and safety.

2. Looked After Children (LAC) – Initial and Review Health Assessments

Performance remained an area of concern. Average waiting times were improving, and Midlands Partnership had increased workforce capacity and implemented risk-based prioritisation; however, demand continued to significantly exceed capacity. Service redesign and quality improvement work were underway. The Committee requested a revised trajectory, which will be submitted once finalised.

IA queried whether a trajectory existed for clearing the backlog. It was confirmed that this was under development due to the complexity of the issue. The service remained fragile, with demand approximately ten times higher than historical levels. Work would continue through the Children and Families Care Group and system partners, with updates to be reported through the Quality & Safety Committee and performance routes.

SH also noted that the non-obstetric ultrasound backlog continued to reduce with no associated harm identified. All proposed risks were accepted onto the risk register except for the AHP workforce gap in the neonatal service at UHM, for which further information was required before a decision could be taken.

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

ICS People, Culture and Inclusion Committee

People Report – SSOT System Meeting

MI presented the report and took the paper as read. She summarised the assurance provided to the meeting regarding workforce numbers aligned to operational plan delivery, finance, sickness absence, inclusion, and winter planning. The Committee held a robust discussion on sickness absence, including mitigations and actions being taken by providers to support a reduction in absence levels.

It was noted that the only significant workforce shortfall within the operational plan related to Staffordshire, Stoke-on-Trent, though this had been mitigated through

reductions in other areas from a financial perspective. Work continued on the medium-term plan for the year.

The Committee discussed the future operating model for strategic workforce functions, noting that these responsibilities would sit clearly with providers under the ICB model, with further consideration required regarding the ICB's ongoing role. The People Report and committee terms of reference were being reviewed as part of the wider governance review.

SL added that continued focus on workforce was essential, particularly regarding agency and bank usage. A deep dive into sickness absence had been undertaken, with particular attention to staff wellbeing, stress levels, and the current organisational climate. Continued monitoring was agreed. No further points were raised.

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

Staffordshire and Stoke-on-Trent Health and Care Senate

RG the report as read and highlighted a number of approvals considered through the Integrated Medicines Authorisation Group. These included approvals relating to RTA red-list medicines, biologic therapies, and the updated asthma treatment guidance.

The Committee also approved the Dry Eye Management Policy, developed collaboratively with optometry partners as part of the Clinical Value Programme. This work was noted as a key collaborative achievement and had received full clinical approval.

Further clinically approved items were noted in relation to the elective strategy and the new media management pathway. These were considered straightforward and aligned with the Senate's single-purpose remit.

No further issues were raised for escalation.

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

Remuneration Committee

SL took the paper as read and there were no further comments.

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

Strategic Commissioning and Transformation Committee

ML provided an update on the first full year of operation since the formation of the Strategic Commissioning function. He noted strong progress in building the team's identity and delivering impactful collaborative work across the system.

He highlighted the positive outcome of the Betley Surgery option review, which had been expedited through the organisation. Significant clinical engagement had enabled timely progress and effective resolution of known issues.

ML also drew attention to the work on Urgent Treatment Centres (UTCs), where improvements to proposed designations had been agreed. He emphasised the importance of clear communication with the public regarding what services UTCs provide, to ensure expectations are well managed at neighbourhood level.

In line with the commitment to place the public at the centre of decision-making, he reported further progress with public consultation on birthing services at County Hospital and St. John's. This work had generated valuable insight into public views and would support future decision-making.

SW provided an update on discussions with the Ministry for Health regarding the Cannock MIU position. They reaffirmed the focus on clarifying the service offer, understanding additional services in place, and ensuring consistency across the full geographical footprint. This forms part of wider neighbourhood-level service development, with final recommendations to be brought forward.

IA observed that no items within the reports had required escalation, noting this was unusual given the breadth of the agenda and suggesting colleagues reflect on how items for alert are defined.

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

Minute No. ICB 29-01.016 – Shropshire, Telford and Wrekin and Saffs, Stoke-on-Trent Committees in Common

016.1 Remuneration Committee in Common

SL the paper. He highlighted that the Committee had discussed the National Emergency Scheme, noting key operational challenges and the work underway to address them. He also highlighted the impact on staff wellbeing and the need for both organisations to manage this effectively.

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

016.2 Transition Committee in Common

IG introduced the paper. He highlighted the significant transformational change occurring across both ICBs, affecting a large number of colleagues through various management and organisational change processes. Members acknowledged the pace and scale of change, the resulting pressures on staff, and the need to support colleague resilience during this period. Appreciation was expressed for staff professionalism despite uncertainty about future roles.

LCY also welcomed the paper's reference to health literacy, emphasising its importance for ensuring people can understand information provided to them. She reminded Members of the need to adhere to the NHS Accessible Information Standard, including for individuals with low or no literacy, and to check understanding at each point of public contact.

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

Minute No. ICB 29-01.017 – Any Other Business notified in Advance

017.1 No further issues were raised.

Minute No. ICB 29-01.018 – Review of new or amended risks following discussions in the Board meeting

018.1 No additional risks were identified following the meeting.

Minute No. ICB 29-01.019 – Meeting Effectiveness

019.1 IA led a short review of meeting effectiveness. Challenges were noted linked to the large group size, meeting space, and ensuring effective participation for online attendees. Further consideration of facilities for these meetings is required.

019.2 Members reflected on the balance of reporting vs. strategic discussion, highlighting the need to shape future agendas to support effective governance and maintain a strong focus on population health outcomes. This work will develop further as the cluster Board matures.

019.3 SW agreed and noted that the upcoming reset work provides an opportunity to clarify Board and ICB functions and ensure alignment with the four ICS principles.

019.4 RD attending online, confirmed a positive experience with clear audio and good engagement across all attendees.

019.5 IA welcomed the feedback and confirmed further evaluation would take place outside the meeting.

ACTION: Further evaluation of meeting effectiveness to take place outside the meeting – IA/SW

15.48 – Meeting Closed

Date and Time of Next Meeting

Date: Thursday, 26 March 2026

Time: 13:30

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

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

Monday, 9 February 2026 at 9.00am
Virtually via Teams

Present:

Ian Green OBE (IG)	Chair (Meeting Chair), NHS STW & NHS SSOT
Simon Whitehouse (SW)	Chief Executive Officer, NHS STW & NHS SSOT
Trevor McMillan OBE (TM)	Non-Executive Director, NHS STW
Mike Lawton (ML)	Deputy Chair, Non-Executive Member, NHS SSOT
Vanessa Whatley (VW)	Interim Chief Nursing Officer, NHS STW
Phil Smith (PS)	Chief System Development and Integration Officer, NHS STW & NHS SSOT
Dr. Lorna Clarson (LC)	Chief Officer of Strategy and Improving Outcomes, NHS STW & NHS SSOT
Dr Rachel Gallyot (RG)	Interim Chief Medical Officer, NHS STW & SSOT
Joanne Williams (JW)	Trust Partner Member and Chief Executive Officer, The Shrewsbury and Telford Hospital NHS Trust and Shropshire Community Health NHS Trust
Dr Buki Adeyemo (BA)	Trust Partner Member and Chief Executive, North Staffordshire Combined Healthcare NHS Trust
Simon Constable (SC)	Trust Partner Member and Chief Executive, University Hospitals of North Midlands
Jon Rouse CBE (JR)	Local Authority Partner Member and Chief Executive Officer, Stoke-on-Trent City Council

In Attendance:

Julie Garside (JG)	Director of Planning, Performance, BI & Analytics, NHS STW
Angela Szabo (AS)	Director of Finance, NHS STW
Gemma Smith (GS)	Director of Commissioning, NHS STW
Helen Dempsey (HD)	Director of Planning, NHS SSOT
Dr Paul Edmonson-Jones (PEJ)	Transformation Director, NHS SSOT
Mish Irvine (MI)	Chief of Staff, NHS STW & NHS SSOT
Claire Finn (CF)	Financial Recovery Director, NHS STW & SSOT
Paul Winter (PW)	Associate Director of Corporate Governance, NHS SSOT
Claire Colcombe (CC)	Board Secretary, NHS STW

Apologies:

Neil Carr OBE	Trust Partner Member and Chief Executive Officer, Midlands Partnership University NHS Foundation Trust
Dave Bennett	Associate Non-Executive Director, NHS STW
Claire Skidmore	Deputy Chief Executive Officer and Chief Finance Officer, NHS STW & NHS SSOT
Cheryl Etches OBE	Non-Executive Director, NHS STW
Roger Dunshea	Non-Executive Director, NHS STW
Siobhan Heafield	Non-Executive Member, NHS SSOT

Shokat Lal	Non-Executive Member, NHS SSOT
Heather Johnstone	Interim Chief Nursing Officer, NHS SSOT
Stacey Keegan	Trust Partner Member and Chief Executive Officer, The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Dr. Ian Chan	Primary Care Partner member, NHS STW
Dr Joanna Chan	Primary Care Partner Member, NHS SSOT
David Sidaway	Local Authority Partner Member and Chief Executive Officer, Telford and Wrekin Council (Virtually)
Patrick Flaherty	Local Authority Partner Member and Chief Executive, Staffordshire County Council

Minute No. ICB-09-02.001 – Welcome & Apologies

- 001.1 IG opened the extraordinary joint meeting, noting the significant work undertaken across both ICBs and partner organisations to reach the current position on planning submissions. Apologies were received from listed members across both ICBs. The meeting was quorate for both organisations once expected members had joined.

Minute No. ICB-09-02.002 – Members' Declarations of Interests

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

[NHS Shropshire, Telford and Wrekin ICB - Register of Interest - January 2026](#)
[NHS Staffordshire, Stoke-on-Trent ICB - Register of Interest - January 2026](#)

- 002.2 Members were invited to declare any new interests or identify any existing conflicts of interest relating specifically to the agenda items for the meeting.
- 002.3 Members confirmed their declarations remained accurate and were recorded on the respective ICB websites. No new or agenda-specific conflicts were declared.

Minute No. ICB-09-02.003 – Board Assurance Statement

- 003.1 The Board received an update on the February BAS submission, which included 20 statements (four more than December). Both ICBs had moved from "maturing" to "fully established" across most domains, with only workforce and 10-year plan delivery remaining "developing," consistent with national expectations.
- 003.2 STW had one outstanding metric (statement 12) pending completion of additional activity phasing work with providers, expected to be finalised ahead of delegated sign-off on 11 February 2026.
- 003.3 The Board was asked to agree and approve the final ratings and commentary of the ICB Board Assurance Statements.
- 003.3 Members recognised the substantial work undertaken by teams across both systems. Following discussion, no further assurances were requested, and the Board approved the BAS submissions for both ICBs.

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

**AGREED and APPROVED the final ratings and commentary of the
ICB Board Assurance Statements.**

Minute No. ICB-09-02.004 – 3 Year Plan: Activity, Finance, Performance and Workforce

004.1 Shropshire, Telford and Wrekin:

004.1.1 Activity and Performance - Activity and performance trajectories had improved since December due to strong provider engagement. Key issues noted:

- Cancer 62-day standard: Plan achieves 77% in 2026/27 (vs 80% national target). Improvement is significant and considered ambitious but deliverable, with further support under discussion with the Cancer Alliance.
- 31-day standard: Marginal amber rating due to interpretation of uplift requirements; full compliance expected in later years.
- 52-week waits: Further work required with RJAH to increase improvement rates; may be subject to national challenge.
- UEC performance: Included for information only (provider-led). Year-on-year improvement is expected, though challenging given historical performance levels. System-wide multi-year improvement planning is underway.

004.1.2 Workforce - Workforce forecasts showed modest growth. Previous data issues in primary care templates had been corrected. Concerns remained about GP supply relative to population growth.

004.1.3 Finance - STW planned to submit a compliant capital and revenue plan. Key points:

- All programme allocations distributed in full.
- 5% ICB efficiency requirement applied to support investment and cost pressures.
- Multi-year efficiency programme in place; around one-third of efficiencies rated as higher risk, including UEC efficiencies and RJAH contract adjustments.
- Provider feedback highlighted the scale of financial progress made over recent years and emphasised the credibility of current planning assumptions.

004.2 Staffordshire & Stoke-on-Trent (SSOT) – Activity & Performance

004.2.1 Provider boards were still finalising their positions; however, expected outcomes had been reflected. Key points:

- RTT: Non-compliant against national expectations. The ICB had already planned for a 7% improvement, but NHS England's suggested stretch to 13.6% was considered unrealistic at this stage. The position remains under review.
- All other ICB metrics (mental health, community, etc.) were compliant.

- UEC performance: Providers emphasised the importance of realistic but improvement-focused trajectories, aligned with historical deliverability.

004.2.2 Finance - The ICB planned to submit a balanced financial plan dependent on £62m efficiencies (5%). Current position:

- £50m efficiencies identified across CHC, prescribing, and other ICS-wide programmes.
- Remaining £12m supported by credible opportunities but requiring further development.
- Local authority members highlighted the need to avoid cost-shunting and expressed improved confidence in joint working and leadership tone compared with the previous year.
- The ICB reaffirmed its commitment to joint value-based approaches and to expanding provider-provider collaboration to deliver efficiencies.
- Capital plan was compliant; final discussions with NHS England were due later the same day.

004.3 The Board was asked to approve the finance, activity & performance and workforce plans as presented.

004.4 Both three-year plans were approved, with delegated authority granted to IA, SW and CS to agree any final amendments required before submission.

RESOLVE: The NHS Shropshire, Telford and Wrekin Integrated Care Board and NHS Staffordshire, Stoke-on-Trent Integrated Care Board **APPROVED** the finance, activity & performance and workforce plans as presented with delegated authority granted to the Chair, CEO and CFO to agree any final amendments required before submission.

Minute No. ICB-09-02.005 – 5 Year Strategic Commissioning Plan - STW

005.1 The first five-year commissioning plan sets out population need, future models of care, alignment with the NHS 10-year plan, and enabling strategies including workforce, digital and financial alignment. Supporting documents include:

- Integrated Strategic Needs Assessment (ISNA)
- Population Health Improvement Plan
- Clinical Strategy
- Commissioning Intentions

005.2 The Population Health Improvement Plan was highlighted as an early-stage document, prioritising measurable metrics and aligning existing programmes with ISNA findings.

005.3 The Board was asked to approve the Five-Year Strategic Commissioning Plan 2026/27 to 2030/31 as the strategic direction for the system and to agree that progress will be monitored through regular Board updates, Committee oversight and the systemwide performance and risk framework.

- 005.4 The Board discussed the need to balance ambition with deliverability and to maintain alignment across both ICBs, particularly in the context of a potential merger. The STW plan was approved.

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

Minute No. ICB-09-02.006 – 5 Year Strategic Commissioning Plan - SSOT

- 006.1 Developed through a parallel process, the SSOT plan also aligns with the joint forward plan, portfolio strategies, opportunity assessments and ongoing transformation work.
- 006.2 The Board was asked to approve the Five-Year Strategic Commissioning Plan as the strategic direction for Staffordshire and Stoke-on-Trent and to agree that progress will be monitored through regular Board updates and Committee oversight.
- 006.2 Both plans share a common strategic framework but reflect local population differences. Members discussed the importance of harmonising approaches and adopting the best elements of each as work progresses. The SSOT plan was approved.
- 006.3 The Board further discussed the importance of expanding public involvement beyond statutory consultations. A more robust engagement plan is being created to ensure inclusion of less-heard groups and those experiencing inequity of access.

RESOLVE: The NHS Shropshire, Telford and Wrekin Integrated Care Board and NHS Staffordshire, Stoke-on-Trent Integrated Care Board **APPROVED** the Five-Year Strategic Commissioning Plan as the strategic direction for Staffordshire and Stoke-on-Trent and **AGREED** that progress will be monitored through regular Board updates and Committee oversight.

Minute No. ICB-09-02.007 – Any other business

- 007.1 No additional items were raised. Members expressed appreciation for the significant work completed by teams and welcomed the positive cultural shift noted by partners.

09:58 – Meeting Closed

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

Meeting Date	Agenda Item	Action	Due Date	Responsible Officer	Outcome/update
29/01/2026	Minute No. ICB-26-01-001b – Leadership Compact	Leadership Compact to be adopted consistently across both Integrated Care Boards to support alignment and shared ways of working as the joint meeting arrangements develop	TBC	Simon Whitehouse/ Mish Irvine	
29/01/2026	Minute No. ICB 29-01.007 – ICB Cluster Chief Executive (CEO) Report	Responses required from relevant teams relating to further detail on the text service and clarification on E-service availability across Staffordshire and Stoke-on-Trent.	TBC	Simon Whitehouse	
29/01/2026	Minute No. ICB 29-01.008 – Residents/Community Story – NHS Staffordshire, Stoke on Trent – End of Life Care	Provide an update on end of life care and neighbourhood development at a future public Board meeting.	TBC	Simon Whitehouse/Board Strategy Session	
29/01/2026	Minute No. ICB 29-01.009 - SBAF	Bring an integrated SBAF to the next meeting.	26/03/2026	Mish Irvine	Completed: Part of Agenda - Action Closed
29/01/2026	Minute No. ICB 29-01.010 – Short and Medium Term Planning	Schedule further meeting for an update and final approval of the Board Assurance Statement ahead of submitting to NHSE.	09/02/2026	Claire Skidmore	Completed: Meeting took place on 11th February 2026 and plans were submitted on 12th February 2026 - Action Closed
29/01/2026	Minute No. ICB 29-01.012 – NHS Reset – Proposed Governance Changes	Bring forward proposals to future Board meeting in common, on how the public voice, including Healthwatch, will continue to be integrated into decision making processes.	March Board	Mish Irvine	
29/01/2026	Minute No. ICB 29-01.019 – Meeting Effectiveness	Further evaluation of meeting effectiveness to take place outside the meeting.	March Board	Ian Green / Simon Whitehouse	

Enclosure No: 04

Report to:	Integrated Care Board							
Date:	26 March 2026							
Title:	Chair Report							
Presenting Officer:	Ian Green OBE, Chair							
Author(s):	Ian Green OBE, Chair							
Document Type:		Action Required (select):						
Report	☒	Business Plan	☐	Information (I)	☒	Discussion (D)	☐	
Strategy	☐	Policy	☐	Assurance (S)	☐	Approval (A)	☐	
Other	☐	(please describe)		Ratification (R)	☐	(check as necessary)		
Is the decision within SOFD powers & limits					Yes	☐	No	☒
Any potential / actual Conflict of Interest?					Yes	☒	No	☒
<i>If Y, the mitigation recommendations:</i>		<i>E.g. Staff have Financial + Non-Financial Professional Interests which can be managed by recording those in minutes and allowing presence in discussions with recusals from formal decisions</i>						
Any financial impacts: ICB or ICS?					Yes	☐	No	☒
<i>If Y, are those signed off by and date:</i>		<i>E.g. Chief Finance Office, dd-mmm-yyyy</i>						
Any impacts on ICB Undertakings?					Yes	☐	No	☒
<i>If Y, are those signed off by and date:</i>		<i>E.g. Chief Finance Office, dd-mmm-yyyy</i>						
Appendices:	None							

(1) Purpose of the Paper:
This report provides a general update from the Chair, relevant to NHS Shropshire, Telford and Wrekin ICB and NHS Staffordshire and Stoke on-Trent ICB that are not reported elsewhere on the agenda.

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

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

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

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

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

(7) Recommendations to Board:

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

1.0 Transition Governance Update

NHS England has ratified the proposed changes to both ICB Constitutions, which were approved at the January 2026 Board in Common meeting. This has initiated a nomination process for the following Board member roles, the number of which on each Board was reduced as part of the approved constitutional changes:

- 1 NHS/Foundation Trust Partner Member for each ICB
- 1 Mental Health Member for each ICB
- 1 Primary Care Partner Member for NHS Shropshire, Telford and Wrekin ICB only

The nomination processes for these roles have been undertaken during February and March, and an appointment panel is scheduled for 23 March 2026. At the time of writing, these processes have not yet concluded. Therefore, I will provide a verbal update on the appointments at the Board meeting in Common meeting on 26 March 2026.

I am keen to ensure that alongside the constitutional changes we put in place mechanisms to fully engage partners in key strategic decisions and I would welcome suggestions as to how this could be achieved.

1.1 Cluster Governance - Joint Committees and Committees-in-Common

A Board Development session (ICB NEDs and Executives) was held in February to review supporting arrangements and new developments for Cluster Committees as they finalise their structures and progress Board-delegated work for both 'business as usual' and the NHS Reset. The session also provided an overview of the supporting Organisational Development (OD) work that will help NED (Non-Executive Directors) Chairs and executives to shape sub-committee structures with the Governance Team. This ensures the main committee maintains a strategic focus on joint responsibilities while delivering delegated activities and functional decisions according to the new Terms of Reference.

By the end of March, all newly arranged committees are expected to have met in common for the first time. In April, meetings will reconvene as full Joint Committees (with the exception of Audit Committees, which will remain in common due to governance requirements). New memberships and areas of focus mean that the Terms of Reference will continue to evolve throughout the first quarter of 2026/27.

A range of new corporate branding, including in-common agendas, reporting templates, minutes, and escalation reports, is being rolled out for use at the first meetings in March and in all subsequent meetings. In line with the new arrangements, a full programme of support will be provided to ensure these are successfully embedded. It should be noted that this is all electronic so there are no cost implications to these changes.

1.2 NHSPS Asset Transfer Expression of Interest

In line with the NHS England process, the ICB Chair, Chief Executive Officer and Chief Finance Officer reviewed the ICB coordinated NHS Property Services (NHSPS) asset transfer

expressions of interest. They approved the joint Staffordshire and Stoke-on-Trent ICB and Shropshire, Telford and Wrekin ICB submission on 11 March 2026. This approval enables the ICB strategic estates lead and provider estates leads to access the necessary estate, capital and revenue information to assess the proposed transfers and determine whether a business case should be developed for formal consideration by provider and ICB boards.

At this stage, the proposed transfers relate only to provider clinical space currently managed by NHSPS, covering both freehold and leasehold estate for Staffordshire and Stoke-on-Trent, and Shropshire, Telford and Wrekin. NHS England will provide the required estates information in April 2026, with any resulting business cases to be submitted for Board approval before the end of July 2026 in line with the national timeline.

Ian Green OBE,

ICB Chair

Enclosure No: 05

Report to:	Integrated Care Board							
Date:	26 March 2026							
Title:	CEO Report							
Presenting Officer:	Simon Whitehouse, CEO							
Author(s):	Simon Whitehouse, CEO							
Document Type:		Action Required (select):						
Report	☒	Business Plan	☐	Information (I)	☒	Discussion (D)	☐	
Strategy	☐	Policy	☐	Assurance (S)	☐	Approval (A)	☐	
Other	☐	(please describe)		Ratification (R)	☐	(check as necessary)		
Is the decision within SOFD powers & limits					Yes	☐	No	☒
Any potential / actual Conflict of Interest?					Yes	☒	No	☒
<i>If Y, the mitigation recommendations:</i>		<i>E.g. Staff have Financial + Non-Financial Professional Interests which can be managed by recording those in minutes and allowing presence in discussions with recusals from formal decisions</i>						
Any financial impacts: ICB or ICS?					Yes	☐	No	☒
<i>If Y, are those signed off by and date:</i>		<i>E.g. Chief Finance Office, dd-mmm-yyyy</i>						
Any impacts on ICB Undertakings?					Yes	☐	No	☒
<i>If Y, are those signed off by and date:</i>		<i>E.g. Chief Finance Office, dd-mmm-yyyy</i>						
Appendices:	None							

(1) Purpose of the Paper:

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

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

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

Date

N/A

Expand as necessary if the report went to multiple meetings

(3) Implications:

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

(4) Statutory Dependencies & Impact Assessments:

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

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

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

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

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

(7) Recommendations to Board:

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

1.0 General Update

1.1 NHS Government Reset Programme

The ICBs continue to work through their response to the national NHS Reset programme and in refocussing the cluster as strategic commissioner for Shropshire, Telford and Wrekin and Staffordshire and Stoke-on-Trent. This includes the development of a new operating model for the cluster and a single leadership structure to discharge the ICBs' statutory functions.

Work continues to develop an affordable structure for the cluster in line with the reduced running cost allowance of £19.40 per head of population (noting that this has been revised to £19.55 in recognition of the national NHS Pay Award). Following receipt of NHS England approval, 164 Voluntary Redundancy applications have so far been approved and are proceeding towards Settlement Agreements. Colleagues started to leave both ICBs in February. Of colleagues leaving there is no doubt that we are losing a significant amount of knowledge, experience and commitment. On behalf of the Board and the executive team, I would like to thank every single colleague that has made the decision to leave through the VR process for their service and contribution to improving the health of the population. Your work has made a positive difference for local people, and we wish you the very best for whatever you choose to do next – thank you.

The Management of Change Consultation for the Senior Leadership Team (Bands 8c, 8D, 9 and VSM 2) has concluded and final structures and job descriptions have been issued following a review of the constructive feedback that has been received. Colleagues were offered a second opportunity to apply for Voluntary Redundancy, which closed after final structures and job descriptions were issued, enabling people to make the most informed decision for them personally. The selection process for roles within the new structure will take place in April.

The Clinical Leadership Management of Change consultation opened on 4 February 2026 and will conclude on 20 March. Work is also on track to design structures and roles for the wider Management of Change process and to finalise options for bases and our approach to agile working, so that we can progress to consultation as planned in March.

Simultaneously, as part of the closure of the Midlands and Lancashire Commissioning Support Unit (MLCSU), arrangements are in place to TUPE transfer colleagues from four teams into the employment of NHS Shropshire, Telford and Wrekin (on behalf of the Cluster) on 1 April with other teams following on an agreed trajectory thereafter. The ICB Cluster Transition Committee continue to meet regularly providing helpful discussion, challenge and assurance. This committee has oversight of the wider change and reform programme, and a more detailed update is included in the Board papers.

1.2 Proposed local government reorganisation in Staffordshire and Stoke-on-Trent

The UK government has launched a statutory consultation on [Local Government Reorganisation \(LGR\) in Staffordshire and Stoke-on-Trent](#), proposing to replace the current two-tier system with new unitary councils. Residents and stakeholders have until 26 March 2026 to provide feedback on the proposals, which aim to streamline services, with potential

implementation by April 2028. The ICB is engaging with Health and Wellbeing Boards and Overview and Scrutiny Committees to review implications for health services, ensure continuity of care, and support effective system planning as the reorganisation progresses. The ICB will be taking the opportunity to respond to the consultation.

1.3 National SRO Dr Minal Bakhai MBE Visits Shropshire Neighbourhood Health Teams

On Monday 9 February, NHS Shropshire, Telford and Wrekin welcomed Dr Minal Bakhai MBE, National SRO for the National Neighbourhood Health Implementation Programme (NNHIP). The visit highlighted the strong progress and effective partnerships across our neighbourhood teams, reinforcing the value of integrated, locally led models of care.

Dr Bakhai spent time with Shropshire Council's Community Wellbeing Outreach Team on the Winter Outreach Wellness Bus. She also observed personalised dementia support and multi-disciplinary working with the Dementia Neighbourhood Team at Much Wenlock and Cressage Surgery and visited the Winter Wellness Clinic and Frailty Neighbourhood Team at Severn Fields Medical Practice in Shrewsbury. Dr Bakhai's reflections were highly positive and provided valuable national insight as we continue to embed and strengthen neighbourhood care across the System.

1.4 Planning Working Group and Planning Submissions

For NHS Staffordshire and Stoke-on-Trent, all planning submissions were successfully submitted ahead of the deadline on 12 February 2026. Feedback from NHSE is expected through the cluster meeting and informally from providers over the coming days. A system-wide review session is scheduled for 4 March to consolidate and align feedback across organisations. I would like to take this opportunity to thank the respective teams (ICB and provider) that have led this process out for their professionalism and 'can do' approach in resolving and working through issues. The approach adopted means that we are in as good a place as possible to start the financial year. There is a significant amount of work still to do, but I am confident that the approach shown so far will enable us to drive this forward in a collaborative manner.

1.5 SaTH exits special measures following sustained improvement

The Shrewsbury and Telford Hospital NHS Trust (SaTH) has exited special measures following an NHS England review. This is an important milestone for our system. SaTH has delivered sustained improvements in finance, performance and governance, including being the most improved Trust nationally for elective recovery (18 week RTT), ranking second for the 28 day Faster Diagnosis Standard, achieving its strongest diagnostics performance in five years, making sustainable progress in maternity and neonatal services (on track to exit the Maternity Safety Support Programme), securing University Trust status, and being on track to deliver a £41m Cost Improvement Plan and reduce its deficit by 50% since 2023/24. This is testament to the substantial, sustained progress delivered by colleagues across the Trust and its work with partners including the ICB. While further progress is needed, particularly in urgent and emergency care and delivery of the Hospitals Transformation Programme by 2028, no local NHS organisation now remains in the highest level of national oversight. This is positive for local people and for our workforce.

2.0 Primary Care

2.1 Primary Care Access Improvement Plan

The response of both NHS Staffordshire and Stoke-on-Trent and NHS Shropshire, Telford and Wrekin to the national Primary Care Access Recovery Plan demonstrates improved patient access and improving satisfaction. The cornerstone of any neighbourhood or community based work is built on having strong and high quality local GP services, with good access being a fundamental aspect of that offer.

For Staffordshire and Stoke-on-Trent:

- 550,641 online consultations delivered (April – November 2025).
- 52% of patients had downloaded the NHS App by November 2025.
- 5,061,906 GP appointments delivered (April – December 2025), a 2.5% increase compared to 2024.
- 55,589 Pharmacy First Clinical Pathway consultations (April – December 2025), up 16,100 on the previous year.
- 455 GP staff trained in care navigation.
- 46,154 extra appointments commissioned through Primary Care Winter Hubs to March 2026.

For Shropshire, Telford and Wrekin:

- 358,050 online consultations delivered (April – November 2025).
- 69% of patients aged 13+ (324,325) registered on the NHS App as of 31 January 2026.
- 2,338,301 GP appointments delivered (April – December 2025) a 0.5% increase compared to 2024.
- 20,382 Pharmacy First Clinical Pathway consultations (April – December 2025), up 4,029 (25%) on the previous year.

2.2 Dental Activity and Equity Programme

NHS dental activity is improving across Staffordshire and Stoke-on-Trent, with data showing rates higher than the previous three years. The dental equity programme has referred 3,436 patients into practices within priority areas. Additional communications are being rolled out across both Staffordshire and Stoke-on-Trent and Shropshire, Telford and Wrekin to support urgent dental appointments, including videos featuring Dr Tony Ahmed to highlight urgent dental symptoms and how patients can access care. To support recruitment and retention, a 'Golden Hello Scheme' for dental therapists and nurses will launch in April 2026.

For Shropshire, Telford and Wrekin, we are on course to meet our 2025/26 plan for Units of Dental Activity (UDA), with additional funding being used to commission recurrent UDAs in local dental access hot spots where poor delivery is impacting local access. Funding is also in place to enable 110% contracted UDA delivery by year end which has so far resulted in an increase in scheduled activity in January 2026 - almost double than the previous month. The current 'Golden Hello Scheme' for STW has set out to recruit 4 WTE posts, 2.8 of which have so far been recruited as of January 2026.

3.0 People and Workforce

3.1 People Team Update

The Shropshire, Telford and Wrekin's People, Culture and Inclusion Committee met in February and received assurance on the Month 10 workforce plan, showing slight improvement on Month 9 in workforce expenditure. Bank usage remains a challenge but is being mitigated by a comprehensive improvement plan, already reducing nursing bank activity. Fragile services are under review to manage increased medical bank demand.

NHS Infrastructure Support costs are £3.1m favourable year-to-date, although headcount reductions in this group are delayed and will carry into 2026/27. Sickness absence has risen slightly, matching the level at this time last year. All partners submitted five-year workforce plans, with the accompanying narrative well received by NHSE regional teams. Key challenges for 2026/27 include implementing transformational plans to deliver key shifts, early focus on the group model, recruiting to substantive posts to reduce agency and bank reliance, and achieving productivity targets.

Since the start of the 2025/26 financial year (FY), overall staffing in Staffordshire and Stoke-on-Trent has reduced by 136 whole-time equivalents (WTE). Despite operational pressures and industrial action, temporary staffing remains positive. January 2026 usage is roughly 390 WTE lower than at the start of the year and 100 WTE lower than January 2025. Pay remains stable despite potential concerns.

Multi-year workforce plans commit to a reduction of 127 WTE by the end of FY26/27, with further reductions planned for FY27/28 and FY28/29, totalling 1,073 WTE less than the March 2026 baseline by the end of FY28/29.

3.2 Staff Survey

Staff Survey results for the clustered ICBs are currently undergoing detailed review following the release of benchmarking data ahead of the public release of the data in mid-March. Comprehensive analysis is underway to fully understand the findings and use both quantitative and qualitative insights to inform targeted people support interventions and organisational development priorities. There is recognition that the national changes and the reduction in the running cost allowance is likely to have an impact on the results this year. However, the executive team are committed to using the results to help shape and develop the cluster approach and to improve the ways of working as the new structure and new operating model is introduced. The outcomes of the survey will be shared with all staff and an action plan will be developed to support the next stages in staff development.

4.0 Urgent and Emergency Care

Within Staffordshire and Stoke-on-Trent, Urgent and Emergency Care (UEC) continues to face significant challenge, with several key metrics off plan. University Hospitals of North Midlands (UHNM) declared a critical incident in January due to UEC pressures, impacting operational delivery. System partners remain focused on recovery of core metrics against plan.

The Integrated Care Coordination (ICC) and Community Rehabilitation and Integration Service (CRIS) continue to demonstrate increased referral numbers during this period, further supported by the ambulance service relaunching 'Call Before You Convey' to enable more patients to access alternative pathways and remain at home. The ICC is receiving record

referral numbers following an enhanced communication programme led by Midlands Partnership Foundation Trust (MPFT), alongside strengthened partnership working with the ambulance provider.

The system has maintained focus on delivery of the Staffordshire and Stoke-on-Trent Integrated Care System's (ICS) Winter Plan for 2025/26. The Winter Plan approach was adopted to ensure resilience across health and care services throughout winter. The plan was presented through ICS governance and ratified by the ICB Board in November. It is monitored by the Surge Multi-Disciplinary Team (MDT), with oversight provided by the Winter Oversight Group and UEC Board, supported by bi-weekly Winter executive reports. This year's plan has taken a collaborative approach, structured around 17 pillars led by representatives from across the system. This has supported a more holistic approach to planning and oversight, incorporating key workstreams with defined deliverable metrics.

To date, 18 schemes had been planned across Staffordshire and Stoke-on-Trent for Winter, including increased Discharge Facilitation over weekends, expansion of the Frailty Same Day Emergency Care (SDEC) at Royal Stoke University Hospital (mirroring County Hospital), and a Community X-Ray Car pilot in the north of the county to support more patients being managed at home. Of the 18 schemes, 10 are on track or completed, four are currently at risk, and four are off track or not expected to be completed. Alternative schemes have been identified to mitigate those unable to be mobilised.

Focus is now shifting to de-escalation planning, with providers finalising plans to enable development of a system-wide approach. In parallel, the 2025/26 system winter lessons learned event is being planned to evaluate the effectiveness of the Winter Plan and inform development of the 2026/27 Winter Plan.

The Shropshire, Telford and Wrekin Urgent and Emergency Care (UEC) Improvement Programme has now transitioned from infrastructure delivery into a sustained phase of operational grip, flow optimisation and system-wide performance improvement.

Following the opening of additional modular bed capacity at Royal Shrewsbury Hospital (RSH) and the expansion of assessment capacity at Princess Royal Hospital (PRH), the focus has shifted toward maximising the impact of this capacity through strengthened discharge governance, improved care coordination and tighter system oversight.

Current priorities are centred on:

- Reducing length of stay and accelerating discharge for patients who no longer meet criteria to reside.
- Strengthening Expected Date of Discharge (EDD) compliance and daily review processes.
- Increasing same-day emergency care utilisation to avoid unnecessary admission.
- Embedding direct access to senior clinical advice for GPs to support admission avoidance.
- Improving system visibility of discharge barriers and community capacity constraints.

A more structured system-level discharge oversight model is now in place, with clearer escalation routes and strengthened partnership working across acute, community, local

authority and voluntary sector partners. This is improving collective ownership of flow across the pathway rather than reliance on acute capacity alone.

Whilst demand remains high and performance continue to be challenged in line with national pressures, there are early signs of improved operational resilience. Increased assessment capacity at PRH is supporting earlier clinical decision-making, and the additional bed base at RSH is reducing sustained escalation risk during peak demand periods.

Importantly, the programme is now framed around three interdependent pillars:

- Pre-Hospital and Care Coordination – strengthening clinical advice, admission avoidance and navigation.
- Acute Flow and Assessment – optimising front door streaming, SDEC and decision-making.
- Discharge and Community Flow – reducing delays, improving community responsiveness and shortening length of stay.

This whole-system model ensures that improvement is not measured solely through bed numbers, but through flow, timeliness of decision-making, reduced avoidable admission and improved patient experience. Trajectory modelling indicates that continued focus on discharge discipline, admission avoidance and system-level oversight will be critical to delivering progressive improvement through 2026/27.

5.0 Planned Care and Cancer

5.1 Launch on the National Cancer Plan

The National Cancer Plan for England, launched on 4 February for World Cancer Day, sets out priorities to improve cancer survival and build an NHS ready for the future. Developed with input from patients, partners, and professionals, it focuses on faster diagnosis, timely treatment, better survival for rare cancers and young people, and support to enhance quality of life after diagnosis. It also builds on the 10-Year Health Plan with commitments to cut waiting times, modernise care, and bring services closer to communities.

The NHS Staffordshire and Stoke-on-Trent Cancer Team is delivering a strong, ambitious programme of cancer awareness campaigns that promote earlier diagnosis, prevention, screening uptake, and improved access to information for local communities. Through targeted public campaigns, community outreach, and close collaboration with Primary Care Networks (PCNs), Voluntary Community and Social Enterprise (VCSE) partners, and screening teams, thousands of residents have received clear, timely messages about cancer symptoms, screening, and healthy behaviours.

The focus is on people from higher deprivation and underserved groups. Through innovative approaches, we are helping to reduce inequalities by:

- Gathering information and delivering support directly into communities
- Holding pop-up community events and supporting health and wellbeing days
- Delivering a cancer awareness bus tour around Staffordshire and Stoke-on-Trent

These initiatives have enabled meaningful conversations with people who may not routinely engage with healthcare services. More information will be available in the ICB 2025/26 Annual Report.

5.2 Cancer Bus Tour

The Cancer Awareness Bus tour, which launched 9 March, is travelling across Staffordshire and Stoke-on-Trent bringing vital cancer information and support directly into local communities. During the tour, the bus will offer free health checks, guidance on recognising signs and symptoms, and information on NHS cancer screening programmes. This initiative supports the NHS priority of earlier cancer diagnosis and improved screening uptake, helping communities act early and improve outcomes. By taking services into local neighbourhoods, the tour reflects our commitment to reducing health inequalities and empowering residents to take control of their health.

5.3 Hormone Replacement Therapy (HRT) pathway - Unexplained Bleeding

The Unexplained Bleeding on HRT pathway was launched in Shropshire, Telford and Wrekin on 9 February 2026. The pathway supports individuals experiencing bleeding while on HRT by ensuring a comprehensive clinical assessment in Primary Care and, where no risk factors for endometrial cancer are identified, enabling timely adjustments to HRT dosage to resolve symptoms.

A cohort of Shropshire, Telford and Wrekin GPs have been trained by the British Menopause Society to deliver specialist HRT titration, and PCNs are now running regular clinics to provide this enhanced support. For cases where bleeding does not settle, the pathway provides direct access to urgent ultrasound at Shrewsbury and Telford Hospital (SaTH), with seamless referral into the Gynaecology team if required.

This new pathway ensures that people experiencing unexplained bleeding on HRT receive the most clinically appropriate care while reducing pressure on the Gynaecology Urgent Suspected Cancer pathway, helping maintain timely access for those with suspected cancer.

6.0 Medicine Optimisation Team

6.1 Prescription Ordering Direct Service

Shropshire, Telford and Wrekin had previously taken the decision to phase out the Prescription Ordering Direct (POD) service. This followed a strategic review and an alignment with national priorities to improve digital access through the increased use of the NHS App.

The POD service, introduced in 2016/17 as a phone and email system to support repeat prescription ordering, was identified as duplicating functions routinely provided by GP practices and the NHS App. The review also identified persistent access challenges, increasing staffing costs and limited value for money, with operating costs exceeding £1 million per year.

A comprehensive communications and engagement plan is in place to support patients through the transition, with a particular focus on helping people move to digital channels where appropriate and ensuring continuity of access for those unable to use digital tools.

6.2 Medicines Value and Financial Recovery

The Medicines Value Programme continues to deliver strong financial performance, achieving £4.2m savings year to date (M10) against a plan of £4.0m and forecasting £4.9m by yearend. This reflects effective systemwide prescribing optimisation and supports the ICB's overall financial recovery plan.

7.0 Birthing services consultation

Between 12 May and 3 August 2025, NHS Staffordshire and Stoke-on-Trent ran a 12-week public consultation on midwife-led birthing services at County Hospital, Stafford, and Samuel Johnson Community Hospital, Lichfield. The proposal sought to make permanent the temporary closures put in place in March 2020 due to COVID-19. While birthing services remain closed, antenatal and postnatal care has continued at both sites, though Samuel Johnson Community Hospital has not offered Glucose Tolerance Testing (GTT) or Anti-D injections since the pandemic.

The consultation received over 1,400 responses. In response to this feedback, the ICB extended engagement for a further four weeks in February 2026 to gather additional views on antenatal care. Findings from this extended engagement will be included in the overall Report of Findings, guiding ICB governance and informing the Decision-Making Business Case.

8.0 Community Transformation

8.1 Wheelchair Procurement

In Staffordshire and Stoke-on-Trent, AJM Healthcare's performance has historically not deviated against the contract standards that have been in place. A Contract Performance Notice (CPN) was issued in August 2025, followed by a Joint Investigation (JI) and an agreed Remedial Action Plan (RAP) with a performance trajectory subsequently agreed. Since then, AJM has exceeded the RAP targets, showing marked improvements in outcomes and reductions in complaints and negative feedback.

To illustrate the scale of the performance improvements some key figures are presented below:

- Elimination of all service user waits of 65 weeks or more.
- A reduction in the "open caseload" i.e. service users awaiting equipment of over 300.
- A 9% reduction in the proportion of current service users waiting more than 18 weeks for equipment (equating to over 230 less patients waiting over 18 weeks).
- A 75% reduction in the number of service users waiting more than 52 weeks for equipment.

The procurement process for the provision of wheelchair services in Staffordshire and Stoke-on-Trent is in progress; Ross Care are the preferred bidder, and we have now entered the standstill period. When this has concluded, an announcement will be made on the Contract Award.

Simon Whitehouse,
ICB Chief Executive Officer

Enclosure No: 06

Report to:	Integrated Care Board			
Date:	26 March 2026			
Title:	CAMHS: Logan's story			
Presenting Officer:	Vanessa Whatley, Interim Chief Nursing Officer for NHS STW			
Author(s):	Harriet Hopkins, Communications and Engagement Lead			
Document Type:		Action Required (select):		
Report	☐	Business Plan	☐	Information (I) ☒
Strategy	☐	Policy	☐	Discussion (D) ☒
Other	☐	(please describe)		Assurance (S) ☐
				Approval (A) ☐
				Ratification ® ☐
		(check as necessary)		
Is the decision within SOFD powers & limits				Yes ☐ No ☒
Any potential / actual Conflict of Interest?				Yes ☐ No ☒
<i>If Y, the mitigation recommendations:</i>		<i>E.g. Staff have Financial + Non-Financial Professional Interests which can be managed by recording those in minutes and allowing presence in discussions with recusals from formal decisions</i>		
Any financial impacts: ICB or ICS?				Yes ☐ No ☒
<i>If Y, are those signed off by and date:</i>		<i>E.g. Chief Finance Office, dd-mmm-yyyy</i>		
Any impacts on ICB Undertakings?				Yes ☐ No ☒
<i>If Y, are those signed off by and date:</i>		<i>E.g. Chief Finance Office, dd-mmm-yyyy</i>		
Appendices:	None			

(1) Purpose of the Paper:
To share Logan's story, as told by himself interviewed by Mark Fletcher (Comms Manager at MPFT), and his experience of transitioning from CAMHS to adult services, using the new Transitional Care Team.

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

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

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

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

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

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

This paper presents the story of *Logan*, a young person from Staffordshire who has recently transitioned from Child and Adolescent Mental Health Services (CAMHS) into adult mental health services, supported throughout by the MPFT's Transitional Care Team. Logan shares his experiences in a short video interview with Mark Fletcher (Communications Manager, MPFT), in which he reflects openly on his mental health journey from adolescence into adulthood.

Logan describes how moving between services can feel overwhelming, particularly at a time when young people are already managing significant personal, social, and emotional change. He highlights the importance of having a consistent point of support during this transition. The Transitional Care Team provided him with continuity, reassurance, and practical help in navigating the complexities of adult mental health services. Logan explains that this support made a positive difference to his confidence, engagement, and overall experience of moving into adult care.

The Transitional Care Team model in South Staffordshire offers valuable lessons as Shropshire, Telford and Wrekin prepares to launch its enhanced CAMHS from 1st April 2026. When we recommissioned CAMHS in Shropshire, Telford and Wrekin, one of our key redesign intentions, shaped directly by public feedback, was to strengthen proactive transition planning and provide more consistent support for young people moving into adult services. Establishing Transitional Care Teams locally will therefore be central to delivering a smoother, more coordinated and person-centred transition. Logan's story demonstrates the benefits of a dedicated transition function and reinforces the importance of designing services around young people's lived experience.

The Board is invited to note the challenges faced by young people during transitions between children's and adult mental health services, recognise the positive impact that the Transitional Care Team has had in Logan's case, and consider the learning for future service development in Shropshire, Telford and Wrekin

(7) Recommendations to Board:

The Board is invited to **note** the challenges faced by young people during transitions between children's and adult mental health services, **recognise** the positive impact that the Transitional Care Team has had in Logan's case, and **consider the learning** for future service development in Shropshire, Telford and Wrekin.

Enclosure No: 07

Report to:	Integrated Care Board						
Date:	26 March 2026						
Title:	Updated Collaboration Agreement 2026/27 – Joint Working Arrangements + Joint & Collaborative Committee Terms of Reference						
Presenting Officer:	Dr Lorna Clarson, Chief Officer of Strategy & Prevention						
Author(s):	Paul Winter and Claire Colcombe						
Document Type:		Action Required (select):					
Report	☐	Business Plan	☐	Information (I)	☐	Discussion (D)	☐
Strategy	☐	Policy	☐	Assurance (S)	☐	Approval (A)	☒
Other	☒	Governance document requiring board approval		Ratification (R)	☐	(check as necessary)	
Is the decision within SOFD powers & limits				Yes	☐	No	☒
Any potential / actual Conflict of Interest?				Yes	☐	No	☒
<i>If Y, the mitigation recommendations:</i>							
Any financial impacts: ICB or ICS?				Yes	☐	No	☒
<i>If Y, are those signed off by and date:</i>							
Any impacts on ICB Undertakings?				Yes	☒	No	☐
<i>If Y, are those signed off by and date: E.g. Chief Finance Office, dd-mmm-yyyy</i>							
Appendices:	1. Briefing Paper for ICB's 2026 final; 2. Collaboration Agreement 2026/27 FINAL; 3. Terms of Reference for Midlands Joint & Collaborative Committee						

(1) Purpose of the Paper:	
To present the Updated Collaboration Agreement for 2026/27 to the Board for formal approval, enabling implementation of joint working arrangements and updated Terms of Reference for the Midlands Joint & Collaborative Committee ahead of the statutory transition planned for April 2026.	
(2) History of the paper, incl. date & whether for A / D / S / I (as above):	Date
First review by ICB Board – today's meeting	26 March 2026

(3) Implications:	
Legal / Regulatory	Required to meet statutory duties linked to the delegation of specialised services from April 2027. Ensures compliance with the NHS Act 2006 and Delegation Agreements.
CQC / Patient Safety	Strengthens quality governance through regional Quality Groups, MASCG, and clinical assurance structures.
Financial (CFO-assured)	No new expenditure; maintains existing pooled fund and risk-share arrangements for specialised services.
Sustainability	N/A
Workforce / Training	Supports transitional year where NHSE continues to host specialised commissioning staff. Training implications minimal.
Equality & Diversity	Agreement embeds adherence to statutory equality duties.
Due Regard: Inequalities	OPIC model designed to reduce inequalities and improve equitable access across Midlands' systems.
Due Regard: wider effect	Enhances system-wide planning, quality improvement and improved outcomes through shared approaches.

(4) Statutory Dependencies & Impact Assessments:						
	Completed?			If N - N/A, Rationale	If Y, Outcome / Date Reported & Signed off	
DPIA	Yes	No	N/A	The Agreement governs governance arrangements, not operational data flows.		
	☐	☐	☒			
EIA	Yes	No	N/A	Click or tap here to enter text.	<i>Outcome and date of completion:</i> Click or tap here to enter text.	
	☐	☐	☐			
QIA	Yes	No	N/A	No direct service change or quality impact at this stage.		
	☐	☐	☒			
Has there been Public / Patient Involvement?				Yes	No	N/A
				☐	☐	☐
				<i>Click or tap here to enter text.</i>		

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

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

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

The Updated Collaboration Agreement 2026/27 sets out the governance, joint working and financial arrangements required for Midlands ICBs and NHS England to continue the safe, effective and collaborative commissioning of delegated and retained specialised services during the 2026/27 transition year.

The Agreement includes the revised Terms of Reference for the Midlands Joint & Collaborative Committee, which will operate as the single regional forum for:

- Joint discharge of delegated specialised commissioning responsibilities.
- Collaborative decision-making with NHS England on retained functions (screening, vaccination, Health & Justice).

This update reflects the policy shift towards establishing the Office of Pan-ICB Commissioning (OPIC) as the regional model for specialist commissioning, ahead of the statutory transfer of functions from NHSE to ICBs in April 2027. The updated governance arrangements are required to be approved by each ICB Board before April 2026 to ensure readiness and continued compliance.

(7) Recommendations to Board:

- ☒ To **APPROVE** the Updated Collaboration Agreement 2026/27, including its Terms of Reference for the Midlands Joint & Collaborative Committee.
- ☒ To **NOTE** that formal approval is required by all Midlands ICBs prior to April 2026.
- ☒ To **ENDORSE** the implementation of the joint working arrangements for the 2026/27 transition year.

Main Body of the Report

2.1 Introduction

This report presents the Updated Collaboration Agreement for 2026/27 for approval by the Integrated Care Board (ICB). The Agreement sets out the governance, operational and joint working arrangements that will apply across all Midlands ICBs and NHS England during the 2026/27 transition year. It includes the updated Terms of Reference for the Midlands Joint & Collaborative Committee, which will act as the unified regional forum for commissioning oversight, replacing the previous East and West Midlands Joint Committees. These updates are required ahead of the statutory changes anticipated from April 2026 and must be approved by each ICB Board prior to that date.

2.2 Background

In line with national policy direction and the anticipated legislative dissolution of NHS England, ICBs are preparing to take on full statutory responsibility for specialised services, Health and Justice, screening, and vaccination services from April 2027. This represents a significant transfer of commissioning accountability, covering services totalling £20bn nationally, including approximately £5bn within the Midlands region.

To support safe and effective transition, all Midlands ICBs are required to operate within an agreed joint governance framework during 2026/27. The national planning framework mandates the establishment of an Office of Pan-ICB Commissioning (OPIC) in each NHS region, with Birmingham & Solihull ICB and Black Country ICB jointly hosting the Midlands OPIC. OPIC will support collaboration, maintain specialist commissioning capacity, and provide a single regional mechanism for decisions requiring a larger planning footprint.

Since April 2024, delegated specialised acute and mental health/learning disability/autism services have been jointly overseen through two separate regional committees; however, to strengthen alignment, the system has agreed to move to a single Midlands Joint & Collaborative Committee with updated responsibilities and decision-making scope. This is reflected in the Terms of Reference embedded within the updated Collaboration Agreement.

2.3 Main Body of report

2.3.1 Purpose and Scope of the Updated Collaboration Agreement

The updated Collaboration Agreement outlines the multi-ICB and NHS England arrangements governing specialised commissioning across the Midlands for the 2026/27 transitional year. It details how ICBs and NHS England will jointly plan, commission, monitor, and assure both delegated services and retained services, ensuring alignment with national policy, statutory duties, and the Delegation Agreements in place.

The Agreement covers:

- Joint decision-making arrangements;
- Establishment of the Joint & Collaborative Committee;
- Financial arrangements including pooled and non-pooled fund mechanisms;

- Clinical, quality and performance oversight structures;
- Subgroups such as MASCG, MHLDACG, Vaccination Governance Group, Screening Governance Group, Health & Justice Improvement Group;
- Transition arrangements while specialised commissioning staff remain hosted by NHS England during 2026/27.

2.3.2 Updated Terms of Reference for the Joint & Collaborative Committee

The Terms of Reference (ToR) define the Committee's statutory basis (under NHS Act 2006 s.65Z6), membership, authority, quorum, and decision-making framework. The Committee's core responsibilities include:

- Providing strategic leadership in commissioning specialised services;
- Overseeing population health insights and developing cross-Midlands commissioning frameworks;
- Providing financial and quality assurance for services within its scope;
- Acting as the formal collaborative forum through which NHS England exercises its retained commissioning functions (e.g., screening, vaccinations, Health & Justice) in consultation with ICBs.

This shift supports a coherent Midlands-wide approach to joint commissioning and reflects the move towards an OPIC operating model.

2.3.3 Operational Arrangements for 2026/27

During 2026/27, all specialised commissioning staff continue to be employed and hosted by NHS England, but work on behalf of the ICBs in preparation for full transfer in April 2027. The Commissioning Team, including clinical and pharmacy leadership, will be responsible for contract management, quality assurance, financial monitoring, and provider oversight, reporting through the governance structure outlined in the Agreement.

This year will also involve organisational development work and workforce design to shape how the Midlands OPIC will operate once hosted by ICBs from April 2027.

2.3.4 Financial Framework

Financial governance is established under Schedule 4 of the Agreement. Key elements include:

- A Midlands-wide risk-share agreement for in-year variation in specialised activity;
- A notional pooled fund for Elective Recovery Fund (ERF) and variable-cost specialised services;
- Clear delegated limits for contract awards, variations, procurement and virements;
- Monthly financial reporting by the hosted specialised commissioning finance team.

The Agreement does not introduce new financial burdens but formalises the mechanisms for shared risk and joint budget stewardship already required for specialised services.

2.3.5 Quality, Safety and Assurance

The Agreement embeds robust clinical and quality structures, including:

- The Specialised Commissioning Quality Group (regional quality forum);
- Monthly reporting of quality concerns to the Joint & Collaborative Committee;
- Alignment with the NHSE Oversight and Assurance Framework;
- Use of Operational Delivery Networks, clinical networks and QSIP for quality surveillance and improvement.

These ensure that delegated and retained services are safe, effective, and equitable.

2.3.6 Equality, Population Health and Reducing Inequalities

Reducing inequalities is a core aim of the OPIC model and the Collaboration Agreement. The governance structure is designed to promote consistent access, reduce unwarranted variation across systems, and support the statutory duty to improve population health outcomes equitably.

2.4 Conclusion

The updated Collaboration Agreement provides a clear and legally compliant foundation for joint commissioning across the Midlands during the required 2026/27 transition year. It strengthens governance, clarifies decision-making responsibilities, aligns the region around a single committee structure, and prepares ICBs for the statutory transfer of specialised commissioning functions in 2027. Approval of the Agreement is therefore essential to ensure continuity, readiness and compliance.

2.5 Recommendation(s)

The Board is asked to:

1. **Approve** the Updated Collaboration Agreement 2026/27, including the updated Terms of Reference for the Joint & Collaborative Committee
2. **Note** the requirement for approval by all Midlands ICBs before April 2026.
3. **Support** continued participation in the regional joint working arrangements and preparatory work for the OPIC transition.

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Briefing Paper for ICB Boards

Date: February 2026

Paper Title: **Direct and Specialised Commissioning Update:** Establishing the Office of Pan ICB Commissioning proposed transition and governance arrangements.

Executive summary: This paper provides a summary of the move from an East Midlands and a West Midlands Joint Committee to a Midlands Joint and Collaborative Committee and the development of the Office of Pan ICB Commissioning (OPIC) as part of the transition prior to transfer/delegation of NHS England's regional commissioning functions

1. Introduction

- 1.1 Following the announcement of the dissolution of NHSE (subject to approval by Parliament to necessary legislative changes) and the publication of the model ICB Blueprint, from April 27, Integrated Care Boards (ICBs) will take over statutory responsibility from NHS England for commissioning suitable specialised services; health and justice services; and screening and vaccination services. Collectively, these services account for £20bn of commissioning spend in 25/26; circa £5bn within the Midlands.
- 1.2 The National Planning Framework confirmed the agreed Direct Commissioning Policy requiring ICBs to establish, in each of the seven regions, an 'Office of Pan ICB Commissioning (OPIC)' with one host ICB per region to support all ICBs across a region in discharging these additional specialist statutory functions. For the Midlands, Birmingham and Solihull & the Black Country Cluster ICBs will be the host ICB for the Midlands
- 1.3 The OPIC model is designed to facilitate ICB collaboration and, where appropriate, 'at scale' commissioning as well as ensuring economies of scale and the critical mass of expert commissioning capability is maintained for these complex and high-profile services.

2. Responsibilities and Accountabilities

- 2.1 The delegation of services does not change the accountability of the services, as under delegation NHSE retains accountability. When a functions transfers both the responsibility and accountability pass to the receiving organisation. Transfers of commissioning functions are subject to the passage of legislation.

Services transferring under new legislation include

- Mental Health Learning Disability and Autism Services
- Specialised Acute
- Health and Justice

- 2.2 For NHS public health functions (section 7A functions) this will be achieved through delegation of the Secretary of State's relevant public health functions directly to ICBs (currently delegated to NHSE).

Services that will be delegated from DHSC to ICBs

- Vaccination Services (including within the secure and detained estate)
- Screening Service (including within the secure and detained estate)
- Child Health Information Services (CHIS)

- 2.3 Under transfer and delegation, the intent is the same, that ICBs have full responsibility for the commissioning functions.

- 2.4 Whilst it is intended that ICBs will be individually responsible, most of their new commissioning functions will require – due to the nature of the services and populations involved – the larger planning and commissioning footprint that OPIC provides.
- 2.5 Other direct commissioning functions of NHS England, including highly specialised services; high secure mental health services; the management of high-cost drugs and devices; and services for the armed forces community will transfer to DHSC (whilst continuing to work with each OPIC) and become the responsibility of the Secretary of State for Health and Social Care.
- 2.6 Staff currently delivering these commissioning functions within NHSE’s seven regional teams will transfer to the host ICBs in April 2027 (or, at the point legislative provisions transferring these functions to ICBs is commenced), forming the seven OPICs. Until transfer NHS England will continue to host staff on behalf of ICBs for specialised services functions already delegated to ICBs.
- 2.7 NHS England’s continued hosting and the OPIC transition will be governed through a Collaboration agreement, overseen by the Midlands Joint and Collaborative Committee

3.0 Current Position

- 3.1 Specified Specialised Acute and MHLDA services were delegated to ICBs in April 2024 and April 2025 with the expected transfer of the specialist team to the host ICB (Birmingham & Solihull ICB) in July 2025. This transfer of staff was subsequently delayed due new policy (as described above).
- 3.2 Since April 2024 Midlands ICBs have successfully undertaken joint decision making for delegated specialised services through two formal Joint Committees, with the East Midlands and West Midlands Joint Committees operating autonomously. Given the intent to align priorities and decision making around care pathways, both Committees have NHSE around the table to support joint decision making on the specialised services currently still retained by NHSE.

4.0 Working towards the future

- 4.1 The vision for OPIC is to create a new model of specialist commissioning, one that succeeds not through structural redesign alone, but through a fundamental shift in how we operate and work together.
- 4.2 OPIC will be built on the foundations of improving population health, reducing health inequalities and improving equitable access to consistently high-quality healthcare. Through shared leadership and collaboration OPIC will operate on behalf of all Midlands ICBs equally.

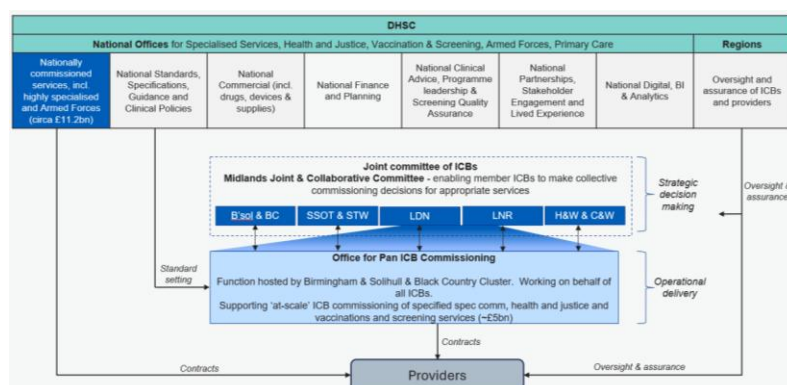


Figure 1: The Model for the Office of Pan-ICB Strategic Commissioning

- 4.2 This model requires a robust governance structure that drives pace and realises the benefits of integration. The running cost allowance (RCA) allocations for the OPIC will be confirmed shortly, this will be **in addition to the core ICB £19 per head RCA allocation**.
- 4.3 Provider Collaboration will be central to the development of new ways of working and will be built on proven principles of governance, shared financial risk, clinical integration and equity. This will enable a move from looking at service fragility and delivery to population health, access and equity promoting specialist innovation.

5.0 Governance

- 5.1 New governance arrangements will build on what works well currently, being capable of effectively overseeing and managing the 2026/27 transition. Transition arrangements will be as close as possible to the April 2027 end state, whilst ensuring each statutory body meets their obligations.
- 5.2 Recognising the move the 5 Clusters, the East Midlands and West Midlands Joint Committees have agreed that a Midlands Joint and Collaborative Committee is the most effective way of ensuring robust joint and collaborative strategic commissioning at scale. This single Midlands Committee will also operate as a Collaborative Committee with NHSE until the point that statutory duties change, so that decisions can be made collaboratively and with ICBs taking a greater leadership role for all relevant services, whilst recognising current NHSE responsibilities and accountabilities.
- 5.3 Moving to the end state governance model in April 2026 will provide ICBs with robust oversight of the transition and transfer of functions alongside managing business as usual, enabling a balance between the two whilst optimising ICB executive involvement. ICBs may also wish to add additional functions to the responsibilities of the Office of Pan ICB Commissioning.
- 5.4 During 2026/27 all staff will remain hosted by NHS England; therefore, as such they will continue to fulfil NHS England's statutory obligations whilst working for and behalf of ICBs.
- 5.5 Moving towards our end state governance and transforming functions prior to April 2027 is pivotal to enable us to maximise opportunities for designing services and pathways of care that better meet local priorities. Therefore, the NHSE employed team will transform to meet the agreed running cost allowance envelope, prior to transfer to the host ICB.
- 5.6 To move into the Midlands Joint and Collaborative Committee, cluster ICB Boards will need to provide their representative with the authority, to enable their executive representative to make decisions, at the Joint and Collaborative Committee, on behalf of their cluster ICB.
- 5.7 As part of the updated governance arrangements, ICB Boards will receive formal output from the Midlands Joint and Collaborative Committee to provide Boards with assurance that their statutory functions are being carried out robustly.

6.0 Next steps

- 6.1 The OPIC will start to operate in shadow form, undergoing transformation change during 2026/27 in readiness for the transfer of functions and staff to BSol and Black Country ICB as the Midlands host ICB.
- 6.2 Further detailed operating model and workforce model will be developed during 2026

- 6.3 The updated Collaboration Agreement, outlines the 2026/27 joint working arrangements and terms of reference for the Joint and Collaborative Committee, and are subject to ICB board approval prior to April 2026.

END

Midlands ICB Specialised Services and NHS England Commissioning Services Collaboration Agreement 2026/27

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THIS AGREEMENT is made on the first day of April 2026

BETWEEN the following clusters of ICBs & NHS England:

Cluster 1

- (1) **NHS Lincolnshire Integrated Care Board** of Bridge House, The Point, Lions Way, Sleaford, NG34 8GG ("Lincolnshire ICB"); and
- (2) **NHS Nottingham & Nottinghamshire Integrated Care Board** of Sir John Robinson House, Sir John Robinson Way, Arnold, Nottingham, NG5 6DA ("Nottingham & Nottinghamshire ICB"); and
- (3) **NHS Derby & Derbyshire Integrated Care Board** of Cardinal Square, 10 Nottingham Road, Derby, Derbyshire, DE1 3QT ("Derby & Derbyshire ICB"). and

Cluster 2

- (4) **NHS Leicester, Leicestershire & Rutland Integrated Care Board** Room G30, Pen Lloyd Building, County Hall, Glenfield, Leicester, LE3 8TB ("Leicester, Leicestershire & Rutland ICB"); and
- (5) **NHS Northamptonshire Integrated Care Board** of Haylock House, Kettering Parkway, Venture Park, Kettering NN15 6EY ("Northamptonshire ICB"); and

Cluster 3

- (6) **NHS Birmingham & Solihull Integrated Care Board** of Eighth Floor, Alpha Tower, Birmingham
- (7) ("Birmingham & Solihull ICB"); and
- (8) **NHS Black Country Integrated Care Board** of Civic Centre, St Peters Square, Wolverhampton WV1 1SD ("Black Country ICB"); and

Cluster 4

- (9) **NHS Herefordshire & Worcestershire Integrated Care Board** of Kirkham House, John Comyn Drive, Perdisswell, Worcester, WR3 7NS ("Herefordshire & Worcestershire ICB"); and
- (10) **NHS Coventry & Warwickshire Integrated Care Board** of Shire Hall, Market Place, Warwick CV34,4RL ("Coventry & Warwickshire ICB"); and

Cluster 5

- (11) **NHS Shropshire, Telford & Wrekin Integrated Care Board** of Halesfield 6, Halesfield, Telford, TF7 4BF ("Shropshire, Telford & Wrekin ICB"); and
- (12) **NHS Staffordshire & Stoke-on-Trent Integrated Care Board** of Stafford Education & Enterprise Park, Weston Road, Stafford, ST18 0BF ("Staffordshire & Stoke-on-Trent ICB");

and

- (13) **NHS England** of **Wellington House, 133-155 Waterloo Road, London, SE1 8UG** (acting under the name NHS England) ("**NHS England**").

each a "Partner" and together the "Partners".

Lincolnshire ICB, Nottingham & Nottinghamshire ICB, Leicester, Leicestershire & Rutland ICB, Northamptonshire ICB, Derby & Derbyshire ICB, Birmingham & Solihull ICB, Black Country ICB, Herefordshire & Worcestershire ICB, Coventry & Warwickshire ICB, Shropshire, Telford & Wrekin ICB and Staffordshire & Stoke-on-Trent ICB are together referred to in this Agreement as the “ICBs”, and “ICB” shall mean any of them.

BACKGROUND

- (A) NHS England has statutory functions to make arrangements for the provision of prescribed services for the purposes of the NHS.
- (B) The ICBs have statutory functions to make arrangements for the provision of services for the purposes of the NHS in their Areas, apart from those commissioned by NHS England.
- (C) Pursuant to section 65Z5 of the NHS Act, NHS England and the ICBs can establish and maintain joint arrangements in respect of the discharge of their Commissioning Functions.
- (D) Under the Delegation Agreement made pursuant to section 65Z5, NHS England has delegated the Delegated Functions to each of the ICBs. NHS England has retained responsibility for the NHS England Reserved Functions and commissioning of the Retained Services.
- (E) It is agreed that to exercise the Delegated Functions in the most efficient and effective manner, some of the Delegated Services are best commissioned collaboratively between multiple ICBs.
- (F) This Agreement sets out the arrangements that will apply between the ICBs and NHS England in relation to the collaborative commissioning of Specialised Services for the ICBs' Populations.

NOW IT IS HEREBY AGREED as follows:

1. COMMENCEMENT AND DURATION

- 1.1 This Agreement has effect from the date of this Agreement and will remain in force unless terminated in accordance with Clause 23 (*Termination & Default*) below.

2. PRINCIPLES AND AIMS

2.1 BACKGROUND

- A. NHS England has statutory functions to make arrangements for the provision of prescribed services for the purposes of the NHS.
- B. The ICBs have statutory functions to make arrangements for the provision of services for the purposes of the NHS in their Areas, apart from those commissioned by NHS England.
- C. Pursuant to section 65Z5 of the NHS Act, NHS England and the ICBs can establish and maintain joint arrangements in respect of the discharge of their Commissioning Functions.
- D. Under the Delegation Agreement made pursuant to section 65Z5, NHS England has delegated the Delegated Functions to each of the ICBs. NHS England has retained responsibility for the NHS England Reserved Functions and commissioning of the Retained Services.
- E. It is agreed that to exercise the Delegated Functions in the most efficient and effective manner, some of the Delegated Services are best commissioned collaboratively between multiple ICBs.
- F. This Agreement sets out the arrangements that will apply between the ICBs and NHS England in relation to the collaborative commissioning of Specialised Services for the ICBs' Populations.
- G. This Agreement sets out the arrangement that will apply between ICBs and NHS England in relation to the collaborative commissioning of NHSE retained commissioning functions

- 2.2 The Partners acknowledge that, in exercising their obligations under this Agreement, each Partner must comply with the statutory duties set out in the NHS Act and must:

- 2.2.1 consider how it can meet its legal duties to involve patients and the public in shaping the provision of Services, including by working with local communities, under-represented groups, and those with protected characteristics for the purposes of meeting the obligation of the Equality Act 2010;
- 2.2.2 consider how, in performing its obligations, it can address health inequalities;
- 2.2.3 at all times exercise functions effectively, efficiently, and economically; and

2.2.4 act always in good faith towards each other.

2.3 The Partners agree:

2.3.1 that successfully implementing this Agreement will require strong relationships and an environment based on trust and collaboration;

2.3.2 to seek to continually improve whole pathways of care including Specialised Services and to design and implement effective and efficient integration;

2.3.3 to act in a timely manner;

2.3.4 to share information and best practice, and work collaboratively to identify solutions, eliminate duplication of effort, mitigate risks, and reduce cost;

2.3.5 to act at all times, ensuring the Partners comply with the requirements of the Delegation Agreements including Mandated Guidance;

2.3.6 to act at all times in accordance with the scope of their statutory powers; and

2.3.7 to have regard to each other's needs and views, irrespective of the relative contributions of the Partners to the commissioning of any Services and, as far as is reasonably practicable, take such needs and views into account.

2.4 The Partners' aims are:

2.4.1 to maximise the benefits to patients of integrating the Delegated Functions with the ICBs' Commissioning Functions through designing and commissioning the Specialised Services as part of the wider pathways of care of which they are a part and, in doing so, promote the Triple Aim;

2.4.2 to maximise the benefits to patients of integrating NHSE retained commissioning functions with the ICB Commissioning Functions through designing and commissioning services as part of the wider pathways of care of which they are a part

3. **SCOPE OF THE ARRANGEMENTS**

3.1 This Agreement sets out the Joint Working Arrangements through which the Partners will work together to commission Services. This may include one or more of the following commissioning mechanisms (the "Flexibilities") although this list is not exhaustive:

3.1.1 Lead Commissioning Arrangements: where agreed Commissioning Functions are delegated to a lead Partner (Lead Partner);

3.1.2 Aligned Commissioning Arrangements: where there is no further delegation of the Commissioning Functions. However, the Partners agree mechanisms to co-operate in the commissioning of identified Services;

3.1.3 Joint Commissioning Arrangements: where the Partners exercise agreed Commissioning Functions jointly;

3.1.4 the establishment of one or more Joint Committees;

3.1.5 the establishment of one or more Commissioning Teams;

- 3.1.6 the establishment of one or more Pooled Funds;
- 3.1.7 the use of one or more Non-Pooled Fund.
- 3.2 At the Commencement Date the Partners agree that the following Joint Working Arrangements shall be in place:
 - 3.2.1 Delegation by NHS England of the Delegated Functions to each individual ICB in accordance with the relevant Delegation Agreement.
 - 3.2.2 Establishment of the following Joint Working Arrangements for delegated and retained services:
 - Maintenance of the established Commissioning Team, hosted by NHS England in accordance with Clause 5.1 through which agreed Delegated and Retained Services may be commissioned in line with the Commissioning Team Agreement in Schedule 6;
 - Delegation of responsibilities by the ICBs to a Joint Committee and other associated sub-groups established in accordance with Schedule 2;
 - Approval of the two schemes for the commissioning of delegated and retained services for the Midlands multi-ICBs and for the collaborative commissioning of retained services as set out in Schedule 3;
 - Establishment of financial risk share and pooled budget arrangement as set out in Schedule 4.

4. **FUNCTIONS**

- 4.1 The purpose of this Agreement is to establish a framework through which the Partners can secure the commissioning of health services in accordance with the terms of this Agreement.
- 4.2 This Agreement shall include such Commissioning Functions as shall be agreed from time to time by the Partners and set out in the relevant Scheme Specifications.
- 4.3 The Scheme Specifications for the Individual Schemes included as part of this Agreement at the Commencement Date are set out in Schedule 3.
- 4.4 Where the Partners add a new Individual Scheme to this Agreement, a Scheme Specification for each Individual Scheme shall be completed and approved by each Partner in accordance with the variation procedure set out in Clause 13 (*Variations*).
- 4.5 The Partners shall work in co-operation and shall endeavour to ensure that all Services are commissioned with all due skill, care and attention irrespective of the Joint Working Arrangements utilised.
- 4.6 Where there are Lead Commissioning Arrangements in respect of any Individual Scheme, unless the Scheme Specification otherwise provides, the Lead Partner shall:
 - 4.6.1 exercise the Functions of each Partner as identified in the relevant Scheme Specification;

- 4.6.2 endeavour to ensure that all Commissioning Functions included in the relevant Individual Scheme are funded as agreed by each Partner in respect of each Financial Year;
- 4.6.3 comply with all relevant legal duties and Guidance of all Partners in relation to the Services being commissioned;
- 4.6.4 perform all commissioning obligations with all due skill, care and attention;
- 4.6.5 undertake performance management and contract monitoring of all service contracts including (without limitation) the use of contract notices where Services fail to deliver contracted requirements;
- 4.6.6 make payment of all sums due to a Provider pursuant to the terms of any Services Contract; and
- 4.6.7 keep the other Partner(s) regularly informed of the effectiveness of the Joint Working Arrangements including any forecasted Overspend or Underspend where there is a Pooled Fund or Non-Pooled Fund.

5. **COMMISSIONING TEAM**

- 5.1 The Partners agree to establish a Commissioning Team(s) as set out in Schedule 6 (Commissioning Team Arrangements)

6. **STAFFING**

- 6.1 The staffing arrangements in respect of each Individual Scheme shall be as set out in the relevant Scheme Specification and Joint Working Arrangements.

7. **JOINT COMMITTEE**

- 7.1 Where Partners intend to form a Joint Committee then the arrangements for the Joint Committee shall be as set out in Schedule 2 (*Governance Arrangements*); and the relevant Joint Committee Terms of Reference.
- 7.2 An ICB may, at its discretion, table for discussion at any Joint Committee meeting an item relating to any ICB Function, in order to facilitate engagement and promote integration and collaborative working. Decision-making in respect of such discussions will remain with the relevant ICB. For the avoidance of doubt, the Joint Committee will not have any authority to take decisions in respect of ICB Functions, outside of services defined in Schedule 3.
- 7.3 NHSE may table for discussion at any Joint Committee meeting an item relating to NHSE's accountability to the Secretary of State and Parliament in respect of any NHSE delegated Functions or any such other of NHSE's Functions that it considers appropriate in order to facilitate engagement and promote integration and collaborative working.

8. **GOVERNANCE**

- 8.1 Overall strategic oversight of partnership working between the Partners shall be as set out in Schedule 2 (*Governance Arrangements*).

- 8.2 Each Partner has internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.
- 8.3 The Governance Arrangements shall set out how the Partners shall provide overall oversight and approval of Individual Schemes and variations to those Individual Schemes.
- 8.4 Each Scheme Specification shall confirm the Governance Arrangements in respect of the Individual Scheme and how that Individual Scheme is reported to each partner.

9. **POOLED FUNDS, NON-POOLED FUNDS AND RISK SHARING**

- 9.1 The Partners may establish Pooled Funds, Non-Pooled Funds and agree Risk Sharing in accordance with Schedule 4 (*Financial Arrangements*).

10. **REVIEW**

- 10.1 Save where the Partners agree alternative arrangements (including alternative frequencies) the Partners shall undertake an Annual Review of the operation of this Agreement, any Pooled Fund and Non-Pooled Fund and the provision of the Services within three (3) months of the end of each Financial Year.
- 10.2 Annual Reviews shall be conducted in good faith.

11. **COMPLAINTS**

- 11.1 Complaints will be managed by the specialised commissioning team hosted by NHSE England in line with the agreed complaints process.
- 11.2 A report summarising complaints, actions and lessons learnt will be provided to the Joint and Collaborative Committee annually.

12. **FINANCES**

- 12.1 The financial arrangements shall be as agreed between the Partners in the relevant Scheme Specification and Schedule 4 (*Financial Arrangements*).
- 12.2 Unless expressly provided otherwise in this Agreement or otherwise agreed in advance in writing by the Partners, each Partner shall bear its own costs as they are incurred.

13. **VARIATION**

- 13.1 The Partners acknowledge that the scope of the Collaboration Arrangements may be reviewed and amended from time to time.
- 13.2 This Agreement may be varied by the agreement of the Partners at any time in writing in accordance with the Partners' internal decision-making processes.
- 13.3 No variations to this Agreement will be valid unless they are recorded in writing and signed for and on behalf of each of the Partners.
- 13.4 Where the Partners agree that there will be:

- 13.4.1 a new Pooled Fund;
- 13.4.2 a new Individual Scheme; or
- 13.4.3 an amendment to a current Individual Scheme,

the Partners shall agree the new or amended Individual Scheme in accordance with the Governance Arrangements and, in respect of amendments, the Scheme Specification. Each new or amended Individual Scheme must be signed by each of the Partners. A request to vary an Individual Scheme, which may include (without limitation) a change in the level of Financial Contributions or other matters set out in the relevant Scheme Specification, may be made by any Partner but will require agreement from all the Partners. The notice period for any variation unless otherwise agreed by the Partners shall be three (3) months or in line with the notice period for variations within the associated Service Contract(s), whichever is the shortest.

13.5 Partners may propose additional schemes to be added to this agreement via the Joint Committees.

13.6 The following approach shall, unless otherwise agreed, be followed by the Partners:

13.6.1 on receipt of a request from one Partner to vary the Agreement including (without limitation) the introduction of a new Individual Scheme or amendments to an existing Individual Scheme, the Partners will first undertake an impact assessment and identify the likely impact of the variation including those Individual Schemes and Service Contracts likely to be affected;

13.6.2 the Partners will agree any action to be taken because of the proposed variation. This shall include consideration of:

13.5.2.1 governance and decision-making arrangements;

13.5.2.2 oversight and assurance arrangements;

13.5.2.3 contracting arrangements; and/or

13.5.2.4 whether the proposed variation could have an impact on a Commissioning Team and/or any Staff;

13.6.3 wherever possible agreement will be reached to reduce the level of funding in the Service Contract(s) in line with any reduction in budget; and

13.6.4 should this not be possible, and one Partner is left financially disadvantaged because of the proposed variation, then the financial risk will, unless otherwise agreed, be apportioned according to the financial risk share arrangement detailed in Schedule 4.

14. DATA PROTECTION

14.1 The Partners must ensure that all Personal Data processed by or on behalf of them while carrying out the Joint Working Arrangements is processed in accordance with the relevant Partner's obligations under Data Protection

Legislation and Data Guidance, and the Partners must assist each other as necessary to enable each other to comply with these obligations.

- 14.2 Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a need-to-know basis. If any Partner:
 - 14.2.1 becomes aware of any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted, or unusable; or
 - 14.2.2 becomes aware of any security breach,in respect of the Relevant Information, it shall promptly notify the relevant Partners and NHS England. The Partners shall fully cooperate with one another to remedy the issue as soon as reasonably practicable.
- 14.3 In processing any Relevant Information further to this Agreement, each Partner shall at all times comply with their own policies and any NHS England policies and guidance on the handling of data.
- 14.4 Any information governance breach must be responded to in accordance with the Information Governance Guidance for Serious Incidents. If any Partner is required under Data Protection Legislation to notify the Information Commissioner's Office or a Data Subject of an information governance breach, then, as soon as reasonably practical and in any event on or before the first such notification is made, the relevant Partner must fully inform the other Partners of the information governance breach. This clause does not require the relevant Partner to provide information which identifies any individual affected by the information governance breach were doing so would breach Data Protection Legislation.
- 14.5 Whether or not a Partner is a Data Controller or Data Processor will be determined in accordance with Data Protection Legislation and any Data Guidance from a Regulatory or Supervisory Body. The Partners acknowledge that a Partner may act as both a Data Controller and a Data Processor.
- 14.6 The Partners will share information to enable joint service planning, commissioning, and financial management subject to the requirements of Law, including the Data Protection Legislation in respect of any Personal Data.
- 14.7 Other than in compliance with judicial, administrative, governmental, or regulatory process in connection with any action, suit, proceedings or claim or otherwise required by any Law, no information will be shared with any third parties save as agreed by the Partners in writing.
- 14.8 Schedule 5 (*Further Information Governance and Sharing Provisions*) makes further provision about information sharing, information governance and includes the data controller agreement (Schedule 5 Appendix 1) .

15. IT INTER-OPERABILITY

- 15.1 The Partners will work together to ensure that all relevant IT systems operated by the Partners in respect of the Joint Working Arrangements are inter-operable and that data may be transferred between systems securely, easily and efficiently.

- 15.2 The Partners will each use reasonable endeavours to help develop initiatives to further this aim.

16. FURTHER ARRANGEMENTS

- 16.1 The Partners must give due consideration to whether any of the Commissioning Functions should be exercised collaboratively with other NHS bodies or Local Authorities including, without limitation, by means of arrangements under section 65Z5 and section 75 of the NHS Act. The Partners must comply with any Guidance around the commissioning of Specialised Services by means of arrangements under section 65Z5 or 75 of the NHS Act.

17. FREEDOM OF INFORMATION

- 17.1 Each Partner acknowledges that the others are a public authority for the purposes of the Freedom of Information Act 2000 ("FOIA") and the Environmental Information Regulations 2004 ("EIR").
- 17.2 Each Partner may be statutorily required to disclose further information about the Agreement and the FOIA or EIA Information in response to a specific request under FOIA or EIR, in which case:
- 17.2.1 each Partner shall provide the other Partners with all reasonable assistance and co-operation to enable them to comply with their obligations under FOIA or EIR;
 - 17.2.2 each Partner shall consult the other Partners as relevant regarding the possible application of exemptions in relation to the FOIA or EIA Information requested; and
 - 17.2.3 each Partner acknowledges that the final decision as to the form or content of the response to any request is a matter for the Partner to whom the request is addressed.
- 17.3 The commissioning team will respond to all FOIA requests on behalf of Partners as part of the administrative responsibility set out in Schedule 6 (Commissioning Team Agreement and Standard Operating Framework).

18. CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY

- 18.1 The Partners must ensure that, in delivering the Joint Working Arrangements, all Staff comply with Law, with Managing Conflicts of Interest in the NHS and other Guidance, and with Good Practice, in relation to gifts, hospitality and other inducements and actual or potential conflicts of interest.
- 18.2 Each ICB must maintain a register of interests in respect of all persons involved in decisions concerning the Joint Working Arrangements. This register must be publicly available. For the purposes of this clause, an ICB may rely on an existing register of interests rather than creating a further register.

19. CONFIDENTIALITY

- 19.1 Except as this Agreement otherwise provides, Confidential Information is owned by the disclosing Partner and the receiving Partner has no right to use it.

- 19.2 Subject to Clause 19.3, the receiving Partner agrees:
- 19.2.1 to use the disclosing Partner's Confidential Information only in connection with the receiving Partner's performance under this Agreement;
 - 19.2.2 not to disclose the disclosing Partner's Confidential Information to any third party or to use it to the detriment of the disclosing Partner; and
 - 19.2.3 to maintain the confidentiality of the disclosing Partner's Confidential Information.
- 19.3 The receiving Partner may disclose the disclosing Partner's Confidential Information:
- 19.3.1 in connection with any Dispute Resolution Procedure;
 - 19.3.2 to comply with the Law;
 - 19.3.3 to any appropriate Regulatory or Supervisory Body;
 - 19.3.4 to its Staff, who in respect of that Confidential Information will be under a duty no less onerous than the Receiving Partner's duty under Clause 19.2;
 - 19.3.5 to NHS bodies for the purposes of carrying out their functions; and
 - 19.3.6 as permitted under any other express arrangement or other provision of this Agreement.
- 19.4 The obligations in Clause 19 will not apply to any Confidential Information which:
- 19.4.1 is in or comes into the public domain other than by breach of this Agreement;
 - 19.4.2 the receiving Partner can show by its records was in its possession before it received it from the disclosing Partner; or
 - 19.4.3 the receiving Partner can prove it obtained or was able to obtain from a source other than the disclosing Partner without breaching any obligation of confidence.
- 19.5 This Clause 19 does not prevent NHS England making use of or disclosing any Confidential Information disclosed by an ICB where necessary for the purposes of exercising its functions in relation to that ICB.
- 19.6 This Clause 19 will survive the termination of this Agreement for any reason for a period of five (5) years.
- 19.7 This Clause 19 will not limit the application of the Public Interest Disclosure Act 1998 in any way whatsoever.

20. LIABILITIES

- 20.1 Subject to Clause 20.2, and 20.3, if a Partner ("First Partner") incurs a Loss arising out of or in connection with this Agreement (including a Loss arising

under an Individual Scheme) as a consequence of any act or omission of another Partner ("Other Partner") which constitutes negligence, fraud or a breach of contract in relation to this Agreement then the Other Partner shall be liable to the First Partner for that Loss.

- 20.2 Clause 20.1 shall only apply to the extent that the acts or omissions of the Other Partner contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other Partner acting in accordance with the instructions or requests of the First Partner. Clause 20.1 shall not apply in respect of Loss where an alternative arrangement has been agreed by the Partners and set out in the relevant Scheme Specification.
- 20.3 If any third party makes a Claim or intimates an intention to make a Claim against any Partner, which may reasonably be considered as likely to give rise to liability under this Clause 20, the Partner that may have a Claim against the Other Partner will:
 - 20.3.1 as soon as reasonably practicable give written notice of that matter to the Other Partner specifying in reasonable detail the nature of the relevant Claim;
 - 20.3.2 not make any admission of liability, agreement, or compromise in relation to the relevant Claim without the prior written consent of the Other Partner (such consent not to be unreasonably conditioned, withheld or delayed); and
 - 20.3.3 give the Other Partner and its professional advisers reasonable access to its premises and Staff and to any relevant assets, accounts, documents and records within its power or control so as to enable the Other Partner and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant Claim.
- 20.4 Each Partner shall at all times take all reasonable steps to minimise and mitigate any loss for which one party is entitled to bring a Claim against the other pursuant to this Agreement.
- 20.5 Unless expressly agreed otherwise, nothing in this Agreement shall affect:
 - 20.5.1 the liability of NHS England to any person in respect of NHS England's Commissioning Functions; or
 - 20.5.2 the liability of any of the ICBs to any person in respect of that ICB's Commissioning Functions.
- 20.6 Each ICB must:
 - 20.6.1 comply with any requirements set out in the Delegation Agreement in respect of Claims and any policy issued by NHS England from time to time in relation to the conduct of or avoidance of Claims or the pro-active management of Claims;
 - 20.6.2 if it receives any correspondence, issue of proceedings, claim document or other document concerning any Claim or potential Claim, immediately notify the other Partners and send each relevant Partner all copies of such correspondence; and

- 20.6.3 co-operate fully with each relevant Partner in relation to such Claim and the conduct of such Claim.

21. DISPUTE RESOLUTION

- 21.1 Where any dispute arises between the Partners in connection with this Agreement, the Partners must use their best endeavours to resolve that dispute.
- 21.2 Where any dispute is not resolved under Clause 21.1 on an informal basis, any Authorised Officer may convene a special meeting of the Partners to attempt to resolve the dispute.
- 21.3 Where any dispute is not resolved under Clause 21.1 or 21.2 the Partners can appoint an independent mediator to attempt to resolve the dispute. The cost of mediation will be borne in equal shares between parties involved in the dispute.
- 21.4 Where any dispute remains unresolved after mediation, the Partners will commission an independent review. The Partners will abide by the independent review findings. The cost will be borne in equal shares between parties involved in the dispute.

22. BREACHES OF THE AGREEMENT

- 22.1 If any Partner ("Relevant Partner") fails to meet any of its obligations under this Agreement, the other Partners (acting jointly) may by notice require the Relevant Partner to take such reasonable action within a reasonable timescale as the other Partners may specify to rectify such failure. Should the Relevant Partner fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 21 (*Dispute Resolution*).
- 22.2 Without prejudice to Clause 22.1, if any Partner does not comply with the terms of this Agreement (including if any Partner exceeds its authority under this Agreement), the other Partners may at their discretion agree to:
 - 22.2.1 waive their rights in relation to such non-compliance;
 - 22.2.2 ratify any decision;
 - 22.2.3 terminate this Agreement in accordance with Clause 23 (*Termination and Default*) below; or
 - 22.2.4 exercise the Dispute Resolution Procedure in accordance with Clause 21 (*Dispute Resolution*).

23. TERMINATION AND DEFAULT

- 23.1 If an ICB wishes to end its participation in this Agreement, the relevant ICB must provide at least six (6) months' notice to the other Partners of its intention to end its participation in this Agreement and must have given prior notification to NHS England. Such notification shall only take effect from the end of 31 March in any calendar year and shall only take effect where alternative arrangements for the provision of the Delegated Services and effective

exercise of the Delegated Functions are in place for the period immediately following termination.

23.2 Each Individual Scheme may be terminated in accordance with the terms set out in the relevant Scheme Specification provided that each Partner is assured that the relevant Services will continue to be appropriately commissioned.

23.3 The ICBs will work together to ensure that there are suitable alternative arrangements in place in relation to the Services.

24. CONSEQUENCES OF TERMINATION

24.1 Upon termination of this Agreement (in whole or in part), for any reason whatsoever, the following shall apply:

24.1.1 the Partners agree that they will work together and co-operate to ensure that the winding down of these arrangements is carried out smoothly and with as little disruption as possible to patients, employees, the Partners and third parties, to minimise costs and liabilities of each Partner in doing so;

24.1.2 where there are Commissioning Team arrangements in place the Partners shall discuss and agree arrangements for the Staff and any financial arrangements;

24.1.3 where a Partner has entered a Service Contract in exercise of the Functions of any other Partner which continues after the termination of this Agreement, all Partners shall continue to provide necessary funding in accordance with the agreed contribution for that Service prior to termination and will enter all appropriate legal documentation required in respect of this;

24.1.4 where there are Lead Commissioning Arrangements in place, the Lead Partner shall make reasonable endeavours to amend or terminate a Service Contract (which shall for the avoidance of doubt not include any act or omission that would place the Lead Partner in breach of the Service Contract) where the other Partner requests the same in writing provided that the Lead Partner shall not be required to make any payments to a Service provider for such amendment or termination unless the Partners shall have agreed in advance who shall be responsible for any such payment;

24.1.5 where there are Joint Commissioning Arrangements in place, the Partners shall co-operate with each other as reasonably necessary to amend or terminate a Service Contract (which shall for the avoidance of doubt not include any act or omission that would place any Partner in breach of the Service Contract) where a Partner requests the same in writing provided that no Partner shall be required to make any payments to a Service provider for such amendment or termination unless the Partners shall have agreed in advance who shall be responsible for any such payment;

24.1.6 where a Service Contract held by a Lead Partner relates all or partially to services which relate to the other Partner's Functions and provided that the Service Contract allows, the other Partner may

request that the Lead Partner assigns the Service Contract in whole or part upon the same terms as the original contract; and

24.1.7 termination of this Agreement shall have no effect on the liability, rights or remedies of any Partner already accrued, prior to the date upon which such termination takes effect.

24.2 The provisions of Clauses 14 (*Data Protection*), 1717 (*Freedom of Information*), 19 (*Confidentiality*), 20 (*Liabilities*) and 24 (*Consequences of Termination*) shall survive termination or expiry of this Agreement.

25. **PUBLICITY**

25.1 The Partners shall use reasonable endeavours to consult one another before making any public announcements concerning the subject matter of this Agreement, the Joint Working Arrangements or any Services provided under the Joint Working Arrangements.

26. **EXCLUSION OF PARTNERSHIP OR AGENCY**

26.1 Nothing in this Agreement shall create or be deemed to create a legal partnership under the Partnership Act 1890 or the relationship of employer and employee between the Partners.

26.2 Save as specifically authorised under the terms of this Agreement, no Partner shall hold itself out as the agent of any other Partner.

27. **THIRD PARTY RIGHTS**

27.1 The Contracts (Rights of Third Parties) Act 1999 shall not apply to this Agreement and accordingly the Partners to this Agreement do not intend that any third party should have any rights in respect of this Agreement by virtue of that Act.

28. **NOTICES**

28.1 Any notices given under this Agreement must be sent by e-mail to the relevant Authorised Officers or their nominated deputies.

28.2 Notices by email will be effective when sent in legible form, but only if, following transmission, the sender does not receive a non-delivery message.

29. **ASSIGNMENT AND SUBCONTRACTING**

29.1 This Agreement, and any rights and conditions contained in it, may not be assigned or transferred by a Partner, without the prior written consent of the other Partners, except to any statutory successor to the relevant Commissioning Function.

30. **SEVERABILITY**

30.1 If any term, condition, or provision contained in this Agreement shall be held to be invalid, unlawful or unenforceable to any extent, such term, condition or provision shall not affect the validity, legality or enforceability of the remaining parts of this Agreement.

31. **WAIVER**

- 31.1 No failure or delay by a Partner to exercise any right or remedy provided under this Agreement or by Law shall constitute a waiver of that or any other right or remedy, nor shall it prevent or restrict the further exercise of that or any other right or remedy. No single or partial exercise of such right or remedy shall prevent or restrict the further exercise of that or any other right or remedy.

32. STATUS

- 32.1 The Partners acknowledge that they are health service bodies for the purposes of section 9 of the NHS Act. Accordingly, this Agreement shall be treated as an NHS contract and shall not be legally enforceable.

33. ENTIRE AGREEMENT

- 33.1 This Agreement constitutes the entire agreement and understanding of the Partners and supersedes any previous agreement between the Partners relating to the subject matter of this Agreement.

34. GOVERNING LAW AND JURISDICTION

- 34.1 Subject to the provisions of Clause 21 (*Dispute Resolution*) and Clause 32 (*Status*), this Agreement shall be governed by and construed in accordance with English Law, and the Partners irrevocably agree that the courts of England shall have exclusive jurisdiction to settle any dispute or claim that arises out of or in connection with this Agreement.

35. FAIR DEALINGS

- 35.1 The Partners recognise that it is impracticable to make provision for every contingency which may arise during the life of this Agreement and they declare it to be their intention that this Agreement shall operate between them with fairness and without detriment to the interests of any Partner and that, if in the course of the performance of this Agreement, unfairness to any Partner does or may result, then the Relevant Partner(s) shall use reasonable endeavours to agree upon such action as may be necessary to remove the cause or causes of such unfairness.

36. COUNTERPARTS

- 36.1 This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Agreement for all purposes.

This Agreement has been entered into on the Commencement Date

SIGNED by Amanda Sullivan

..... (Signature)

for and on behalf of NHS Nottingham &
Nottinghamshire Integrated Care Board, Derby &
Derbyshire Integrated Care Board and
Lincolnshire Integrated Care Board

..... (Date)

SIGNED by Toby Sanders (Signature)

for and on behalf of NHS Northamptonshire
Integrated Care Board and NHS Leicester,
Leicestershire & Rutland Integrated Care Board (Date)

SIGNED by Simon Trickett (Signature)

for and on behalf of NHS Herefordshire &
Worcestershire Integrated Care Board and
Coventry and Warwickshire Integrated Care
Board (Date)

SIGNED by David Melbourne (Signature)

for and on behalf of NHS Birmingham & Solihull
Integrated Care Board and the Black Country
Integrated Care Board (Date)

SIGNED by Simon Whitehouse (Signature)

for and on behalf of NHS Shropshire, Telford &
Wrekin Integrated Care Board and Staffordshire &
Stoke on Trent Integrated Care Board (Date)

SIGNED by Roz Lindridge (Signature)

For and on behalf of NHS England
..... (Date)

SCHEDULE 1: DEFINITIONS AND INTERPRETATIONS

1. In this Agreement, unless the context otherwise requires, the following words and expressions shall have the following meanings:

“Agreement”	means this agreement between the Partners comprising these terms and conditions together with all schedules attached to it;
“Aligned Commissioning Arrangements”	means the arrangements by which the Partners agree to commission a Service in a co-ordinated and collaborative manner. For the avoidance of doubt, an aligned commissioning arrangement does not involve the delegation of any functions between ICBs;
“Annual Review”	means the annual review of the arrangements under this Agreement by the Partners;
“Area”	means the geographical area covered by the ICBs;
“Authorised Officer”	the individual(s) appointed as Authorised Officer in accordance with the agreed Terms of Reference;
“Claim”	means for or in relation to the Commissioning Functions (a) any litigation or administrative, mediation, arbitration or other proceedings, or any claims, actions or hearings before any court, tribunal, or the Secretary of State, any governmental, regulatory, or similar body, or any department, board or agency or (b) any dispute with, or any investigation, inquiry or enforcement proceedings by any governmental, regulatory or similar body or agency;
“Clinical Commissioning Policies”	a nationally determined clinical policy sets out the commissioning position on a particular clinical treatment issue and defines accessibility (including a not for routine commissioning position) of a medicine, medical device, diagnostic technique, surgical procedure, or intervention for patients with a condition requiring a specialised service;
“Clinical Reference Groups”	means a group consisting of clinicians, commissioners, public health experts, patient and public voice representatives and professional associations, which offers specific knowledge and expertise on the best ways that Specialised Services should be provided;
“Collaborative Commissioning Agreement”	means an agreement under which NHS Commissioners set out collaboration arrangements in respect of commissioning Specialised Services Contracts;
“Commencement Date”	[means 1 April 2024];
“Commissioning Functions”	the respective statutory functions of the Partners in arranging for the provision of services as part of the health service;
“Commissioning Team”	means a staffing arrangement for commissioning agreed Services through an integrated team structure. This can be either set up using: 1. Lead Commissioning (one Partner hosts the Unit as Lead and all functions are delegated to that Partner); or 2. Joint Commissioning or Aligned Commissioning (one Partner may host but no functions are delegated). The Partners will need to agree whether decisions are taken via a Joint Commissioning

arrangement such as a Joint Committee or whether each Partner is required to take decisions;

"Confidential Information"	means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement or Joint Working Arrangements made pursuant to it and: i. which comprises Personal Data or which relates to any patient or his treatment or medical history; ii. the release of which is likely to prejudice the commercial interests of a Partner; or iii. which is a trade secret;
"Contracting Standard Operating Procedure"	means any contracting standard operating procedure produced by NHS England in respect of the Delegated Specialised Services;
"Data Controller"	shall have the same meaning as set out in the Data Protection Legislation;
"Data Processor"	shall have the same meaning as set out in the Data Protection Legislation;
"Data Sharing Agreement"	means any data sharing agreement entered in accordance with Schedule 5 (<i>Further Information Governance and Sharing Provisions</i>);
"Data Guidance"	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement regarding information governance, confidentiality, privacy, or compliance with Data Protection Legislation to the extent published and publicly available or their existence or contents have been notified to the ICB by NHS England and/or any relevant Regulatory or Supervisory Body. This includes but is not limited to guidance issued by NHS Digital, the National Data Guardian for Health & Care, the Department of Health and Social Care, NHS England, the Health Research Authority, the UK Health Security Agency, and the Information Commissioner;
"Data Protection Legislation"	means the UK General Data Protection Regulation, the Data Protection Act 2018, the Regulation of Investigatory Powers Act 2000, the Telecommunications (Lawful Business Practice) (Interception of Communications) Regulations 2000 (SI 2000/2699), the Privacy and Electronic Communications (EC Directive) Regulations 2003 (SI 2426/2003), the common law duty of confidentiality and all applicable laws and regulations relating to the processing of Personal Data and privacy, including where applicable the guidance and codes of practice issued by the Information Commissioner;
"Data Protection Officer"	shall have the same meaning as set out in the Data Protection Legislation;
"Data Security and Protection Toolkit"	means the toolkit at: https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/data-security-and-protection-toolkit or as amended or replaced from time to time
"Delegated Commissioning Group" "DCG"	means the advisory forum in respect of Delegated Services set up by NHS England currently known as the Delegated Commissioning Group for Specialised Services;

“Delegation Agreement(s)”	means the Delegation Agreements under which NHS England delegate specific NHS England Specialised Services Commissioning Functions to each ICB;
“Delegated Functions”	means the Specialised Services Commissioning Functions of NHS England delegated to each ICB under a Delegation Agreement;
“Delegated Services”	means those Specialised Services commissioned in exercise of the Delegated Functions;
“Dispute Resolution Procedure”	the procedure set out in Clause 21 (<i>Dispute Resolution</i>);
“EIR”	means the Environmental Information Regulations 2004;
“Finance Guidance”	guidance, rules and operating procedures produced by NHS England that relate to these Joint Working Arrangements, including but not limited to the following: • Commissioning Change Management Business Rules; • Contracting Standard Operating Procedure; • Cashflow Standard Operating Procedure; • Finance and Accounting Standard Operating Procedure; • Service Level Framework Guidance;
“Flexibilities”	Mean the flexibilities that the Partners may use to work in a co-ordinated manner as set out at Clause 3 (<i>Scope of the Arrangements</i>);
“Financial Contribution”	means the financial contributions agreed by each Partner in respect of an Individual Scheme in any Financial Year;
“Financial Year”	means each financial year running from 1 April in any year to 31 March in the following calendar year;
“FOIA”	the Freedom of Information Act 2000 and any subordinate legislation made under it from time to time, together with any guidance or codes of practice issued by the Information Commissioner or relevant government department concerning this legislation;
“FOIA or EIR Information”	has the meaning given under section 84 of FOIA or the meaning given for “environmental information” under the EIR as applicable;
“Good Practice”	means using standards, practices, methods and procedures conforming to the law, reflecting up-to-date published evidence and exercising that degree of skill and care, diligence, prudence and foresight which would reasonably and ordinarily be expected from a skilled, efficient and experienced commissioner;
“Governance Arrangements”	means the governance arrangements in respect of the Arrangements agreed by the Partners and as set out in Schedule 2 (<i>Governance Arrangements</i>);
“Guidance”	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which the Partners have a duty to have regard (and whether specifically mentioned in this Agreement or not), to the extent that the same are published and publicly available or the existence or contents of them have been notified by any relevant Regulatory or Supervisory Body;
“High-Cost Drugs”	means medicines not reimbursed though national prices/ identified on the NHS England high-cost drugs list;
“ICB Reserved Functions”	Where there is any delegation of an ICB’s Commissioning Functions or further delegation of Delegated Functions, those functions that remain reserved to each ICB;

“Indemnity Arrangement”	means either: (i) a policy of insurance; (ii) an arrangement made for the purposes of indemnifying a person or organisation; or (iii) a combination of (i) and (ii);
“Individual Scheme”	means an arrangement in relation to how the ICBs will work together using one or more of the Flexibilities which has been agreed by the Partners to be included within this Agreement as part of the Joint Working Arrangements;
“Joint Committee”	means the joint committee(s) established by the partners that perform functions under this Agreement on the terms set out in their Terms of Reference;
“Joint Functions”	any Functions that are delegated to a Joint Committee;
“Joint Commissioning”	means Partners agreeing to jointly exercise agreed Commissioning Functions on behalf of each other in exercise of the functions of each Partner part of that Individual Scheme. This may, for example, be through agreeing to enter into the same contract or by use of a Joint Committee;
“Joint Working Arrangements”	means the Flexibilities that the Partners have agreed to use to work in a co-ordinated manner which, at the Commencement Date, are as set out in Clause 3;
"Law"	means: i. any statute or proclamation or any delegated or subordinate legislation; i. any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and i. any judgment of a relevant court of law which is a binding precedent in England;
“Lead Commissioning Arrangements”	means the arrangements by which one Partner commissions Services in relation to an Individual Scheme on behalf of another Partner or Partners in exercise of the Commissioning Functions of the ICB Partners;
“Lead Partner”	means the Partner responsible for commissioning under a Lead Commissioning Arrangement;
“Loss”	means all damages, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services) proceedings, demands and charges whether arising under statute, contract or common law;
“Managing Conflicts of Interest in the NHS”	means the NHS publication by that name available at: https://www.england.nhs.uk/publication/managing-conflicts-of-interest-in-the-nhs-guidance-for-staff-and-organisations/ or such publication that amends or replaces that publication;
“Mandated Guidance”	means any protocol, policy, guidance, guidelines, framework or manual relating to the exercise of Delegated Functions and issued by NHS England from time to time as mandatory;

“National Standards”	means the service standards for each Specialised Service, as set by NHS England and included in Clinical Commissioning Policies or National Specifications;
“National Specifications”	the service specifications published by NHS England in respect of Specialised Services;
“Need to Know”	has the meaning set out in Schedule 5 (<i>Further Information Governance and Sharing Provisions</i>);
“NHS Act”	the National Health Service Act 2006;
“NHS England Functions”	NHS England’s Commissioning Functions exercisable under or by virtue of the NHS Act;
“NHS England Reserved Functions”	those aspects of the Specialised Commissioning Functions for which NHS England retains commissioning responsibility;
“Non-Personal Data”	means data which is not Personal Data;
“Non-Pooled Funds”	means the budget detailing the financial contributions of the Partners which are not included in a Pooled Fund in respect of a particular Service as set out in the relevant Scheme Specification;
“Operational Days”	means a day other than a Saturday, Sunday, Christmas Day, Good Friday or a bank holiday in England;
“Partners”	means the parties to this Agreement;
“Personal Data”	has the meaning set out in the Data Protection Legislation;
“Pooled Funds”	means any pooled fund established and maintained by the Partners as a pooled fund;
“Population”	means the population for which an ICB or all the ICBs have the responsibility for commissioning health services;
“Provider Collaborative”	means a group of Providers who have agreed to work together to improve the care pathway for one or more Services;
“Provider Collaborative Arrangements”	means the arrangements entered in respect of a Provider Collaborative;
“Provider Collaborative Guidance”	means any guidance published by NHS England in respect of Provider Collaboratives;
“Regional Quality Group”	means a group set up to act as a strategic forum at which regional partners from across health and social care can share, identify, and mitigate wider regional quality risks and concerns as well as share learning so that quality improvement and best practice can be replicated;
“Regulatory or Supervisory Body”	means any statutory or other body having authority to issue guidance, standards, or recommendations with which the relevant Party and/or Staff must comply or to which it or they must have regard, including: i. CQC; ii. NHS England; iii. the Department of Health and Social Care;

- iv. NICE;
- v. Healthwatch England and Local Healthwatch;
- vi. the General Medical Council;
- vii. the General Dental Council;
- viii. the General Optical Council;
- ix. the General Pharmaceutical Council;
- x. the Healthcare Safety Investigation Branch; and
- xi. the Information Commissioner;

“Relevant Information”	means the Personal Data and Non-Personal Data processed under this Agreement, and includes, where appropriate, “confidential patient information” (as defined under section 251 of the NHS Act), and “patient confidential information” as defined in the 2013 Report, The Information Governance Review – “ <i>To Share or Not to Share?</i> ”;
“Reserved Functions”	means NHS England Reserved Functions or ICB Reserved Functions;
“Relevant Networks”	Clinical means those clinical networks identified by NHS England as required to support the commissioning of Specialised Services for the Population;
“Retained Services”	means those Specialised Services for which NHS England shall retain commissioning responsibility, as set out the Delegation Agreement;
“Risk Sharing”	means an agreed arrangement for risk and benefit sharing between the Partners;
“Scheme Specification”	means a specification setting out the Joint Working Arrangements in respect of an Individual Scheme agreed by the Partners to be commissioned under this Agreement;
“Services”	means such health services as agreed from time to time by the Partners as commissioned under the Joint Working Arrangements and more specifically defined in each Scheme Specification;
“Service Contract”	means an agreement entered into by one or more of the Partners in exercise of its obligations under this Agreement to secure the provision of Services in accordance with the relevant Individual Scheme
“Single Point of Contact”	the member of Staff appointed by each relevant Partner in accordance with Paragraph 13 of Schedule 5 (<i>Further Information Governance and Sharing Provisions</i>)
“Special Category Personal Data”	has the meaning set out in the Data Protection Legislation;
“Specialised Commissioning Budget”	means the budget identified by NHS England in respect of each ICB for the purpose of exercising the Delegated Functions;
“Specialised Commissioning Functions”	means the statutory functions conferred on NHS England under Section 3B of the NHS Act 2006 and Regulation 11 of the National Health Service Commissioning Board and Clinical Commissioning

“Specified Purpose”	means the purpose for which the Relevant Information is shared and processed to facilitate the exercise of the Joint Working Arrangements as specified in Schedule 5 (<i>Further Information Governance and Sharing Provisions</i>) to this Agreement;
“Specialised Services”	means the services commissioned in exercise of the Specialised Commissioning Functions;
“Specialised Services Contract”	means a contract for the provision of Specialised Services entered in the exercise of the Specialised Commissioning Functions;
“Specialised Services Provider”	means a provider party to a Specialised Services Contract;
“Staff”	means the Partners’ employees, officers, elected members, directors, voluntary staff, consultants, and other contractors and sub-contractors acting on behalf of any Partner (whether the arrangements with such contractors and sub-contractors are subject to legally binding contracts) and such contractors’ and their sub-contractors’ personnel;
“Standard Operating Framework”	means the agreement(s) that sets out the arrangements for a Commissioning Team;
“Terms of Reference”	means the Terms of Reference for the Joint Committee agreed between the Partners at the first meeting of the Joint Committee;
“Triple Aim”	means the duty on each of the Partners in making decisions about the exercise of their functions, to have regard to all likely effects of the decision in relation to: i. the health and well-being of the people of England; ii. the quality of services provided to individuals by the NHS; iii. efficiency and sustainability in relation to the use of resources by the NHS;
“Underspend”	means any expenditure from a Pooled Fund or Non-Pooled Fund in a Financial Year which is less than the value of the agreed contributions by the Partners for that Financial Year;
“UK GDPR”	means Regulation (EU) 2016/679 of the European Parliament and of the Council of 27th April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (General Data Protection Regulation) as it forms part of the law of England and Wales, Scotland and Northern Ireland by virtue of section 3 of the European Union (Withdrawal) Act 2018 .

2. References to statutory provisions shall be construed as references to those provisions as respectively amended or re-enacted (whether before or after the Commencement Date) from time to time.
3. The headings of the Clauses in this Agreement are for reference purposes only and shall not be construed as part of this Agreement or deemed to indicate the meaning of the relevant Clauses to which they relate. Reference to Clauses are Clauses in this Agreement.

4. References to Schedules are references to the schedules to this Agreement and a reference to a Paragraph is a reference to the paragraph in the Schedule containing such reference.
5. References to a person or body shall not be restricted to natural persons and shall include a company, corporation, or organisation.
6. Words importing the singular number only shall include the plural.
7. Use of the masculine includes the feminine and all other genders.
8. Where anything in this Agreement requires the mutual agreement of the Partners, then unless the context otherwise provides, such agreement must be in writing.
9. Any reference to the Partners shall include their respective statutory successors, employees and agents.
10. In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.
11. Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

SCHEDULE 2: GOVERNANCE ARRANGEMENTS

1. Joint & Collaborative Committee

- 1.1. The overall oversight and governance arrangements for these collaborative working arrangements will be discharged through a Joint Committee established by the ICBs.
- 1.2. The Terms of Reference and other detailed arrangements that support the operation of the Joint Committee are appended to this Schedule. They set out that the Joint Committee will have delegated authority on behalf of the ICBs respectively to discharge the functions delegated to the ICBs by NHS England in respect of Specialised Services, including establishing appropriate subsidiary arrangements to enable effective decision-making and detailed oversight of performance, finance, and quality.
- 1.3. The NHS England regional commissioning team will continue to work jointly with the Joint Committee on the commissioning of retained specialised services. This will include, where appropriate, discharging its authority (through accountable directors) in consultation with the Joint Committee.
- 1.4. The subsidiary arrangements established by the Joint Committee will include appropriate schemes of reservation and delegation in place to enable Sub-Groups of the Joint Committee and/or members of staff employed by Joint Commissioning Team to have the authority to make decisions. These arrangements will be developed in collaboration with NHS England to support effective working on both the delegated and retained services.

2. Subgroups

- 2.1.1 There will be joint subgroups established by the partners to support these arrangements, these being:
 - **Midlands Acute Specialised Commissioning Group (MASCg)**
 - **Mental Health Learning Disability & Autism Commissioning Group (MHLDACG)**
 - **Specialised Commissioning Quality Group**
 - **Finance and Contracting Group**
- 2.1.2 The following NHS England Subgroups for NHSE decision making with ICB colleagues in attendance
 - **Vaccination Governance Group**
 - **Screening Governance Group**
 - **Health and Justice Assurance and Improvement Group (HJAIG)**
- 2.1. Subsidiary arrangements established by the Joint Committees will include providing delegated authority to **Midlands Acute Specialised Commissioning Group (MASCg)** and **Mental Health Learning Disability & Autism Commissioning Group (MHLDACG)**, Joint Sub-Groups established by all the partners to make decisions on both the delegated and retained services.
- 2.2. The role of MASCg and the MHLDACG will be to support the partners and the Joint Committee in ensuring that the delivery of the delegated and retained services is effective, efficient, and economical and in line with each partner's statutory responsibilities. The role of these subgroups will be to
 - **Review** all business cases including for Contract Variations and extensions, investments, single tender actions, consultancy spend and CSU spend
 - **Approve** business cases within functional limits unless specifically escalated to the Joint Committee for approval
 - **Prepare** annual plans and monitor performance maintaining oversight and remediation

- **Review** detailed monthly financial information on actual, planned, forecast outturn
 - **Deliver** strategic and operational plans
- 2.3. MASCG and MHLDACG will report and make recommendations to the Joint Committees in respect of delegated services and to Midlands Commissioning Group in respect of the retained services and will always operate in accordance with its agreed terms of reference (which are set out in Appendix 1-7 of this schedule) and the relevant schemes of reservation and delegation and standing financial instructions for delegated and retained services.
- 2.4. Each of the partners will appoint a member of MASCG and MHLDACG who is authorised to act as part of the group and participate in collective decision making on behalf of their organisation. MASCG will also ensure that its decisions are taken with the advice of suitable subject matter experts.
- 2.5. **Specialised Commissioning Quality Group** – This group, chaired by the Regional Medical Director for Commissioning (RMDC) will provide a forum to share and discuss potential and known issues which impact on the quality and safety of Acute Specialised Commissioned services in the Midlands region and agree any remedial action.
- 2.6. The purpose of the Specialised Commissioning Quality Group is to provide a forum for routinely and systematically bringing together partners from across ICSs and the region to share insight and intelligence in relation to quality concerns, to identify opportunities for improvement and to develop regional responses as required. The focus of the discussions will be on intelligence, learning, issues and risks that are recurrent and/ or have an impact wider than individual ICSs.
- 2.9 **Finance and Contracting Subgroup** – will have responsibility to oversee the management of the pooled fund on behalf of the Joint Committees.
- 2.10 The purpose of the Finance and Contracting Subgroup is to provide robust joint financial management of the pooled fund on behalf of the ICBs in line with the terms set out in schedule 4 of this agreement.
- **Review** annual plan including investment plan
 - **Review** monthly update on financial position against plan and forecast outturn by service type
 - **Receive** a quarterly summary of clinical business cases, Contract variations or extensions approved by Joint Committee
 - **Review** STAs, losses and special payments and consultancy spend
- 2.11 **Vaccination Governance Group (VGG)** – will make decisions on the commissioning, quality and value of Vaccination Services and will always operate in accordance with its agreed terms of reference (which are set out in Appendix 1 of this schedule) and NHS England schemes of reservation and delegation and standing financial instructions for Vaccination services. The role of this subgroup will be to
- **Review** all business cases including for Contract Variations and extensions, investments, single tender actions, consultancy spend and CSU spend
 - **Approve** business cases within functional limits unless specifically escalated to the Joint Committee for approval
 - **Prepare** annual plans and monitor performance maintaining oversight and remediation
 - **Review** detailed monthly financial information on actual, planned, forecast outturn
 - **Deliver** strategic and operational plans
- 2.12 The Vaccination Governance Group will ensure ICB collaboration in all decisions in relation to the portfolio it holds

2.13 **Screening Governance Group (SGG)** – will make decisions on the commissioning, quality and value of Screening Services and will always operate in accordance with its agreed terms of reference (which are set out in Appendix 1 of this schedule) and NHS England schemes of reservation and delegation and standing financial instructions for Screening services. The role of this subgroup will be to

- **Review** all business cases including for Contract Variations and extensions, investments, single tender actions, consultancy spend and CSU spend
- **Approve** business cases within functional limits unless specifically escalated to the Joint Committee for approval
- **Prepare** annual plans and monitor performance maintaining oversight and remediation
- **Review** detailed monthly financial information on actual, planned, forecast outturn
- **Deliver** strategic and operational plans

2.12 The Screening Governance Group will ensure ICB collaboration in all decisions in relation to the portfolio it holds

2.13 **Health and Justice Assurance and Improvement Group (HJAIG)** - will make decisions on the commissioning, quality and value of Health and Justice (Including SARC) Services and will always operate in accordance with its agreed terms of reference (which are set out in Appendix 1 of this schedule) and NHS England schemes of reservation and delegation and standing financial instructions for Health and Justice and SARC Services. The role of this subgroup will be to

- **Review** all business cases including for Contract Variations and extensions, investments, single tender actions, consultancy spend and CSU spend
- **Approve** business cases within functional limits unless specifically escalated to the Joint Committee for approval
- **Prepare** annual plans and monitor performance maintaining oversight and remediation
- **Review** detailed monthly financial information on actual, planned, forecast outturn
- **Assure** performance and quality of commissioned service provider delivery against national and local requirements and standards
- **Deliver** strategic and operational plans

3. Clinical Governance

3.1. The ICBs will access the clinical, pharmaceutical, and quality governance functions provided by the Midlands Commissioning Multidisciplinary Team (employed by NHS England) via the Joint Working arrangements.

3.2. Clinical engagement and leadership will be secured at multiple tiers across the Midlands region and will draw upon established clinical networks including those formally commissioned plus the informal networks that have been recognised over time.

3.3. The Specialised Services Operational Delivery Networks (ODNs) will continue to be formally commissioned by NHS England. NHS England will retain the financial responsibility for the ODNs and will continue to play a key role in supporting understanding of clinical quality for the relevant services.

3.4. At a senior clinical level, the Collaborative Clinical Executive Forum (CCEF), a regional forum of Acute Provider and ICB Chief Medical Officers (CMOs), will continue to meet regularly and engage with the Midlands Commissioning Team. Advice offered via that forum will feed into the decision-making process via the Midlands Acute Specialised Commissioning Group (MASCG) and into the Joint Committees.

- 3.5. The Commissioning Team will include Medical Director, Pharmacy and Nursing roles which will provide a vital conduit to local systems and the national clinical leadership architecture.
- 3.6. Governance and decision-making for high-cost drugs assurance will be via Joint Committees and their sub-groups. The pharmacy team for High Costs Drugs will work across ICBs and NHS England drawing on the expertise of the specialised commissioning pharmacy team and collaborating with senior pharmacists from across the region, including High-Cost Drugs pharmacists, specialist pharmacists, and regional cancer pharmacists.
- 3.7. High-cost tariff excluded drugs will continue to be reimbursed through a national process by NHS England irrespective of whether they are used for delegated services, meaning that ICBs will not bear the financial risk of new specialised drugs growth.

4. Quality Governance

- 4.1. Key quality concerns requiring escalation relating to the Joint Services will be reported monthly to the Joint Committees by the Specialised Commissioning Quality Group, Vaccination Governance Group, Screening Governance Group and Health and Justice Assurance and Improvement Group. Furthermore, key quality concerns for all services will continue to be reported to and discussed at the NHSE led Regional Quality Group, of which all ICBs are members. These groups will ensure key quality concerns are fed back into systems to inform conversations at a local level.
- 4.2. Key quality concerns involving specialised services will also be reported into Midlands Acute Specialised Commissioning Group (MASCg) of which all 11 Midlands ICBs are members and have representation. Specialised Commissioning Quality Group will provide a forum for delegated decision making on quality matters.
- 4.3. Key quality concerns involving all other functions will also be reported to the Joint Committee as appropriate
- 4.4. To be proactive on identification of areas for quality improvement, a Quality Surveillance and Improvement Programme (QSIP) has been established to support implementation of the NHSE Midlands Acute Specialised Commissioning Quality Surveillance & Improvement Framework (QSIF). The QSIP aims to provide strategic direction and support implementation of the Quality Surveillance and Improvement Framework QSIF and will agree priorities for the Programme in addition to evaluating risks related to the Programme and to devise and implement mitigations and remedial action. The QSIF involves triangulating intelligence and data from several sources (e.g., CQC reports, specialised services dashboards, national audit etc) to monitor the quality of each service. This work is overseen by the QSIP Programme Board, has ICB representation, is chaired by the RMDC and reports to MASCg.
- 4.5. The Joint Committees will also agree a comprehensive Quality Assurance Framework which will provide a high-level description of the proposed overarching governance arrangements including for quality assurance in the Midlands region in terms of how decisions are made; outline reporting flows; where assurances will be sought, and the structures put in place to ensure that NHSE and ICB's act within their powers and discharge their responsibilities correctly and appropriately.

5. Financial Governance

- 5.1 The Financial governance arrangements in Schedule 4 shall apply to the Collaborative Arrangements.
- 5.7 **Risk Management Arrangements** - In line with their overall role to provide strategic decision-making, leadership, and oversight for the joint services the Joint Committee will establish a

monitoring and management in relation to risk and issue management and escalation, and co-ordinating the approach to intervention with providers where there are quality or contractual issues. This will include feeding back to individual ICBs for consideration of any impact on their own risk management arrangements.

- 5.8 A formal risk register will be maintained by the Midlands Commissioning Team and reported monthly through the Midlands Acute Specialised Commissioning Group to ensure ICBs are aware of any risks they may impact their systems.

6. Assurance arrangements

- 6.1. The Joint Committees will be responsible for ensuring that the ICBs are able to meet their obligations under the NHSE Oversight and Assurance Framework in relation to the delegation of specialised services which, requires that the ICBs must at all times operate in accordance with:
- (a) the Oversight and Assurance Framework published by NHS England;
 - (b) any national oversight and/or assurance guidance in respect of Specialised Services and/or joint working arrangements; and
 - (c) any other relevant NHS oversight and assurance guidance;
- collectively known as the “Assurance Processes”.

And that the ICBs must:

- (a) Develop and operate in accordance with mutually agreed ways of working in line with the Assurance Processes.
- (b) Oversee the provision of Delegated Services and the outcomes being delivered for their patients and Populations in accordance with the Assurance Processes.
- (c) Assure Providers are meeting, or have an improvement plan in place to meet, National Standards.
- (d) Provide any information and comply with specific actions in relation to the Delegated Specialised Services, as required by NHS England, including metrics and detailed reporting in accordance with the Terms of Reference.

Terms of Reference

Midlands Joint and Collaborative Committee

	- For the ICBs to jointly discharge commissioning responsibilities for Specialised Services that have been delegated to them by NHS England which NHS England requires them to exercise collaboratively - To act as a Collaborative forum for NHS England to discharge its retained Direct Commissioning responsibilities (including for retained Specialised Services, Health and Justice Services and Screening and Immunisation Services) in consultation with the ICBs. The Joint & Collaborative Committee will make decisions on the strategic planning and delivery, including resource allocation, oversight and assurance, to improve health and care outcomes and reduce health inequalities for services within its purview. The Joint & Collaborative Committee will establish sub-groups or sub-committees with such Terms of Reference and delegated responsibilities as it agrees.
The Terms of Reference	These Terms of Reference support effective partnership working between all Partners acting through this Joint & Collaborative Committee. They set out the role, responsibilities, membership, decision-making powers and reporting arrangements of the Joint & Collaborative Committee.
Statutory Framework	The Joint & Collaborative Committee is established pursuant to section 65Z6 of the NHS Act 2006. Apart from as set out in the Agreement, the Joint & Collaborative Committee does not affect, and must act in accordance with, the statutory responsibilities and accountabilities of the Partners.
Role of the Joint Committee	The Joint & Collaborative Committee and aligned subsidiary arrangements will be responsible for the safe, effective, efficient and economic discharge of the Joint Functions by the ICBs. It will also serve as a collaborative forum for NHS England to make decisions on retained Direct Commissioning services (Retained Specialised Services, Health and Justice Services and Immunisation and Screening services). This will involve the discharge of the following key responsibilities: Strategic Leadership: - Supporting setting the strategic direction for commissioning across the Midlands, ensuring clarity of purpose, outcomes and value for all services outlined in Schedule 3 of the Collaboration Agreement. - Oversight of the development and integration of Strategic Commissioning Frameworks for agreed Pan ICB commissioning across the Midlands. - Oversight of the development of system plans and strategies to enable the three shifts, with clear outcome metrics, financial sustainability, and public accountability for the defined population that are evidence based and responsive to population health needs. Population Health and Insight: - Oversight of work to ensure members have a deep understanding of population health needs through advance analytics, predictive modelling, and citizen insight. - Ensuring that there is effective use of robust, high-quality data and insight in the development of evidence-based prioritization frameworks aligned to value and equity. - Ensuring that there is alignment with other relevant plans and strategies including Integrated Care Strategies, Joint Strategic Needs Assessments and Health and Wellbeing Strategies. Value, Prioritisation and Investment: - Approving system-wide commissioning priorities based on value, equity, and outcomes to support investment and disinvestment decision making. - Developing subsidiary arrangements to enable effective and efficient operational decision making arrangements that will support the exercise of the Joint Functions by sub-groups and/or staff working on behalf of the partners

	Innovation and Delivery: • Supporting the development of strategies including setting expectations for outcome-based commissioning. • Oversight of collaborative commissioning across the Midlands for all services within its scope with other ICBs and NHS England. • Acting as a forum for discussion and making recommendations on issues where further joint action or working between ICBs and NHSE commissioners would be of benefit outside the arrangements delegated to it
Accountability and reporting	The Joint & Collaborative Committee will be formally accountable to the Boards of the ICBs for the functions delegated by them to the Joint & Collaborative Committee through their Schemes of Reservation and Delegation (SORDs). The Joint & Collaborative Committee operates as the collaborative body for NHS England to make decisions on direct and retained services in consultation with the ICBs through its accountable officers to NHS England's Regional Director and National Directors in line with NHSE the Scheme of Reservation and Delegation (SORDs). The Joint & Collaborative Committee may also report to NHS England's Delegated Commissioning Group (DCG) for Specialised Services on its proceedings and decisions relating to Specialised Services. The Chair (or, at their discretion, another member) may also attend the DCG to present reports on behalf of the committee. Where an ICB Board or National or Regional Directors requests that the Joint & Collaborative Committee provides information or reports on its proceedings or decisions, the Partners must comply with that request within a reasonable timescale.
Membership	<u>ICB Membership</u> The core voting membership of the Committee will be made up of one Authorised Officer (who must be the CEO or their nominated representative) from each of the ICB Clusters. Each of the ICB Clusters must ensure that the members nominated on their behalf are of a suitable level of seniority and duly authorised to act on its behalf and to agree to be bound by the final position or decision taken at any meeting of the Joint & Collaborative Committee. The Authorised Officers may nominate a named substitute who may attend meetings on their behalf with the same decision-making authority. <u>NHSE Membership</u> The NHSE Regional Director of Commissioning (or their nominated representative) will attend meetings of the Committee to take decisions in relation to the retained services in consultation with the wider committee. <u>Other Participants</u> Each of the Partners may be represented at meetings by representatives who may observe proceedings and contribute to the deliberations as required, but these will not have the right to vote. The Partners may also identify individuals or representatives of other organisations that may be invited to observe proceedings and contribute to the Joint & Collaborative Committee's deliberations as required. These representatives will not have the right to vote. <u>Term of Membership</u>

	Members (and any substitutes appointed) will hold their appointment until the partner they represent nominates an alternative member or they cease to hold their substantive role with the relevant partner. <u>Membership Lists</u> The Chair (or in the absence of a Chair, the Partners themselves) shall ensure that there is prepared (and updated from time to time) a list of the members and named substitutes and that this list is made available to the Partners. <u>Other Attendees</u> The Joint & Collaborative Committee will be supported by a Secretariat, who will be provided by the Office of Pan ICB Commissioning.
Chair	The Joint & Collaborative Committee will appoint two of the Authorised Officers as Co-Chairs of the Joint & Collaborative Committee. The Co-Chairs will serve as Strategic leads for Specialised Services and Health & Justice/Screenings & Immunisation respectively. The Joint & Collaborative Committee will confirm or appoint new Co-Chairs at the first meeting of each financial year.
Meetings	The Joint Committee shall meet at least quarterly. At its first meeting (and at the first meeting following each subsequent anniversary of that meeting) the Joint & Collaborative Committee shall prepare a schedule of meetings for the forthcoming year ("the Schedule"). The Co-Chair(s), or in the absence of a Chair, the Partners themselves, shall see that the Schedule is notified to the members. Any of the Partners may call for a special meeting outside of the Schedule as they see fit, by giving notice of their request to the Co-Chairs. The Co-Chairs may, following consultation with the Partners, confirm the date on which the special meeting is to be held and then issue a notice giving not less than four weeks' notice of the special meeting.
Quorum	A Joint & Collaborative Committee meeting will be quorate if at least one authorised representative member (or substitute) from each ICB Cluster is in attendance. Attendance at meetings by telephone/video conferencing will count towards the quorum.
Decisions and veto.	The Joint & Collaborative Committee must seek to make decisions relating to the exercise of the ICB Cluster Joint Functions on a consensus basis. The Partners must ensure that matters requiring a decision are anticipated and that sufficient time is allowed prior to Joint & Collaborative Committee meetings for discussions and negotiations between Partners to take place. Where it has not been possible, despite the best efforts of the Core Membership, to come to a consensus decision on any matter relating to ICB Cluster Joint Functions put before the Joint & Collaborative Committee, the Chair of Part may require the decision to be put to a vote. Where such a vote is required, each Authorised Officer will have one vote, per cluster ICB, with decisions being made by a simple majority of those voting. Any disputes will be resolved using the dispute resolution process outline in section 21 of the Collaboration agreement.
Conduct and conflicts of interest	Members will be expected to act consistently with existing statutory guidance, NHS Standards of Business Conduct and relevant organisational policies. The NHS Standards of Business Conduct policy is available from: https://www.england.nhs.uk/publication/standards-of-business-conduct-policy/ Members should act in accordance with the Nolan Principles (the Seven Principles of Public Life): https://www.gov.uk/government/publications/the-7-principles-of-public-life

	Members should refer to and act consistently with the NHSE guidance: <i>Managing Conflicts of Interest in the NHS: Guidance for staff and organisations</i> . See: https://www.england.nhs.uk/ourwork/coi/
Confidentiality of proceedings	The Joint & Collaborative Committee is not subject to the Public Bodies (Admissions to Meetings) Act 1960. Admission to meetings is at the discretion of the Partners. All members in attendance are required to give due consideration to the possibility that the material presented to the meeting, and the content of any discussions, may be confidential or commercially sensitive, and to not disclose information or the content of deliberations outside of the meeting's membership, without the prior agreement of the Partners.
Publication of notices, minutes and papers	The Office of Pan ICB Commissioning shall provide sufficient resources, administration and secretarial support to ensure the proper organisation and functioning of the Joint & Collaborative Committee. The Chair(s), with the support of the Secretariat Lead, shall see that notices of meetings, together with an agenda listing the business to be conducted and supporting documentation, is issued to the Partners one working week (or, in the case of a special meeting, three calendar days prior to the date of the meeting). The proceedings and decisions taken shall be recorded in minutes, and those minutes circulated in draft form within one week of the date of the meeting. The Joint & Collaborative Committee shall confirm those minutes at its next meeting.
Review of the Terms of Reference	These terms of reference will be reviewed in six & twelve months of the Joint & Collaborative Committee establishment and then at least annually thereafter. Any changes to the Joint & Collaborative Committee decision-making membership or core functions must be approved by the partners. Other changes to the terms of reference may be agreed by the Joint & Collaborative Committee and reported to the Partners for assurance.
Date of Approval of Terms of Reference	TBC

The secretariat can be contacted on jomelling@nhs.net

SCHEDULE 3: INDIVIDUAL SCHEMES

PART 1 MIDLANDS SCHEME FOR DELEGATED SPECIALISED SERVICES IN 2026/2027

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

- 1.1 This scheme sets out the arrangements through which the Partners will work together to commission the specialised services delegated to the Midlands Integrated Care Boards (ICBs) by NHS England.
- 1.2 The Partners' aims are:
- (a) to maximise the benefits to patients of integrating the Delegated Functions with the ICBs' Commissioning Functions through designing and commissioning the Specialised Services as part of the wider pathways of care of which they are a part and, in doing so, promote the Triple Aim.

2 SERVICES AND FUNCTIONS

- 2.1 NHS England has delegated the statutory function for the commissioning of the specified specialised services to the ICBs. The key powers and duties that the ICBs will be required to carry out in exercise of the delegated functions being, in summary:
- (a) decisions in relation to the commissioning and management of the delegated services;
 - (b) planning delegated services for the population, including carrying out needs assessments;
 - (c) undertaking reviews of delegated services in respect of the population;
 - (d) supporting the management of the specialised commissioning budget for delegated services;
 - (e) co-ordinating a common approach to the commissioning and delivery of delegated services with other health and social care bodies in respect of the population where appropriate; and
 - (f) such other ancillary activities that are necessary to exercise the specialised commissioning functions.
- 2.2 A list of the delegated services included within the scheme are detailed within schedule 2 of the Delegation Agreement.

- 2.3 The services are being provided to the populations within the Midlands ICBs geographical footprints.

3 PARTNERS

- 3.1 The partners of this scheme are Lincolnshire ICB, Nottingham & Nottinghamshire ICB and Derby & Derbyshire ICB (Cluster 1), Leicester, Leicestershire & Rutland ICB and Northamptonshire ICB (Cluster 2), Birmingham and Solihull ICB and Black Country ICB (Cluster 3), Coventry & Warwickshire ICB and Herefordshire & Worcestershire ICB (Cluster 4) and Shropshire, Telford & Wrekin ICB and Staffordshire ICB & Stoke on Trent ICB (Cluster 5).

4 THE ARRANGEMENTS

- 4.1 The Scheme will be overseen by the Midlands Joint Committee whose role shall be to carry out the strategic decision-making, leadership and oversight functions relating to the commissioning of specified delegated specialised services as agreed by the partners and outlined in Schedule 2 of this Collaboration Agreement.
- 4.2 Administrative and management functions will be provided to the Partners by the Commissioning Team, which is hosted by NHS England. Details of which are set out in an Commissioning Team Agreement and Standard Operating Framework between all parties.
- 4.3 Details of the financial arrangements relating to this scheme are contained with Schedule 4 of the ICB Collaboration Agreement.

5 GOVERNANCE ARRANGEMENTS

- 5.1 The scheme shall be governed by the Midlands Joint Committee, as set out in Schedule 2 of the ICB Collaboration Agreement.
- 5.2 The terms of reference of the Midlands Joint Committee are set out in the in schedule 2 of the ICB Collaboration Agreement

6 COMMISSIONING, CONTRACTING, ACCESS

6.1 Commissioning Arrangements

Delegated services will be commissioned from providers on behalf of the ICBs by the Commissioning Team hosted by NHS England in line with legislative requirements, NHS planning guidance and the Delegation Agreement between the ICBs and NHS England.

6.2 Contracting Arrangements

The list of contracts which are in place across the Midlands for delegated specialised services are contained in Appendix 1. This includes details of Lead Commissioning arrangements where this has been determined.

6.2.1 The contracting arrangement for the scheme will be as follows:

- The scheme will encompass all existing contracts.
- The contracts will be agreed in line with the National Contracting SOP, the Delegation agreement and the ICB Collaboration Agreement.
- The contracts will be funded in line with the pooled budget arrangements detailed in Schedule 4 of the ICB Collaboration Agreement.
- The contracts will be managed on behalf of the ICBs, by the Commissioning Team.

6.3 Access

The scheme will apply to all delegated specialised services provided via contracts with providers.

7. HIGH-COST DRUGS

7.1 All identified service lines that are delegated include any activities within these areas including High-Cost drugs and support through the networks. Financial responsibility for HCD and networks remains within NHSE, and responsibility will be managed through collaboration and appropriate decision making.

8. FINANCIAL GOVERNANCE ARRANGEMENTS

8.1. The financial governance arrangements are set out in Schedule 4 of the ICB Collaboration Agreement.

9. NON FINANCIAL RESOURCES

9.1. The non-financial resources required to deliver the scheme will be provided by NHS England in accordance with Schedule 6 of the Collaboration Agreement.

10. STAFF

- 10.1. The commissioning team responsible for the operational delivery of specialised commissioning for delegated services will be employed by NHS England covering both retained and delegated services.
- 10.2. The arrangement through which the commissioning team will provide this support to the ICBs is set out in agreed Joint Working Arrangements.

11. ASSURANCE AND MONITORING

- 11.1. The arrangements in relation to assurance and monitoring in relation to this scheme are contained Schedule 2 of this agreement.

12. AUTHORISED OFFICERS

- 12.1. The authorised officers for this scheme are as follows:

Partner	Name of Authorised Officer – Tier 1
Cluster 1 Nottingham & Nottinghamshire ICB Derby & Derbyshire ICB Lincolnshire ICB	Amanda Sullivan
Cluster 2 Northamptonshire ICB Leicester, Leicestershire & Rutland ICB	Toby Sanders
Cluster 3 Birmingham and Solihull ICB Black Country ICB	David Melbourne
Cluster 4 Herefordshire & Worcestershire ICB Coventry and Warwickshire ICB	Simon Trickett
Cluster 5 Shropshire Telford and Wrekin ICB Staffordshire & Stoke on Trent ICB	Simon Whitehouse

13. INTERNAL APPROVALS

- 13.1. The levels of authority relating to this scheme are described within Schedule 4 of the Collaboration Agreement.

14. REGULATORY REQUIREMENTS

- 14.1. Details in relation to regulatory requirements in relation to this scheme are contained within the delegation agreement and will be fulfilled on behalf of the ICBs by the Commissioning Team.

15. COMPLAINTS

- 15.1 Complaints for delegated services will be managed by the specialised commissioning team hosted by NHSE England in line with the agreed complaints process.
- 15.2 A report summarising complaints, actions and lessons learnt will be provided to the Joint Committee annually.

PART 2 – RETAINED SERVICES SCHEME

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

1 OVERVIEW OF THE SCHEME FOR NHS ENGLAND RETAINED SPECIALISED SERVICES IN 2026/27

- 1.1 This scheme sets out the arrangements through which the Partners will work together to commission the specialised services for which responsibility is being retained by NHS England.
- 1.2 The Partners' aims are:
 - (a) to maximise the benefits to patients by working collaboratively on the Retained Functions through designing and commissioning the Specialised Services as part of the wider pathways of care of which they are a part and, in doing so, promote the Triple Aim.

2 SERVICES AND FUNCTIONS

- 2.1 NHS England will retain the statutory function for the commissioning of a number of specialised services. Whilst this responsibility is being retained by NHS England the staff involved will be also be working on the commissioning of delegated specialised services and it will involve the ICBs in the of delivery of these functions being, in summary:
 - (a) decisions in relation to the commissioning and management of the services;
 - (b) planning for the services for the population, including carrying out needs assessments;
 - (c) undertaking reviews of services in respect of the population;
 - (d) supporting the management of the specialised commissioning budget for the services;
 - (e) co-ordinating a common approach to the commissioning and delivery of the services with other health and social care bodies in respect of the population where appropriate; and
- 2.2 A list of the services included within the scheme are detailed within the Appendix of this Schedule.
- 2.3 The services are being provided to the populations within the Midlands ICBs geographical footprints.

3 PARTNERS

- 3.1 The partners for joint working within this scheme are NHS England, Lincolnshire ICB, Nottingham & Nottinghamshire ICB and Derby & Derbyshire ICB (Cluster 1), Leicester, Leicestershire & Rutland ICB and Northamptonshire ICB (Cluster 2), Birmingham and Solihull ICB and Black Country ICB (Cluster 3), Coventry & Warwickshire ICB and Herefordshire & Worcestershire ICB (Cluster 4) and Shropshire, Telford & Wrekin ICB and Staffordshire ICB & Stoke on Trent ICB (Cluster 5).

4 THE ARRANGEMENTS

- 4.1 NHS England will retain responsibility for the delivery of the functions covered by this scheme, working with the ICBs through appropriate consultation with and reporting to the Midlands Joint Committee.
- 4.2 Administrative and management functions will be provided to deliver the scheme by the multi-disciplinary commissioning team, hosted by NHS England. Details of which are set out in a commissioning team agreement between all parties.
- 4.3 Financial arrangements for this scheme will follow NHS England's budgetary and financial arrangements.

5 GOVERNANCE ARRANGEMENTS

- 5.1 NHS England will continue to hold responsibility for the delivery of the functions covered by the scheme.
- 5.2 Decision making will be in line with NHS England's Scheme of Reservation and Delegation subject to decisions being taken in consultation with the ICBs and the Joint Committee where appropriate.
- 5.3 The exercise of NHS England functions in consultation with the Joint Committee will be achieved by NHS England Officers with appropriate delegated authority attending meetings of the Midlands Joint Committee when exercising that authority.
- 5.4 NHS England will report on the delivery of the functions under this scheme to the Midlands Joint Committees.

6 COMMISSIONING, CONTRACTING, ACCESS

6.1 Commissioning Arrangements

- 6.1.1 Services will be commissioned from providers by the Commissioning Team in line with legislative requirements and the NHS planning guidance.

6.2 Contracting Arrangements

- 6.2.1 The scheme will be administered by the Commissioning Team.
- 6.2.2 The contracting arrangement for the scheme will be as follows:
 - The scheme will encompass all existing contracts.
 - The contracts will be agreed in line with the National Contracting SOP and the ICB Collaboration Agreement.
 - The contracts will be funded by NHS England.
 - The contracts will be managed by the Commissioning Team.

6.3 Access

The scheme will apply to all delegated specialised services provided via contracts with providers.

7 HIGH-COST DRUGS

- 7.1 All identified service lines that are delegated include any activities within these areas including High-Cost drugs and support through the networks. Financial responsibility for HCD and

networks remains within NHSE, and responsibility will be managed through collaboration and appropriate decision making.

8 FINANCIAL GOVERNANCE ARRANGEMENTS

- 8.1 The financial governance arrangements will be in line with NHS England's Scheme of Reservation and Delegation and Standing Financial Instructions.

9 NON-FINANCIAL RESOURCES

- 9.1 The non-financial resources required to deliver scheme will be provided by NHSE in accordance with Schedule 6 of the ICB & NHSE Collaboration Agreement.

10 STAFF

- 10.1 The commissioning team responsible for the operational delivery of all specialised commissioning (delegated and retained) services will be employed by NHS England.

11 ASSURANCE AND MONITORING

- 11.1 NHS England's requirements in relation to Assurance and Monitoring will apply to this scheme.

12 INTERNAL APPROVALS

- 12.1 The levels of authority relating to this scheme will follow NHS England's Scheme of Reservation and Delegation and Standing Financial Instructions

13 REGULATORY REQUIREMENTS

- 13.1 NHS England will retain responsibility for fulfilling the regulatory requirements in relation to this scheme.

14 COMPLAINTS

- 14.1 Complaints will be managed by the specialised commissioning team within NHSE England in line with the agreed complaints process.

PART 3 – HEALTH AND JUSTICE & SCREENING AND VACCINATION SERVICES SCHEME

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

1 OVERVIEW OF THE SCHEME FOR NHS ENGLAND RETAINED SPECIALISED SERVICES IN 2026/27

- 1.1 This scheme sets out the arrangements through which the Partners will work together to commission Health and Justice and Screening and Vaccination Services for which responsibility is being retained by NHS England in 2026/27 but will be delegated to the ICBs in the future.
- 1.2 The Partners' aims are:
 - (a) to maximise the benefits to patients by working collaboratively on the Retained Functions through designing and commissioning the Specialised Services as part of the wider pathways of care of which they are a part and, in doing so, promote the Triple Aim.

2 SERVICES AND FUNCTIONS

- 2.1 NHS England has determined that the statutory function for the commissioning of the Health and Justice and Screening and Vaccination services is suitable for future delegation to the ICBs. Whilst this responsibility is being retained by NHS England for 2025/26 it will involve the ICBs in the of delivery of these functions being, in summary:
 - (a) decisions in relation to the commissioning and management of the services;
 - (b) planning for the services for the population, including carrying out needs assessments;
 - (c) undertaking reviews of services in respect of the population;
 - (d) supporting the management of the specialised commissioning budget for the services;
 - (e) co-ordinating a common approach to the commissioning and delivery of the services with other health and social care bodies in respect of the population where appropriate; and
- 2.2 A list of the services included within the scheme are detailed within the Appendix of this Schedule.
- 2.3 The services are being provided to the populations within the Midlands ICBs geographical footprints.

3 PARTNERS

- 3.1 The partners for joint working within this scheme are NHS England, Lincolnshire ICB, Nottingham & Nottinghamshire ICB and Derby & Derbyshire ICB (Cluster 1), Leicester, Leicestershire & Rutland ICB and Northamptonshire ICB (Cluster 2), Birmingham and Solihull ICB and Black Country ICB (Cluster 3), Coventry & Warwickshire ICB and Herefordshire & Worcestershire ICB (Cluster 4) and Shropshire, Telford & Wrekin ICB and Staffordshire ICB & Stoke on Trent ICB (Cluster 5).

4 THE ARRANGEMENTS

- 4.1 NHS England will retain responsibility for the delivery of the functions covered by this scheme, working with the ICBs through appropriate consultation with and reporting to the Midlands Joint Committee.
- 4.2 Administrative and management functions will be provided to deliver the scheme by the multi-disciplinary commissioning team, hosted by NHS England. Details of which are set out in a commissioning team agreement between all parties.
- 4.3 Financial arrangements for this scheme will follow NHS England's budgetary and financial arrangements.

5 GOVERNANCE ARRANGEMENTS

- 5.1 NHS England will continue to hold responsibility for the delivery of the functions covered by the scheme.
- 5.2 Decision making will be in line with NHS England's Scheme of Reservation and Delegation subject to decisions being taken in consultation with the ICBs and the Joint Committee where appropriate.
- 5.3 The exercise of NHS England functions in consultation with the Joint Committee will be achieved by NHS England Officers with appropriate delegated authority attending meetings of the Midlands Joint Committee when exercising that authority.
- 5.4 NHS England will report on the delivery of the functions under this scheme to the Midlands Joint Committees.

6 COMMISSIONING, CONTRACTING, ACCESS

6.1 Commissioning Arrangements

- 6.1.1 Services will be commissioned from providers by the Commissioning Team in line with legislative requirements and the NHS planning guidance.

6.2 Contracting Arrangements

- 6.2.1 The scheme will be administered by the Commissioning Team.
- 6.2.2 The contracting arrangement for the scheme will be as follows:
 - The scheme will encompass all existing contracts.
 - The contracts will be agreed in line with the National Contracting SOP and the ICB Collaboration Agreement.
 - The contracts will be funded by NHS England.
 - The contracts will be managed by the Commissioning Team.

6.3 Access

The scheme will apply to all delegated specialised services provided via contracts with providers.

7 FINANCIAL GOVERNANCE ARRANGEMENTS

- 7.1 The financial governance arrangements will be in line with NHS England's Scheme of Reservation and Delegation and Standing Financial Instructions.

8 NON-FINANCIAL RESOURCES

- 8.1 The non-financial resources required to deliver scheme will be provided by NHSE in accordance with Schedule 6 of the ICB & NHSE Collaboration Agreement.

9 STAFF

- 9.1 The commissioning team responsible for the operational delivery of these services will be employed by NHS England.

10 ASSURANCE AND MONITORING

- 10.1 NHS England's requirements in relation to Assurance and Monitoring will apply to this scheme.

11 INTERNAL APPROVALS

- 11.1 The levels of authority relating to this scheme will follow NHS England's Scheme of Reservation and Delegation and Standing Financial Instructions

12 REGULATORY REQUIREMENTS

- 12.1 NHS England will retain responsibility for fulfilling the regulatory requirements in relation to this scheme.

13 COMPLAINTS

Complaints will be managed by the specialised commissioning team within NHSE England in line with the agreed complaints process.

SCHEDULE 3: Appendix 1 List of SERVICES AND CONTRACTS held with Providers for DELEGATED SERVICES

SERVICES

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
2	Adult congenital heart disease services	13X	Adult congenital heart disease services (non-surgical)
		13Y	Adult congenital heart disease services (surgical)
3	Adult specialist pain management services	31Z	Adult specialist pain management services
4	Adult specialist respiratory services	29M	Interstitial lung disease (adults)
		29S	Severe asthma (adults)
		29L	Lung volume reduction (adults)
		29V	Complex home ventilation (adults)
5	Adult specialist rheumatology services	26Z	Adult specialist rheumatology services
6	Adult secure mental health services	22S(a)	Secure and specialised mental health services (adult) (medium and low) – excluding LD/ASD/WEMS/ABI/DEAF
		22S(c)	Secure and specialised mental health services (adult) (Medium and low) – ASD MHLDA PC
		22S(d)	Secure and specialised mental health services (adult) (Medium and low) – LD MHLDA PC
7	Adult Specialist Cardiac Services	13A	Complex device therapy
		13B	Cardiac electrophysiology & ablation
		13C	Inherited cardiac conditions
		13E	Cardiac surgery (inpatient)
		13F	PPCI for ST- elevation myocardial infarction
		13H	Cardiac magnetic resonance imaging
		13T	Complex interventional cardiology
		13Z	Cardiac surgery (outpatient)
8	Adult specialist eating disorder services	22E	Adult specialist eating disorder services MHLDA PC
9	Adult specialist endocrinology services	27E	Adrenal Cancer (adults)
		27Z	Adult specialist endocrinology services
11	Adult specialist neurosciences services	08O	Neurology (adults)
		08P	Neurophysiology (adults)
		08R	Neuroradiology (adults)
		08S	Neurosurgery (adults)
		08T	Mechanical Thrombectomy
		58A	Neurosurgery LVHC national: surgical removal of clival chordoma and chondrosarcoma
		58B	Neurosurgery LVHC national: EC-IC bypass (complex/high flow)
		58C	Neurosurgery LVHC national: transoral excision of dens
		58D	Neurosurgery LVHC regional: anterior skull based tumours
		58E	Neurosurgery LVHC regional: lateral skull based tumours
		58F	Neurosurgery LVHC regional: surgical removal of brainstem lesions
		58G	Neurosurgery LVHC regional: deep brain stimulation
		58H	Neurosurgery LVHC regional: pineal tumour surgeries - resection
		58I	Neurosurgery LVHC regional: removal of arteriovenous malformations of the nervous system
		58J	Neurosurgery LVHC regional: epilepsy
		58K	Neurosurgery LVHC regional: insula glioma's/complex low grade glioma's
		58L	Neurosurgery LVHC local: anterior lumbar fusion
		58M	Neurosurgery LVHC local: removal of intramedullary spinal tumours
		58N	Neurosurgery LVHC local: intraventricular tumours resection
		58O	Neurosurgery LVHC local: surgical repair of aneurysms (surgical clipping)
	Adult specialist neurosciences services (continued)		

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
		58P	Neurosurgery LVHC local: thoracic discectomy
		58Q	Neurosurgery LVHC local: microvascular decompression for trigeminal neuralgia
		58R	Neurosurgery LVHC local: awake surgery for removal of brain tumours
		58S	Neurosurgery LVHC local: removal of pituitary tumours including for Cushing's and acromegaly
12	Adult specialist ophthalmology services	37C	Artificial Eye Service
		37Z	Adult specialist ophthalmology services
13	Adult specialist orthopaedic services	34A	Orthopaedic surgery (adults)
		34R	Orthopaedic revision (adults)
15	Adult specialist renal services	11B	Renal dialysis
		11C	Access for renal dialysis
		11T	Renal Transplantation
16	Adult specialist services for people living with HIV	14A	Adult specialised services for people living with HIV
17	Adult specialist vascular services	30Z	Adult specialist vascular services
18	Adult thoracic surgery services	29B	Complex thoracic surgery (adults)
		29Z	Adult thoracic surgery services: outpatients
29	Haematopoietic stem cell transplantation services (adults and children)	02Z	Haematopoietic stem cell transplantation services (adults and children)
		ECP	Extracorporeal photopheresis service (adults and children)
30	Bone conduction hearing implant services (adults and children)	32B	Bone anchored hearing aids service
		32D	Middle ear implantable hearing aids service
32	Children and young people's inpatient mental health service	23K	Tier 4 CAMHS (general adolescent inc eating disorders) MHLDA PC
		23L	Tier 4 CAMHS (low secure) MHLDA PC
		23O	Tier 4 CAMHS (PICU) MHLDA PC
		23U	Tier 4 CAMHS (LD) MHLDA PC
		23V	Tier 4 CAMHS (ASD) MHLDA PC
35	Cleft lip and palate services (adults and children)	15Z	Cleft lip and palate services (adults and children)
36	Cochlear implantation services (adults and children)	32A	Cochlear implantation services (adults and children)
40	Complex spinal surgery services (adults and children)	06Z	Complex spinal surgery services (adults and children)
		08Z	Complex neuro-spinal surgery services (adults and children)
45	Cystic fibrosis services (adults and children)	10Z	Cystic fibrosis services (adults and children)
54	Fetal medicine services (adults and adolescents)	04C	Fetal medicine services (adults and adolescents)
58	Specialist adult gynaecological surgery and urinary surgery services for females	04A	Severe Endometriosis
		04D	Complex urinary incontinence and genital prolapse
58A	Specialist adult urological surgery services for men	41P	Penile implants
		41S	Surgical sperm removal
		41U	Urethral reconstruction
59	Specialist allergy services (adults and children)	17Z	Specialist allergy services (adults and children)
61	Specialist dermatology services (adults and children)	24Z	Specialist dermatology services (adults and children)
62	Specialist metabolic disorder services (adults and children)	36Z	Specialist metabolic disorder services (adults and children)

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
63	Specialist pain management services for children	23Y	Specialist pain management services for children
64	Specialist palliative care services for children and young adults	E23	Specialist palliative care services for children and young adults
65	Specialist services for adults with infectious diseases	18A	Specialist services for adults with infectious diseases
		18E	Specialist Bone and Joint Infection (adults)
72	Major trauma services (adults and children)	34T	Major trauma services (adults and children)
78	Neuropsychiatry services (adults and children)	08Y	Neuropsychiatry services (adults and children)
83	Paediatric cardiac services	23B	Paediatric cardiac services
94	Radiotherapy services (adults and children)	01R	Radiotherapy services (Adults)
		51R	Radiotherapy services (Children)
		01S	Stereotactic Radiosurgery / radiotherapy
98	Specialist secure forensic mental health services for young people	24C	FCAMHS MHLDA PC
103A	Specialist adult haematology services	03C	Castleman disease
105	Specialist cancer services (adults)	01C	Chemotherapy
		01J	Anal cancer (adults)
		01K	Malignant mesothelioma (adults)
		01M	Head and neck cancer (adults)
		01N	Kidney, bladder and prostate cancer (adults)
		01Q	Rare brain and CNS cancer (adults)
		01U	Oesophageal and gastric cancer (adults)
		01V	Biliary tract cancer (adults)
		01W	Liver cancer (adults)
		01X	Penile cancer (adults)
		01Y	Cancer Outpatients (adults)
		01Z	Testicular cancer (adults)
		04F	Gynaecological cancer (adults)
		19V	Pancreatic cancer (adults)
		19C	Biliary tract cancer surgery (adults)
		19M	Liver cancer surgery (adults)
		19Q	Pancreatic cancer surgery (adults)
		24Y	Skin cancer (adults)
		29E	Management of central airway obstruction (adults)
		51A	Interventional oncology (adults)
		51B	Brachytherapy (adults)
		51C	Molecular oncology (adults)
		61M	Head and neck cancer surgery (adults)
		61Q	Ophthalmic cancer surgery (adults)
		61U	Oesophageal and gastric cancer surgery (adults)
		61Z	Testicular cancer surgery (adults)
		33C	Transanal endoscopic microsurgery (adults)
		33D	Distal sacrectomy for advanced and recurrent rectal cancer (adults)
106	Specialist cancer services for children and young adults	01T	Teenage and young adult cancer
		23A	Children's cancer
106A	Specialist colorectal surgery services (adults)	33A	Complex surgery for faecal incontinence (adults)
		33B	Complex inflammatory bowel disease (adults)
107	Specialist dentistry services for children	23P	Specialist dentistry services for children
108	Specialist ear, nose and throat services for children	23D	Specialist ear, nose and throat services for children
109	Specialist endocrinology services for children	23E	

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
			Specialist endocrinology and diabetes services for children
110	Specialist gastroenterology, hepatology and nutritional support services for children	23F	Specialist gastroenterology, hepatology and nutritional support services for children
112	Specialist gynaecology services for children	73X	Specialist paediatric surgery services - gynaecology
113	Specialist haematology services for children	23H	Specialist haematology services for children
114	Specialist haemoglobinopathy services (adults and children)	38S	Sickle cell anaemia (adults and children)
		38T	Thalassemia (adults and children)
115	Specialist immunology services for adults with deficient immune systems	16X	Specialist immunology services for adults with deficient immune systems
115A	Specialist immunology services for children with deficient immune systems	16Y	Specialist immunology services for children with deficient immune systems
115B	Specialist maternity care for adults diagnosed with abnormally invasive placenta	04G	Specialist maternity care for women diagnosed with abnormally invasive placenta
118	Neonatal critical care services	NIC	Specialist neonatal care services
119	Specialist neuroscience services for children	23M	Specialist neuroscience services for children
		07Y	Paediatric neurorehabilitation
		08J	Selective dorsal rhizotomy
120	Specialist ophthalmology services for children	23N	Specialist ophthalmology services for children
121	Specialist orthopaedic services for children	23Q	Specialist orthopaedic services for children
122	Paediatric critical care services	PIC	Specialist paediatric intensive care services
124	Specialist perinatal mental health services (adults and adolescents)	22P	Specialist perinatal mental health services (adults and adolescents) MHLDA PC
125	Specialist plastic surgery services for children	23R	Specialist plastic surgery services for children
126	Specialist rehabilitation services for patients with highly complex needs (adults and children)	07Z	Specialist rehabilitation services for patients with highly complex needs (adults and children)
127	Specialist renal services for children	23S	Specialist renal services for children
128	Specialist respiratory services for children	23T	Specialist respiratory services for children
129	Specialist rheumatology services for children	23W	Specialist rheumatology services for children
130	Specialist services for children with infectious diseases	18C	Specialist services for children with infectious diseases
131	Specialist services for complex liver, biliary and pancreatic diseases in adults	19L	Specialist services for complex liver diseases in adults
		19P	Specialist services for complex pancreatic diseases in adults
		19Z	Specialist services for complex liver, biliary and pancreatic diseases in adults
		19B	Specialist services for complex biliary diseases in adults
132	Specialist services for haemophilia and other related bleeding disorders (adults and children)	03X	Specialist services for haemophilia and other related bleeding disorders (Adults)
		03Y	Specialist services for haemophilia and other related bleeding disorders (Children)
134	Specialist services to support patients with complex physical disabilities (excluding wheelchair services) (adults and children)	05C	Specialist augmentative and alternative communication aids (adults and children)
		05E	Specialist environmental controls (adults and children)
		05P	Prosthetics (adults and children)

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
135	Specialist paediatric surgery services	23X	Specialist paediatric surgery services - general surgery
136	Specialist paediatric urology services	23Z	Specialist paediatric urology services
139A	Specialist morbid obesity services for children	35Z	Specialist morbid obesity services for children
139AA	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital	04P	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital
ACC	Adult Critical Care	ACC	Adult critical care

Acute Services Standard Contracts

BIRMINGHAM COMMUNITY HEALTHCARE NHS FOUNDATION TRUST
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST
CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST
DERBYSHIRE COMMUNITY HEALTH SERVICES
GEORGE ELIOT HOSPITAL NHS TRUST
HCRG
KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST
MIDLANDS PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST
NORTHAMPTON GENERAL HOSPITAL NHS TRUST
NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST
SOUTH WARWICKSHIRE NHS FOUNDATION TRUST
THE DUDLEY GROUP NHS FOUNDATION TRUST
THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST
THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST
THE ROYAL WOLVERHAMPTON NHS TRUST
THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST
UNITED LINCOLNSHIRE HOSPITALS NHS TRUST
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST
UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST
UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST
WALSALL HEALTHCARE NHS TRUST

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST
WYE VALLEY NHS TRUST

Section 75 Contract

LINCOLNSHIRE COMMUNITY HEALTH SERVICES NHS TRUST

Specialised Mental Health, Learning Disability and Autism Lead Provider Contracts

Lead Provider	Coordinating Commissioner
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST (EM ADULT SECURE)	LLR ICB
NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST (EM CYPMH)	LLR ICB
LEICESTERSHIRE PARTNERSHIP NHS TRUST (EM ADULT EATING DISORDER SERVICES)	LLR ICB
DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST (EM PERINATAL SERVICES)	LLR ICB
BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST (WM ADULT SECURE)	BSOL ICB
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST (WM CYPMH)	BSOL ICB
MIDLANDS UNIVERSITY PARTNERSHIP NHS FOUNDATION TRUST (WM ADULT EATING DISORDER SERVICES)	SSOT ICB
MIDLANDS UNIVERSITY PARTNERSHIP NHS FOUNDATION TRUST (WM PERINATAL SERVICES)	SSOT ICB

SCHEDULE 3: APPENDIX 2 – NHS ENGLAND COMMISSIONING RESPONSIBILITY AND ACCOUNTABILITY (RETAINED) SPECIALISED SERVICES

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
4	Adult specialist respiratory services	29E	Management of central airway obstruction
		29V	Complex home ventilation
15	Adult specialist renal services	11T	Renal transplantation
29	Haematopoietic stem cell transplantation services (adults and children)	02Z	Blood and marrow transplantation services
		ECP	Extracorporeal photopheresis service
45	Cystic fibrosis services (adults and children)	10Z	Cystic fibrosis services
55	Gender dysphoria services (children and adolescents)	22A	Gender identity development service for children and adolescents
56	Gender dysphoria services (adults)	22Z	Gender identity services
		42A	Gender dysphoria: genital surgery (trans feminine)
		42B	Gender dysphoria - genital surgery (trans masculine)
		42C	Gender dysphoria: chest surgery (trans masculine)
		42D	Gender dysphoria - non-surgical services
		42E	Gender dysphoria: other surgical services
58	Specialist adult gynaecological surgery and urinary surgery services for females	04K	Specialised services for women with complications of mesh inserted for urinary incontinence and vaginal prolapse (16 years and above)
		04L	Reconstructive surgery and congenital anomalies of the female genital tract
65	Specialist services for adults with infectious diseases	18T	Tropical Disease
82	Paediatric and perinatal post mortem services	F23	Paediatric and perinatal post mortem services
87	Positron emission tomography-computed tomography services (adults and children)	01P	Positron emission tomography- computed tomography services (PETCT)
89	Primary malignant bone tumours service (adults and adolescents)	01O	Primary malignant bone tumours service (adults and adolescents)
101	Severe intestinal failure service (adults)	12Z	Severe intestinal failure service
103A	Specialist adult haematology services	03C	Castleman disease
105	Specialist cancer services (adults)	01L	Soft tissue sarcoma
		01X	Penile cancer
111	Clinical genomic services (adults and children)	20G	Genomic laboratory testing services
		20H	Pre-Implantation genetic diagnosis and associated in-vitro fertilisation services
		20Z	Specialist clinical genomics services
		MOL	Molecular diagnostic service
114	Specialist haemoglobinopathy services (adults and children)	38S (DPC)	Sickle cell anaemia -direct patient care
		38T (DPC)	Thalassemia - direct patient care
		38X (HCC)	Haemoglobinopathies coordinating centres (HCCs)
		38X (SHT)	Specialist Haemoglobinopathies Teams (SHTs)
115	Specialist immunology services for adults with deficient immune systems	16X	Specialist immunology services for adults with deficient immune systems
115A	Specialist immunology services for children with deficient immune systems	16Y	Specialist immunology services for children with deficient immune systems
134	Specialist services to support patients with complex physical disabilities	05C	Specialist augmentative and alternative communication aids

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
	(excluding wheelchair services) (adults and children)	05E	Specialist environmental controls
137	Spinal cord injury services (adults and children)	06A	Spinal cord injury services (adults and children)
6	Adult secure mental health services	22S(a)	Secure and specialised mental health services (adult) (Medium and low) - including LD / ASD / WEMS / ABI / DEAF
		22S(b)	Secure and specialised mental health services (adult) (Medium and low) - Excluding LD / ASD / WEMS / ABI / DEAF
		22S(c)	Secure and specialised mental health services (adult) (Medium and low) - ASD
		22S(d)	Secure and specialised mental health services (adult) (Medium and low) – LD
		22S(e)	Secure and specialised mental health services (adult) Medium Secure Female WEMS
		22S(f)	Secure and specialised mental health services (adult) (Medium and low) – ABI
		22S(g)	Secure and specialised mental health services (adult) (Medium and low) - DEAF
		YYY	Specialised mental health services exceptional packages of care
8	Adult specialist eating disorder services	22E	Adult specialist eating disorder services
32	Children and young people's inpatient mental health service	22C	Tier 4 CAMHS (MSU)
		24E	Tier 4 CAMHS (children's service)
		23K	Tier 4 CAMHS (general adolescent inc eating disorders)
		23L	Tier 4 CAMHS (low secure)
		23O	Tier 4 CAMHS (PICU)
		23U	Tier 4 CAMHS (LD)
		23V	Tier 4 CAMHS (ASD)
98	Specialist secure forensic mental health services for young people	24C	FCAMHS
102	Severe obsessive compulsive disorder and body dysmorphic disorder service (adults and adolescents)	22F	Severe obsessive compulsive disorder and body dysmorphic disorder service
116	Specialist mental health services for Deaf adults	22D	Specialist mental health services for Deaf adults
124	Specialist perinatal mental health services (adults and adolescents)	22P	Specialist perinatal mental health services
133	Specialist services for severe personality disorder in adults	22T	Specialist services for severe personality disorder in adults

SCHEDULE 3: Appendix 3 – NHS ENGLAND COMMISSIONING RESPONSIBILITY AND ACCOUNTABILITY (RETAINED) Health and Justice and Screening and Vaccinations Services

Screening Programmes

NHS England commissions 11 national population screening programmes:

Antenatal & Newborn Screening

- Infectious diseases in pregnancy (HIV, hepatitis B, syphilis)
- Fetal anomaly screening
- Sickle cell and thalassaemia screening
- Newborn blood spot screening
- Newborn hearing screening
- Newborn and infant physical examination (NIPE)

Adult Screening

- Abdominal Aortic Aneurysm (AAA) screening
- Bowel cancer screening
- Breast cancer screening
- Cervical screening
- Diabetic eye screening

Vaccinations

NHS England commissions the national immunisation programmes, which include:

- Routine Childhood Vaccinations
 - 6-in-1 vaccine
 - MMR (Measles, Mumps, Rubella)
 - Hib/MenC
 - MenB
 - MenACWY
 - HPV
 - Pre-school boosters
- Adult Vaccinations
 - Seasonal influenza (flu)
 - Pneumococcal
 - Shingles
- Targeted Vaccinations
 - Hepatitis B (including neonatal)

- BCG (Tuberculosis)
- Mpox (for at-risk groups)
- MenB for gonorrhoea (specific risk groups)
- COVID-19 Vaccination Programme
- School-age Immunisation Programmes (HPV, flu, MenACWY)

Child Health Information Services

Health and Justice Services

NHS England commissions healthcare for people in secure and detained environments, including:

- Prison Healthcare
 - Primary care (GP, nursing, optometry, therapies)
 - Mental health services
 - Substance misuse services
 - Dental services
 - Public health services (including screening and immunisation)
- Children and Young People's Secure Estate
 - Physical health
 - Mental health
 - Neurodevelopmental support
 - Substance misuse services
- National CYP Vanguard pilots
- Immigration Removal Centres (IRCs)
 - Adult healthcare
 - Mental health services
 - Primary care and dental care
- Short-Term Holding Facilities
 - Basic healthcare provision

Non-Custodial Settings

- Liaison and Diversion Services
 - Early identification and support for vulnerable individuals in police custody or courts
 - Referral into community services (eg mental health and social care referrals)
 - Recommendations to the court regarding sentencing options

- RECONNECT (not a treatment service)
 - Continuity of care support following release from prison
- Mental Health Treatment Requirements
 - Mental health interventions under a court order
- Court healthcare (Midlands and North of England) – co-commissioned with MoJ
 - Peripatetic paramedic based service

As well as commissioning services for survivors of sexual assault and abuse

- Sexual Assault Referral Centres (SARCs) – co-commissioned with Police and OPCCs
 - Section 7a services
 - Access to psychotherapies
 - Forensic medical services
- National Pathfinders (complex mental health)

SCHEDULE 4: FINANCIAL ARRANGEMENTS

PART A: FINANCIAL RISK MANAGEMENT

1 ESTABLISHMENT OF A RISK SHARE

- 1.1 The ICBs have agreed to establish and maintain a risk share arrangement for in-year financial management, based on the defined reserves held for elective activity under ERF and variable services within the specialised commissioning contracts.
- 1.2 The principles of the risk management agreement are that in year financial risk will be managed collectively across the ICBs in the Midlands. All allocations received for ERF and reserves specifically held for non-ERF variable services will be considered collectively as part of a notional pooled fund, managed by the specialised commissioning finance team on behalf of the ICBs. In year variation in contract performance will be monitored collectively and funds will be transferred between ICBs proportionately to fund the financial impact of in year variable activity to opening allocations.
- 1.3 The monies held in the notional Pooled Fund may only be expended on the following:
 - Performance payments associated with the Elective Recovery Scheme (ERF),
 - Activity above opening contract levels for defined variable services within the specialised commissioning contracts,
 - Approved expenditure agreed by all parties in the Pooled Fund.(collectively known as "Permitted Expenditure")
- 1.4 The Pooled Fund is explicitly for the management of in year expenditure against specialised services contractual commitments. This includes contractual commitments for the population of Midlands ICBs including any out of region contractual arrangements.
- 1.5 The Pooled Fund is not intended to be the route for recurrent commissioning decisions for specialised services. Such decisions would be made through the governance structure established in East and West Midlands.
- 1.6 The Partners may only depart from the definition of Permitted Expenditure or exceed Pooled Fund budget with the express written agreement of each relevant Partner and in line with approved delegations.
- 1.7 The Specialised Commissioning Finance Team, on behalf of the Midlands ICBs, shall be responsible for providing the financial administrative systems for the Pooled Fund and the Pooled

Fund Manager will be the Director of Commissioning of Finance. The Specialised Services Finance and Contracting subgroup will be responsible for oversight of the management of the pooled fund and ensuring that the Pooled Fund Manager complies with its obligations under this Agreement.

2. RISK EXPOSURE

2.1. Elective Services

2.1.1. Elective activity is managed through the Elective Recovery Fund. Baseline activity is outlined within the Indicative Activity Plan (IAP) and is included within the fixed element of ERF payments which are included in opening provider contracts.

2.1.2. Any financial impact of agreement of final IAPs will need to be managed from the performance reserve and are subject to the terms of this Pooled Fund Agreement.

2.1.3. The 2026/27 ERF process allows for additional activity payments under the Activity Management Process. These will be managed through the terms of this Pooled Fund Agreement.

2.2. Variable Activity

2.2.1. There are a small number of variable services within the contract, these being:

- Chemotherapy
- Diagnostic Imaging
- Nuclear Medicine
- PRT-CT
- Molecular Radiotherapy
- Renal Transplant

2.2.2. These services are paid on a cost per case basis. Opening baselines for variable services will be based on 2025/26 outturn.

2.2.3. For 2026/27 radiotherapy services have a blended payment approach with activity above planned levels being reimbursed at 50% of tariff. Performance payments are included within variable activity and therefore included within the risk share agreements.

2.2.4. All ICBs have created a reserve to manage 2026/27 activity growth in variable services. Payments above opening contract values for variable services will be subject to the terms of this Pooled Fund Agreement.

3. POOLED FUND MANAGEMENT

3.1. The Pooled Fund Manager for Pooled Fund shall have the following duties and responsibilities:

- The day-to-day operation and management of the notional Pooled Fund and risk management arrangements,
- Ensuring that all expenditure from the Pooled Fund is in accordance with the provisions of this Agreement and the relevant Scheme Specification,
- Maintaining an overview of all joint financial issues affecting the Partners in relation to the Services and the Pooled Fund,
- Ensuring that full and proper records for accounting purposes are kept in respect of the Pooled Fund,
- Reporting to the relevant governance group as required by this Agreement,
- ensuring action is taken to manage any projected under or overspends relating to the Pooled Fund in accordance with this Agreement, and
- preparing and submitting reports as required by the relevant Scheme Specification.

5. RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPEND

- 5.1. The Specialised Commissioning Team Pooled Fund manager shall manage expenditure within the notional pooled fund and shall use reasonable endeavours to ensure that the expenditure is limited to Permitted Expenditure.
- 5.2. The Pooled Fund Manager shall not be in breach of its obligations under this Agreement if an Overspend occurs provided that it has used reasonable endeavours to ensure that the only expenditure from a Pooled Fund has been incurred and it has informed the Partners of any variance.
- 5.3. In the event that the Pooled Fund Manager identifies an actual or projected Overspend the Pooled Fund Manager must ensure that the Partners are informed as soon as reasonably possible.
- 5.4. If expenditure from the Pooled Fund in any Financial Year is less than the aggregate value of the Financial Contributions made for that Financial Year, financial resources will be returned to the Partners proportionate to the contributions to the Pooled Fund. Arrangements shall be subject to the Law and the Standing Orders and Standing Financial Instructions of the Partners.
- 5.5. Any unmitigated net variance will need to be recognised in the Agreement of Balances exercise completed as part of the month 09 financial reporting process.

5.6. Residual variances (under or overspend), after mitigations and application of contingency, will be allocated to ICBs proportionately to contributions to the Pooled Fund.

5.7. Illustrative examples of the application of the risk share

5.7.1. Variable Activity using Chemotherapy variable activity performance.

ICB	Contract	Forecast	Variance	% Variance	Apply risk share	Risk Shared Forecast	Risk Shared % variance	Impact of risk share
ICB 1	9,000	10,000	1,000	11.11%	653	9,653	7.25%	347
ICB 2	8,500	9,000	500	5.88%	617	9,117	7.25%	-117
ICB 3	7,500	9,000	1,500	20.00%	544	8,044	7.25%	956
ICB 4	8,500	10,000	1,500	17.65%	617	9,117	7.25%	883
ICB 5	11,000	11,000	0	0.00%	798	11,798	7.25%	-798
ICB 6	9,500	10,500	1,000	10.53%	689	10,189	7.25%	311
ICB 7	10,000	9,000	-1,000	-10.00%	725	10,725	7.25%	-1,725
ICB 8	9,000	9,500	500	5.56%	653	9,653	7.25%	-153
ICB 9	7,500	8,500	1,000	13.33%	544	8,044	7.25%	456
ICB 10	5,000	5,500	500	10.00%	363	5,363	7.25%	137
ICB 11	11,000	11,500	500	4.55%	798	11,798	7.25%	-298
Total	96,500	103,500	7,000	7.25%	7,000	103,500	7.25%	0

5.7.2. Elective Activity

ICB	Opening Contract	Finalisation of IAP	Performance Payments	Outturn	Variance	% Variance	Apply risk share	Risk Shared Forecast	Risk Shared % variance	Impact of risk share
ICB 1	90,000		2,000	92,000	2,000	2.22%	2,798	92,798	3.11%	-798
ICB 2	85,000	2,000	3,000	90,000	5,000	5.88%	2,642	87,642	3.11%	2,358
ICB 3	75,000		4,000	79,000	4,000	5.33%	2,332	77,332	3.11%	1,668
ICB 4	85,000		0	85,000	0	0.00%	2,642	87,642	3.11%	-2,642
ICB 5	110,000		3,000	113,000	3,000	2.73%	3,420	113,420	3.11%	-420
ICB 6	95,000		2,000	97,000	2,000	2.11%	2,953	97,953	3.11%	-953
ICB 7	100,000	4,000	4,000	108,000	8,000	8.00%	3,109	103,109	3.11%	4,891
ICB 8	90,000		1,000	91,000	1,000	1.11%	2,798	92,798	3.11%	-1,798
ICB 9	75,000		2,000	77,000	2,000	2.67%	2,332	77,332	3.11%	-332
ICB 10	50,000		0	50,000	0	0.00%	1,554	51,554	3.11%	-1,554
ICB 11	110,000		3,000	113,000	3,000	2.73%	3,420	113,420	3.11%	-420
Total	965,000	6,000	24,000	995,000	30,000	3.11%	30,000	995,000	3.11%	0

PART B: OTHER FINANCIAL ARRANGEMENTS

6. BUDGETARY DELEGATION

- 6.1. Commissioning decisions will be made in line with the Arrangements agreed by the Midlands Joint and Collaborative Commissioning Committee which has Delegated Authority to set approval limits in line with those arrangements.
- 6.2. ICBs have agreed to delegate budgetary responsibility via the joint committees to the specialised commissioning team for the processing and delivery of specialised services transactions. These delegations are to facilitate the delivery of contract signature, purchase orders and non-purchase order invoices and budgetary virement.

7. AUDIT ARRANGEMENTS

- 7.1. Transactions through ICB ledgers will be subject to audit through existing internal audit arrangements. It will be the responsibility of ICBs to ensure that this appropriately referenced in the audit plan.
- 7.2. The Specialised Commissioning Team responsible for the management of specialised commissioning resources will be employed by NHS Birmingham and Solihull ICB but will access all ICB ledgers to process transactions for specialised services.

8. FINANCIAL MANAGEMENT

- 8.1. Financial transactions for delegated specialised services will be processed through the ISFE2 ledger system of the eleven Midlands ICBs. Specialised Commissioning team will have appropriate access to ICB ledgers enabled.
- 8.2. Financial monitoring reports will be produced by the hosted Specialised Commissioning Team on behalf of the ICBs.
- 8.3. Financial reports will be prepared monthly within ten working days of the end of the month. Forecast outturn positions will be included in the monitoring reports from quarter 2.
- 8.4. Monthly budget reporting with variance analysis and forecasting will be provided to Joint Committee Finance Subgroup, Host ICB, and Partner ICBs including:
- ICB reporting based on risk management arrangements,
 - Overall financial performance report to be shared with all ICBs,
 - Management and review of reserves and investments.

Schedule 4 - Appendix 1

Budgetary Delegation Schedule for Specialised Services Only

Contract award, signature and variation			
Description of delegation: Approval of contract award reports, providing requirements for competitive tendering have been met. Approval of contract signature and variation* Signature of contracts and contract variations must be made by the host commissioners			
Delegated Limit		Up to £50m	Up to £250m
Limits are annual values			
Approvers and/or restrictions No variation can be granted to a contract awarded under the PCR threshold where the value of the variation results in the contract value exceeding the PCR threshold.		Director of Specialised Commissioning Director of Commissioning Finance (specialised) – for contract variations	Regional Director of Commissioning Director of Commissioning Finance (specialised) – for contract award

Purchase Requisitions, invoices and non POs			
Description of delegation: Approval of purchase requisitions, purchase credit notes, invoices and non-purchase order invoices. Approval of contract payments to NHS providers.			
Delegated Limit	Up to £50k (Bands 8A-D)	Up to 100k (Band 9)	Up to £1m or 1/12 of contract value for NHS Providers
Approvers and/or restrictions Expenditure must be covered by a relevant budget. Purchase orders should be raised for all nonhealthcare goods and services and the non-purchase order route should only be used in exceptional circumstances.	Commissioning Assistant Directors Contract Managers or Budget Holders For delegated and retained functions	Deputy Directors For delegated and retained functions	Director of Specialised Commissioning Director of Commissioning Finance (specialised) For delegated and retained functions

Budget Virements			
Description of delegation: Approval of budget virements/movements within approved revenue and capital budgets.			
Delegated Limit	Up to £50k	Up to £2m	Over £2m
Approvers and/or restrictions Expenditure must be covered by a relevant budget. Purchase orders should be raised for all nonhealthcare goods and services and the non-purchase order route should only be used in exceptional circumstances.	Specialised commissioning Contract Managers or Budget Holders	Director of Specialised Commissioning Director of Commissioning Finance (specialised)	MASCG

Budgetary Delegation Schedule for Retained Services Only

Delegated Limit	Up to £50m	Up to £250m	£250m to £750m
Limits are annual values			
Approvers and/or restrictions No variation can be granted to a contract awarded under the PCR threshold where the value of the variation results in the contract value exceeding the PCR threshold.	Director of Specialised Commissioning Director of Commissioning Finance (specialised) – for contract variations For delegated and retained functions	Regional Director of Commissioning for NHSE functions Director of Commissioning Finance (specialised) – for contract award for NHSE functions Joint & Collaborative Committee for delegated functions	Regional Director of Commissioning for NHSE functions Joint & Collaborative Committee for delegated functions

Purchase Requisitions, invoices and non POs			
Description of delegation: Approval of purchase requisitions, purchase credit notes, invoices and non-purchase order invoices. Approval of contract payments to NHS providers.			
Delegated Limit	Up to £50k (Bands 8A-D)	Up to 100k (Band 9)	Up to £1m or 1/12 of contract value for NHS Providers
Approvers and/or restrictions Expenditure must be covered by a relevant budget. Purchase orders should be raised for all nonhealthcare goods and services and the non-purchase order route should only be used in exceptional circumstances.	Commissioning Assistant Directors Contract Managers or Budget Holders For delegated and retained functions	Deputy Directors For delegated and retained functions	Director of Specialised Commissioning Director of Commissioning Finance (specialised) For delegated and retained functions

Budget Virements				
Description of delegation: Approval of budget virements/movements within approved revenue and capital budgets.				
Delegated Limit	Up to £50k (Bands 8A-D)	Up to 100k (Band 9)	Up to £2m	Over £2m
Approvers and/or restrictions Expenditure must be covered by a relevant budget. Purchase orders should be raised for all nonhealthcare goods and services	Commissioning Assistant Directors Contract Managers or Budget Holders For delegated and retained functions	Deputy Directors For delegated and retained functions	Director of Specialised Commissioning Director of Commissioning Finance (specialised) For delegated and retained functions	Regional Director of Commissioning for NHSE functions Joint & Collaborative Committee for delegated functions

SCHEDULE 5: FURTHER INFORMATION GOVERNANCE AND SHARING PROVISIONS

PART 1

1. Introduction

- 1.1. This Schedule sets out the scope for the secure and confidential sharing of information between the Partners on a Need To Know basis, in order to enable the Partners to exercise their functions in pursuance of this Agreement.
- 1.2. References in this Schedule (*Further Information Governance and Sharing Provisions*) to the Need to Know basis or requirement (as the context requires) should be taken to mean that the Data Controllers' Staff will only have access to Personal Data or Special Category Personal Data if it is lawful for such Staff to have access to such data for the Specified Purpose in paragraph 2.1 and the function they are required to fulfil at that particular time, in relation to the Specified Purpose, cannot be achieved without access to the Personal Data or Special Category Personal Data specified.
- 1.3. This Schedule and the Data Sharing Agreements entered into under this Schedule are designed to:
 - 1.3.1. provide information about the reasons why Relevant Information may need to be shared and how this will be managed and controlled by the Partners;
 - 1.3.2. describe the purposes for which the Partners have agreed to share Relevant Information;
 - 1.3.3. set out the lawful basis for the sharing of information between the Partners, and the principles that underpin the exchange of Relevant Information;
 - 1.3.4. describe roles and structures to support the exchange of Relevant Information between the Partners;
 - 1.3.5. apply to the sharing of Relevant Information relating to Specialised Services Providers and their Staff;
 - 1.3.6. apply to the sharing of Relevant Information whatever the medium in which it is held and however it is transmitted;
 - 1.3.7. ensure that Data Subjects are, where appropriate, informed of the reasons why Personal Data about them may need to be shared and how this sharing will be managed;
 - 1.3.8. apply to the activities of the Partners' Staff; and
 - 1.3.9. describe how complaints relating to Personal Data sharing between the Partners will be investigated and resolved, and how the information sharing will be monitored and reviewed.

2. Purpose

- 2.1. The Specified Purpose of the data sharing is to facilitate the exercise of the Joint Working Arrangements.

- 2.2. Each Partner must ensure that they have in place appropriate Data Sharing Agreements to enable data to be received from any third party organisations from which the Partners must obtain data in order to achieve the Specified Purpose. Where necessary specific and detailed purposes must be set out in a Data Sharing Agreement that complies with all relevant legislation and Guidance.

3. Benefits of information sharing

- 3.1. The benefits of sharing information are the achievement of the Specified Purpose, with benefits for service users and other stakeholders in terms of the improved delivery of the Services.

4. Lawful basis for sharing

- 4.1. The Partners shall comply with all relevant Data Protection Legislation requirements and Good Practice in relation to the processing of Relevant Information shared further to this Agreement.
- 4.2. The Partners shall ensure that there is a Data Protection Impact Assessment ("DPIA") that covers processing undertaken in pursuance of the Specified Purpose. The DPIA shall identify the lawful basis for sharing Relevant Information for each purpose and data flow.
- 4.3. Where appropriate, the Relevant Information to be shared shall be set out in a Data Sharing Agreement.

5. Restrictions on use of the Shared Information

- 5.1. Each Partner shall only process the Relevant Information as is necessary to achieve the Specified Purpose and shall not use or process Relevant Information for any other purpose unless agreed in writing by the Data Controller that released the information to the other. There shall be no other use or onward transmission of the Relevant Information to any third party without a lawful basis first being determined, and the originating Data Controller being notified.
- 5.2. Access to, and processing of, the Relevant Information provided by a Partner must be the minimum necessary to achieve the Specified Purpose. Information and Special Category Personal Data will be always handled on a restricted basis, in compliance with Data Protection Legislation requirements, and the Partners' Staff should only have access to Personal Data on a justifiable Need to Know basis.
- 5.3. Neither the provisions of this Schedule nor any associated Data Sharing Agreements should be taken to permit unrestricted access to data held by any of the Partners.
- 5.4. Neither Partner shall subcontract any processing of the Relevant Information without the prior consent of the other Partner. Where a Partner subcontracts its obligations, it shall do so only by way of a written agreement with the sub-contractor which imposes the same obligations as are imposed on the Data Controllers under this Agreement.
- 5.5. The Partners shall not cause or allow Data to be transferred to any territory outside the United Kingdom without the prior written permission of the responsible Data Controller.
- 5.6. Any particular restrictions on use of certain Relevant Information should be included in a Data Sharing Agreement.

6. Ensuring fairness to the Data Subject

- 6.1. In addition to having a lawful basis for sharing information, the UK GDPR generally requires that the sharing must be fair and transparent. To achieve fairness and transparency to the Data Subjects, the Partners will take the following measures as reasonably required:
 - 6.1.1. amendment of internal guidance to improve awareness and understanding among Staff;
 - 6.1.2. amendment of respective privacy notices and policies to reflect the processing of data carried out further to this Agreement, including covering the requirements of articles 13 and 14 UK GDPR and providing these (or making them available to) Data Subjects;
 - 6.1.3. ensuring that information and communications relating to the processing of data is clear and easily accessible; and
 - 6.1.4. considering carrying out activities to promote public understanding of how data is processed where appropriate.
- 6.2. Each Partner shall procure that its notification to the Information Commissioner's Office, and record of processing maintained for the purposes of Article 30 UK GDPR, reflects the flows of information under this Agreement.
- 6.3. The Partners shall reasonably co-operate in undertaking any DPIA associated with the processing of data further to this Agreement, and in doing so engage with their respective Data Protection Officers in the performance by them of their duties pursuant to Article 39 UK GDPR.
- 6.4. Further provision in relation to specific data flows may be included in a Data Sharing Agreement between the Partners.

7. Governance: Staff

- 7.1. The Partners must take reasonable steps to ensure the suitability, reliability, training and competence, of any Staff who have access to Personal Data, and Special Category Personal Data, including ensuring reasonable background checks and evidence of completeness are available on request.
- 7.2. The Partners agree to treat all Relevant Information as confidential and imparted in confidence and must safeguard it accordingly. Where any of the Partners' Staff are not healthcare professionals (for the purposes of the Data Protection Act 2018) the employing Partners must procure that Staff operate under a duty of confidentiality which is equivalent to that which would arise if that person were a healthcare professional.
- 7.3. The Partners shall ensure that all Staff required to access Personal Data (including Special Category Personal Data) are informed of the confidential nature of the Personal Data. The Partners shall include appropriate confidentiality clauses in employment/service contracts of all Staff that have any access whatsoever to the Relevant Information, including details of sanctions for acting in a deliberate or reckless manner that may breach the confidentiality or the non-disclosure provisions of Data Protection Legislation requirements, or cause damage to or loss of the Relevant Information.

- 7.4. Each Partner shall provide evidence (further to any reasonable request) that all Staff that have any access to the Relevant Information whatsoever are adequately and appropriately trained to comply with their responsibilities under Data Protection Legislation and this Agreement.
- 7.5. The Partners shall ensure that:
- 7.5.1. only those Staff involved in delivery of the Agreement use or have access to the Relevant Information;
 - 7.5.2. that such access is granted on a strict Need to Know basis and shall implement appropriate access controls to ensure this requirement is satisfied and audited. Evidence of audit should be made freely available on request by the originating Data Controller; and
 - 7.5.3. specific limitations on the Staff who may have access to the Relevant Information are set out in any Data Sharing Agreement entered in accordance with this Schedule.

8. Governance: Protection of Personal Data

- 8.1. At all times, the Partners shall have regard to the requirements of Data Protection Legislation and the rights of Data Subjects.
- 8.2. Wherever possible (in descending order of preference), only anonymised information, or strongly or weakly pseudonymised information will be shared and processed by the Partners. The Partners shall co-operate in exploring alternative strategies to avoid the use of Personal Data to achieve the Specified Purpose. However, it is accepted that some Relevant Information shared further to this Agreement may be Personal Data or Special Category Personal Data.
- 8.3. Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a Need-to-Know basis.
- 8.4. If any Partner becomes aware of:
- 8.4.1. any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted, or unusable; or
 - 8.4.2. any security vulnerability or breach in respect of the Relevant Information, it shall promptly, within 48 hours, notify the other Partners. The Partners shall fully co-operate with one another to remedy the issue as soon as reasonably practicable, and in making information about the incident available to the Information Commissioner and Data Subjects where required by Data Protection Legislation.
- 8.5. In processing any Relevant Information further to this Agreement, the Partners shall process the Personal Data and Special Category Personal Data only:
- 8.5.1. in accordance with the terms of this Agreement and otherwise (to the extent that it acts as a Data Processor for the purposes of Article 27-28 GDPR) only

in accordance with written instructions from the originating Data Controller in respect of its Relevant Information;

- 8.5.2. to the extent as is necessary for the provision of the Specified Purpose or as is required by Law or any regulatory body; and
 - 8.5.3. in accordance with Data Protection Legislation requirements, in particular the principles set out in Article 5(1) and accountability requirements set out in Article 5(2) UK GDPR; and not in such a way as to cause any other Data Controller to breach any of their applicable obligations under Data Protection Legislation.
- 8.6. The Partners shall act generally in accordance with Data Protection Legislation requirements. This includes implementing, maintaining, and keeping under review appropriate technical and organisational measures to ensure and demonstrate that the processing of Personal Data is undertaken in accordance with Data Protection Legislation, and in particular to protect the Personal Data (and Special Category Personal Data) against unauthorised or unlawful processing, and against accidental loss, destruction, damage, alteration or disclosure. These measures shall:
- 8.6.1. take account of the nature, scope, context, and purposes of processing as well as the risks, of varying likelihood and severity for the rights and freedoms of Data Subjects; and
 - 8.6.2. be appropriate to the harm which might result from any unauthorised or unlawful processing, accidental loss, destruction or damage to the Personal Data and Special Category Personal Data and having the nature of the Personal Data (and Special Category Personal Data) which is to be protected.
- 8.7. Each Partner shall:
- 8.7.1. ensure that only Staff as provided under this Schedule have access to the Personal Data and Special Category Personal Data;
 - 8.7.2. ensure that the Relevant Information is kept secure and in an encrypted form, and shall use all reasonable security practices and systems applicable to the use of the Relevant Information to prevent and to take prompt and proper remedial action against, unauthorised access, copying, modification, storage, reproduction, display, or distribution, of the Relevant Information;
 - 8.7.3. obtain prior written consent from the originating Partner to transfer the Relevant Information to any third party;
 - 8.7.4. permit any other Partner or their representatives (subject to reasonable and appropriate confidentiality undertakings), to inspect and audit the data processing activities carried out further to this Agreement (and/or those of its agents, successors, or assigns) and comply with all reasonable requests or directions to enable each Partner to verify and/or procure that the other is in full compliance with its obligations under this Agreement; and
 - 8.7.5. if requested, provide a written description of the technical and organisational methods and security measures employed in processing Personal Data.

The Partners shall adhere to the specific requirements as to information security set out in any Data Sharing Agreement entered in accordance with this Schedule.

8.8. The Partners shall use best endeavours to achieve and adhere to the requirements of the NHS Digital Data Security and Protection Toolkit.

8.9. The Partners' Single Points of Contact set out in paragraph 13 will be the persons who, in the first instance, will have oversight of third-party security measures.

9. Governance: Transmission of Information between the Partners

9.1. This paragraph supplements paragraph 8 of this Schedule.

9.2. Transfer of Personal Data between the Partners shall be done through secure mechanisms including use of the N3 network, encryption, and approved secure (NHS.net or gcsx) e-mail.

9.3. Wherever possible, Personal Data should be transmitted and held in pseudonymised form, with only reference to the NHS number in 'clear' transmissions. Where there are significant consequences for the care of the patient, then additional data items, such as the postcode, date of birth and/or other identifiers should also be transmitted, in accordance with good information governance and clinical safety practice, to ensure that the correct patient record and/or data is identified.

9.4. Any other special measures relating to security of transfer should be specified in a Data Sharing Agreement entered in accordance with this Schedule.

9.5. Each Partner shall keep an audit log of Relevant Information transmitted and received during this Agreement.

9.6. The Partners' Single Point of Contact notified pursuant to paragraph 13 will be the persons who, in the first instance, will have oversight of the transmission of information between the Partners.

10. Governance: Quality of Information

10.1. The Partners will take steps to ensure the quality of the Relevant Information and to comply with the principles set out in Article 5 UK GDPR.

11. Governance: Retention and Disposal of Shared Information

11.1. A non-originating Partner shall securely destroy or return the Relevant Information once the need to use it has passed or, if later, upon the termination of this Agreement, howsoever determined. Where Relevant Information is held electronically, the Relevant Information will be deleted, and formal notice of the deletion sent to the that shared the Relevant Information. Once paper information is no longer required, paper records will be securely destroyed or securely returned to the Partner they came from.

11.2. Each Partner shall provide an explanation of the processes used to securely destroy or return the information, or verify such destruction or return, upon request and shall comply with any request of the Data Controllers to dispose of data in accordance with specified standards or criteria.

11.3. If a Partner is required by any Law, regulation, or government or regulatory body to retain any documents or materials that it would otherwise be required to return or destroy

in accordance with this Schedule, it shall notify the other Partners in writing of that retention, giving details of the documents or materials that it must retain.

- 11.4. Retention of any data shall comply with the requirements of Article 5(1)(e) GDPR and with all Good Practice including the Records Management NHS Code of Practice, as updated, or amended from time to time.
- 11.5. The Partners shall set out any special retention periods in a Data Sharing Agreement where appropriate.
- 11.6. The Partners shall ensure that Relevant Information held in paper form is held in secure files, and, when it is no-longer needed, destroyed using a crosscut shredder or subcontracted to a confidential waste company that complies with European Standard EN15713.
- 11.7. Each Partner shall ensure that, when no longer required, electronic storage media used to hold or process Personal Data are destroyed or overwritten to current policy requirements.
- 11.8. Electronic records will be considered for deletion once the relevant retention period has ended.

In the event of any bad or unusable sectors of electronic storage media that cannot be overwritten, the Partner shall ensure complete and irretrievable destruction of the media itself in accordance with policy requirements.

12. Governance: Complaints and Access to Personal Data

- 12.1. The Partners shall assist each other in responding to any requests made under Data Protection Legislation made by persons who wish to access copies of information held about them ("Subject Access Requests"), as well as any other exercise of a Data Subject's rights under Data Protection Legislation or complaint to or investigation undertaken by the Information Commissioner.
- 12.2. Complaints about information sharing shall be reported to each Partner. Complaints about information sharing shall be routed through each Partner's own complaints procedure unless otherwise provided for in the Joint Working.
- 12.3. The Partners shall use all reasonable endeavours to work together to resolve any dispute or complaint arising under this Schedule or any data processing carried out further to it.
- 12.4. Basic details of the Agreement shall be included in the appropriate log under each Partner's publication scheme.

13. Governance: Single Points of Contact

- 13.1. The Partners each shall appoint a Single Point of Contact to whom all queries relating to the particular information sharing should be directed in the first instance.

14. Monitoring and review

- 14.1. The Partners shall monitor and review on an ongoing basis the sharing of Relevant Information to ensure compliance with Data Protection Legislation and best practice.

Specific monitoring requirements must be set out in the relevant Data Sharing Agreement.

SCHEDULE 5: Appendix 1

Dated: 1 April 2026

(1) NHS ENGLAND (SPECIALISED COMMISSIONING)

and

(2) **MIDLANDS NHS INTEGRATED CARE BOARD**

Joint Controller Agreement for Delegated Specialised
Services support via NHS England Commissioning Teams in
Financial Year
2026/27

THIS AGREEMENT is made on the 1st day of April 2026

Between

(13) NHS Midlands Integrated Care Boards and NHS England.

(14)

Introduction

The ICBs and NHS England wish to enter into this Joint Controller Agreement (the “**Agreement**”) in respect of the administrative and management services (the “**Administrative and Management Services**”) to be provided by the NHS England regional teams currently commissioning Specialised Services (the “**Commissioning Teams**”) to the Midlands ICBs during the financial year 2026/27 (1 April 2026 – 31 March 2027) for all Delegated Specialised Services, as set out further in the Collaboration Agreement.

Background

- a) NHS England has statutory functions to arrange for the provision of prescribed services for the purposes of the NHS. This includes the services known as “**Specialised Services**”.
- b) The ICBs have statutory functions to arrange for the provision of services for the purposes of the NHS in their areas, apart from those commissioned by NHS England.
- c) NHS England has entered into a Delegation Agreement for Specialised Services with the ICB under Section 65Z5 of the NHS Act 2006, and also a Commissioning Team Agreement which outlines the scope and basis of the Administrative and Management Services which NHS England has agreed to provide to the ICB during the financial year 2026/27.
- d) This Agreement sets out the respective roles of the Parties in respect of Personal Data Processed in connection with the Administrative and Management Services, in accordance with the Data Protection Legislation.

It is agreed:

1 Commencement, duration and status of this Agreement

- 1.1 This Agreement shall come into force on the 1 April 2026 and continue until 31 March 2027 unless extended by written agreement from all Partners.
- 1.2 Termination of the Commissioning Team Agreement shall also have the effect of terminating this Agreement

- 1.3 Unless otherwise provided, the words and expressions defined in the Delegation Agreement and Commissioning Team Agreement shall have the same meaning and effect in this Agreement.
- 1.4 The following definitions shall apply this Agreement:
- 1.4.1 **"Commissioning Support Data"** means the Personal Data and Non-Personal Data Processed in connection with the Administrative and Management Services, and includes, where appropriate, "confidential patient information" (as defined under section 251 of the NHS Act), and "patient confidential information" as defined in the 2013 Report, The Information Governance Review – *"To Share or Not to Share?"*), and as further defined in clause 2 below;
- 1.4.2 **"Data Protection Impact Assessment"** shall have the same meaning as set out in the UK GDPR;
- 1.4.3 **"Joint Controller"** shall have the same meaning as set out in the UK GDPR; and
- 1.4.4 **"Personal Data Breach"** shall have the same meaning as set out in the UK GDPR.

2 Key principles and aims

- 2.1 The Parties agree and acknowledge that it is necessary for NHS England to Process certain Personal Data in for it to perform the Administrative and Management Services, as comprised within the Commissioning Support Data.
- 2.2 The Parties record their understanding and agreement in relation to the Commissioning Support Data as follows:

(a)

Subject matter	The performance of the Administrative and Management Services by NHS England so as to assist the ICBs in being able to perform the Delegated Functions.
Duration	This Parties agree that this Agreement applies for the duration of the Commissioning Team Agreement, but for the avoidance of doubt, the Parties acknowledge that their legal obligations under the UK GDPR in respect of the Commissioning Support Data survive expiry or termination of this Agreement, however arising.
Nature and purpose of the processing	The Commissioning Support Data enables NHS England to undertake analysis on, and otherwise take account of, the health needs of the ICB's local population and to provide tailored advice and support to the ICB in connection with the ICB's Delegated Functions.
Type of personal data	Patient level, and so directly identifiable, data is shared by NHS providers with NHS England via its national data landing platform, whereupon it is

	pseudonymised by the Arden and GEM DSCRO before it is made available to commissioners, including NHS England, as needed and relevant for their particular functions.
Categories of Data Subject	Patients in England.

(b)

- 2.3 The Parties have determined the following in respect of their roles under the Data Protection Legislation:
- 2.3.1 they will together determine the purpose and means for which the Commissioning Support Data is Processed in order for NHS England to provide the Administrative and Management Services and therefore that they are Joint Controllers in this context;
- 2.3.2 the ICB is an independent Data Controller for any Personal Data it Processes in order for it to perform the Delegated Functions; and
- 2.3.3 NHS England is an independent Data Controller for any Personal Data Processed in order for it to perform the Retained Functions.
- 2.4 The Parties agree that NHS England is the **"Lead Controller"** in respect of the Commissioning Support Data. As Lead Controller, NHS England has responsibility for ensuring that the Processing of the Commissioning Support Data is performed in accordance with Data Protection Legislation.
- 2.5 The Parties agree that this Agreement is necessary to enable NHS England to carry out the Administrative and Management Services. This Agreement defines the principles and procedures that the Parties shall adhere to and the responsibilities the Parties owe to each other and to Data Subjects, in accordance with the Data Protection Legislation.

3 Lead Controller obligations

- 3.1 The Lead Controller is responsible for providing the Data Subjects with clear and sufficient information as to the way in which the Commissioning Support Data will be processed.
- 3.2 To comply with its obligation at clause 3.1 of this Agreement, the Lead Controller shall provide the Data Subjects with a privacy notice where the circumstances so require. The Lead Controller is responsible for ensuring that its privacy notice addresses all matters required to be included by Articles 13 and/or 14 of the UK GDPR.
- 3.3 The Lead Controller is responsible for making available to Data Subjects the essence of the arrangements contemplated by this Agreement in accordance with Article 26(2) of the UK GDPR.

4 Joint Controller obligations

- 4.1 The Parties are jointly responsible for determining the purposes and means for and by which the Commissioning Support Data may be processed, in light of the collective and shared purpose arising out of NHS England's performance of the Administrative and Management Services for the benefit of the ICB. The Parties agree and acknowledge that the legal bases which apply to the Processing of the Commissioning Support Data are as follows:
- 4.1.1 Article 6(1)(e) UK GDPR, on the basis that it is necessary for NHS England to Process the Commissioning Support Data in order for it deliver the Administrative and Management Services and in reliance on NHS England's statutory powers under section 2(2) of the NHS Act 2006; and
 - 4.1.2 Article 9(2)(h) UK GDPR, on the basis that is necessary for NHS England to Process the Commissioning Support Data in order for it to deliver the Administrative and Management Services as they relate to the management of health care systems and services.
- 4.2 The Parties agree to promptly inform each other if either Party becomes aware of any non-compliance with the terms of this Agreement or the Data Protection Legislation.
- 4.3 The Parties agree to cooperate and assist each other with fulfilling their obligations under the Agreement and complying with the Data Protection Legislation. In particular, it is agreed that:
- 4.3.1 NHS England shall assist the ICB as the Lead Controller with complying with Article 26 of the UK GDPR and as further set out in this Agreement;
 - 4.3.2 the Parties shall promptly inform each other of any request they receive under the FOIA, UK GDPR or any other Applicable Law which involves any Commissioning Support Data, but in any event no later than two working days after receiving the request;
 - 4.3.3 the Parties shall provide each other with such assistance as is necessary to enable each other to comply with any requests they receive under the FOIA, the UK GDPR or any other Applicable Law;
 - 4.3.4 if requested, the Parties shall make available to each other all information necessary to comply with auditing requirements and/or demonstrate compliance with the Agreement and Data Protection Legislation;
 - 4.3.5 To the extent permitted by law, the Parties shall promptly notify each other of any communication they receive or are made aware of that suggests non-compliance in

respect of the way in which the Commissioning Support Data has or is being controlled or processed under this Agreement; and

- 4.3.6 Taking account of the nature of Processing and the Commissioning Support Data, the Parties undertake to assist each other with meeting their respective obligations relating to security of processing, the notification of Personal Data Breaches and the completion of Data Protection Impact Assessments.

5 Personal Data Breaches

- 5.1 The Parties shall inform each other of any actual or suspected Personal Data Breach as soon as is practicable, but in any event no later than 24 hours after becoming aware of the actual or suspected Personal Data Breach, irrespective of whether there is a requirement to notify any Supervisory Authority or Data Subjects.
- 5.2 The Parties agree to provide each other with reasonable assistance to facilitate the handling of any Personal Data Breaches in an expeditious and compliant manner.

6 Effect of termination

- 6.1 This Agreement shall continue in force unless and until it has expired or is otherwise terminated in accordance with clause 1 above.
- 6.2 Notwithstanding expiry of termination of this Agreement the Parties will continue to retain Commissioning Support Data in accordance with the Data Protection Legislation and subject to any applicable legal, regulatory or professional retention periods.

7 Transfers

- 7.1 For the purposes of this clause 'transfers' means the sharing of the Commissioning Support Data by a Party (**Disclosing Party**) with a Third Party and shall include, but is not limited to, the following:
- 7.1.1 the Disclosing Party granting a Third Party access to the Commissioning Support Data; and/or
 - 7.1.2 the Disclosing Party sub-contracting the processing of Commissioning Support Data.
- 7.2 The Data Discloser may only transfer the Commissioning Support Data in circumstances where it is lawful to do so in accordance with Data Protection Legislation. If the Data Discloser grants a Third Party access to the Commissioning Support Data it must comply with Articles 28 and 30 of the UK GDPR, as applicable, and shall remain liable for any acts and/or omissions of the Third Party.

SCHEDULE 6: COMMISSIONING TEAM ARRANGEMENTS

1. Introduction

This agreement sets out the purpose of the Office of Pan ICB Commissioning, how it will operate and how it will be governed from 1st April 2026 to 31st March 2027.

From April 27 (subject to approval by Parliament to necessary legislative changes) Integrated Care Boards (ICBs) will take over statutory responsibility from NHS England for commissioning suitable specialised Acute and Mental health, Learning Disability & Autism services; Health and Justice services; and Screening and Vaccination services. Collectively, these services account for circa £5bn within the Midlands in 2025/26.

Whilst it is intended that ICBs will be individually responsible, most of their new commissioning functions will require – due to the nature of the services and populations involved – a large planning and commissioning footprint. This will mean that ICBs will need to establish (or build upon existing) appropriate multi-ICB governance arrangements, such as a joint committee.

Seven ‘Offices for Pan-ICB Commissioning’ (OPICs) – one per NHS region - will be established to support all ICBs across a region in discharging these additional statutory functions. The OPIC model is designed to facilitate ICB collaboration and, where appropriate, ‘at scale’ commissioning as well as ensuring a critical mass of expert commissioning capability is maintained for these complex, high profile and often contentious areas of service provision.

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Staff currently delivering these commissioning functions within NHSE’s seven regional teams will transfer to the host ICBs in April 2027 (or, at the point legislative provisions transferring these functions to ICBs are commenced)

NHS England will continue to host staff working on behalf of ICBs for the commissioning of the Specialised Acute and MHLDA services that were delegated in April 2024 and April 2025.

This agreement will commence on 1st April 2026 for one year only. This will be a transition year to further develop the future operating model with NHSE remaining the employing organisation.

This agreement is between the following clusters of ICBs & NHS England:

Cluster 1

NHS Lincolnshire Integrated Care Board

NHS Nottingham & Nottinghamshire Integrated Care Board

NHS Derby & Derbyshire Integrated Care Board

Cluster 2

NHS Leicester, Leicestershire & Rutland Integrated Care Board

NHS Northamptonshire Integrated Care Board

Cluster 3

NHS Birmingham & Solihull Integrated Care Board

NHS Black Country Integrated Care Board

Cluster 4

NHS Herefordshire & Worcestershire Integrated Care Board

NHS Coventry & Warwickshire Integrated Care Board

Cluster 5

NHS Shropshire, Telford & Wrekin Integrated Care Board

NHS Staffordshire & Stoke-on-Trent Integrated Care Board

and

NHS England

This Joint Working Agreement should be read in conjunction with:

- Overarching governance documents
 - Delegation Agreement
 - Joint and Collaborative Committee Terms of Reference
 - OPIC Commissioning & Operating Framework
- National guidance relating to the roles and responsibilities of NHS England in relation to directly commissioning services.

2. Values and Principles

In creating the Office of Pan ICB Commissioning we will create a new model of specialist commissioning, one that succeeds not through structural redesign alone, but through a fundamental shift in how we operate and work together. We will continue to transform the way health services are strategically commissioned across the Midlands, by creating a collaborative, resilient, and equity-driven system that works at scale while remaining responsive to local needs.

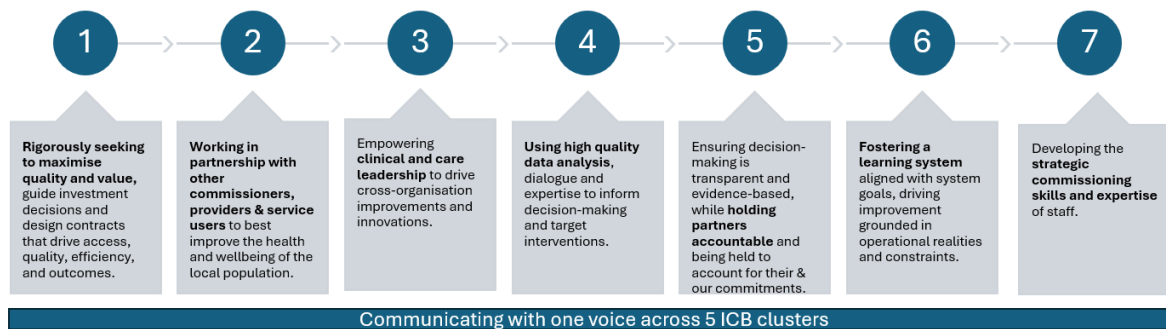
The Office of Pan ICB Commissioning will:

- Support a safe transfer / delegation of commissioning responsibilities and accountabilities from NHSE to ICBs from 2027.
- Bring together Strategic Commissioning of specialist services across the 5 cluster ICBs - Establishing a Midlands-wide centre of excellence that supports all ICBs equally, hosted by one ICB on behalf of all. Enabling consistent, high-quality commissioning through a shared operating model, while allowing flexibility for local decision-making.
- Improve Health Equity and Outcomes - Use data-driven planning to tackle health inequalities and improve outcomes for underserved populations. Shift focus from service fragility to population health, access, and equity.
- Empower Clinical and Community Leadership - Embed clinical leadership and co-production at the heart of commissioning. Ensure services are shaped by patients, providers, and communities.

- Deliver Value-Based, Outcome-Focused Care - Align commissioning decisions with measurable outcomes, patient experience, and cost-effectiveness. Drive efficiency and sustainability across specialist services.
- Enable Integration and Innovation - Support pathway redesign and integration across care settings. Foster provider collaboration and innovation through shared governance and financial risk models.

Midlands ICBs are committed to collaborate and commission at scale, to maximise resilience and strategic commissioning capability in these important areas of healthcare provision. The Office for Pan ICB Commissioning will provide a Midlands wide centre of excellence focussing on specialist commissioning knowledge and expertise, connecting with and through colleagues at cluster, place and provider level. It will be built on the following principles of collaboration and co-production:

As Strategic Commissioners Our Guiding Principles Are:

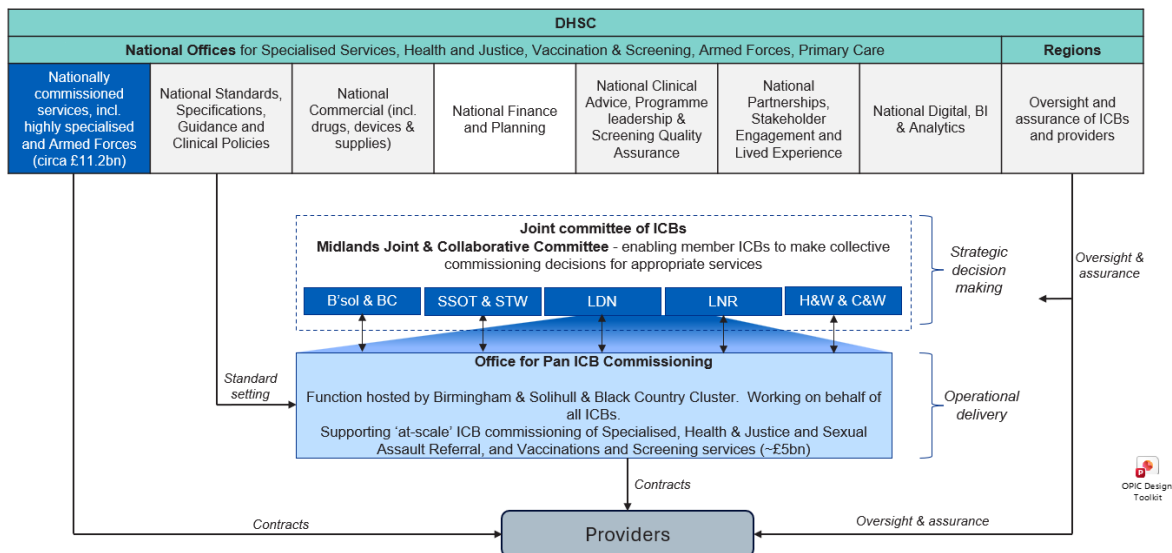


The Multidisciplinary Team will work coherently and consistently and will champion specialised care on behalf of the 12 commissioning partners. They will work as a part of a network of partners, enabling staff to deliver across complex geographies and as part of multi-layered systems and local collaboration.

3. Operating Model

The founding principles of the operating model are:

- Operate Midlands wide by default, whilst working at ICB Cluster or East/West footprints when it makes sense to do so.
- OPIC hosted by NHSE until transfer to the host ICB, so must fulfil its current statutory functions whilst being future proof and in line with ICBs development as strategic commissioners.
- Develop as a cohesive entity operating based on collaboration, co-production and transparency working with ICB leadership and guidance.
- Clear points of communication and relationship management across ICBs, OPIC and into national commissioning functions.
- The strategic commissioning framework, ICB blueprint and OPIC design toolkit will frame its core purpose.
- Financially sustainable within OPIC RCA envelope.



7

Delegated services

The Midlands Specialised Commissioning Team has been working with and on behalf of all Midlands ICBs since 2023/24 with a joint working agreement and subsequent set of delegation processes in April 2024 and April 2025.

We commission:

- Circa. 150 specialised services aligned to the prescribed service manual.
- Acute and Mental Health, Learning Disability and Autism Services (MHLDA).
- ICB delegated service responsibility and NHSE retained responsibility as well as contracting processes for current Highly Specialised Services (HSS).
- High-Cost Medicines, including medicines optimisation and care transformation.

We operate:

- A single integrated Midlands team working on behalf of ICBs and NHSE.
- Subject matter expertise aligned to 6 programmes of care (Women and Children's, Trauma, Internal Medicine, Cancer, Blood and Infection and MHLDA).

NHS England Commissioned Services

Health and Justice

Commissioning of healthcare for a range of individuals in touch with the criminal justice system

- **Custodial healthcare services:** Male Prisons, Female Estate, Young Offenders Institutes, & Secure Holding Facilities. *16 contracts across 4 providers operating within 28 establishments.*
- **Non-custodial healthcare services:** Liaison and Diversion Services, RECONNECT, Mental Health Treatment Requirements (MHTRs) *across 9 providers.* Court Healthcare co-commissioned with the MoJ (PECS) by the Midlands H&J team covering the North of England and the Midlands regions (*1 contract, 1 provider*).
- **Children and Young Peoples (CYP) Services:** 2 x secure children's homes and 1 planned new safe centre (welfare only unit) *2 contracts across 2 providers.*
- **Sexual Assault Referral Centres (SARCs)** for Adults and for Children and Young People. Co-commissioned with Police and Crime Commissioners / Police Forces. *12 locations, 8 contracts across 5 providers.*

Screening

Responsibility for delivery of:

Cancer Programmes: Cervical Screening, Breast Screening, Bowel Screening

Adult Non-Cancer Programmes: Diabetic Eye Screening, Abdominal Aortic Aneurysm (AAA) Screening,

Antenatal and Newborn programme: Six separate programmes

Child Health Information Services (CHIS)

Commissioning functions include:

- Service transformation and improvement, develop innovative solutions and implementation plans to meet local need and ensure best value
- Coordinate management of screening incidents/issues.
- Oversee local end-to-end screening pathways to address gaps & ensure alignment Effective contract management, monitoring and development and delivery of improvement/equity plans
- Use data and insight to identify population needs

Vaccinations

Through our well-established vaccination governance group, we work with all ICB vaccination leads to ensure alignment with system prevention strategies, making joint decisions on vaccination delivery for routine and seasonal programmes (see annex for detail):

Childhood programmes – Measles, Mumps, Rubella, Varicella (MMRV), Diphtheria, Pertussis, Meningococcal C etc

Seasonal programmes – Covid (spring/winter) & Flu (winter)

School Age Programmes - *flu, Human Papilloma Virus (HPV), Meningococcal ACWY (Men-ACWY), Tetanus/Diphtheria/Polio (Td/IPV), MMR / MMRV (catch-up)*

Adult Programmes - Pertussis, Respiratory Syncytial Virus (RSV), Pneumococcal, Shingles, MPOX/Gonorrhoea

Maternal programmes – Flu, Pertussis, RSV

Neonatal Programmes – BCG for TB prevention, Hepatitis B

Commissioning Support Services

Finance

- Contract negotiation and management for all specialist services including all NHSE retained and delegated services – delivered, where appropriate through ICB lead contract arrangements.
- Development of activity plans for all contracts and services
- Management and processing of all contract variations.
- Provider relationships – contract management, review meetings across all NHS and Independent sector providers
- Management of payments for all specialist services
- Support to ICBs through finance and contracting governance groups, management of risk share arrangements, pricing policy
- Management of financial allocations including operational and strategic financial planning

Monthly reporting and ledger management

Healthcare Public Health

The key public health functions embedded in OPIC

- **Specialised commissioning:** At regional level, a full and integral member of specialised commissioning teams. Liaison with public health colleagues across the

system to assist in optimising prevention, service planning and quality across whole pathways of care.

- **Health and Justice:** Provide public health expert advice and guidance to HMPPS and NHSE, in commissioning of health services in the secure and detained estate. Health needs through data analysis and interpretation, service audits and reviews.
- **Dental public health:** Provide specialist dental public health & clinical leadership, advice and guidance for Local Integrated Care Systems supporting the commissioning of ICB Dental services
- **Screening and Immunisations:** Technical PH knowledge and operational experience in screening and immunisation pathways, including quality assurance, incident response, and compliance with national standards.

Clinical and Quality

Delivery of Statutory Quality Duties for commissioned services through three separate Clinical & Quality teams:

- Acute Specialised Commissioning
- Mental Health, Learning Disability & Autism (MHLDA) Specialised Commissioning
- Health & Justice (Custodial and Non-Custodial) and Vaccination & Screening
- **Quality Surveillance (Control):** through Provider Contract Review Meetings
- **Quality Assurance:** Undertaking Desktop/Peer Reviews, Clinical Quality Visits (CQVs), Audits **Quality Improvement & Quality Planning:** Working with Clinical Networks/Programme of Care, including thematic learning e.g. from Deaths in Custody (DICs) and PSIRF
- **Clinical Leadership:** providing specialist advice and support

Corporate and Governance

Ensure all activities across commissioning are aligned, efficient and well-managed, as the operational backbone for governance and delivery.

- **Programme Management** – Ensures projects and initiatives are coordinated, managed and deliver outcomes.
- **Change Management** – Designing and implementing change programmes, managing people, processes and transitions.
- **OD, EDI and HR** - Improving directorate effectiveness and capability
- **Comms and Engagement** - Media and stakeholder advice, incident & issue management, proactive media management
- **Corporate Governance** - – Ensure accountability, transparency and compliance
- **Business coordination** - Risk and issue management, reporting and assurance

3.NHSE Hosting

NHSE commissioning team (working on delegated ICB services and NHSE commissioned services) will operate seamlessly across NHSE and cluster ICBs. NHSE will meet all associated costs of employing staff commissioning NHSE services working jointly with ICBs and hosting staff who support services already delegated to ICBs, this will include but not limited to the following

- Corporate support will be provided by NHSE as the host organisation including estates, IT, legal support, HR and business administration.

- The Multidisciplinary Team will link with NHSE Regional and National directorates regarding risk management where this is appropriate.
- Although the responsibility for commissioning of the 59 specialised services is delegated to the Midlands ICBs on 1st April 2024, accountability remains with NHSE. This will be managed by the NHSE Midlands regional team through an Oversight and Assurance Framework informed by subject matter expertise provided by the Multidisciplinary Team and wider regional commissioning integration team.
- The team will work to ensure consistency of communication through the established governance model, recognising the different populations and system issues in the Midlands. The team will remain pan-Midlands in structure.

Liabilities

NHS England shall be liable for any losses arising out of negligent acts or omissions in respect of the provision of Administrative and Management Services except where such losses arise as a result of action taken in accordance with instruction from any ICB or a failure of an ICB to provide on request appropriate instruction.

NHS England will meet the liabilities as a result of:

- Death or personal injury caused by its negligence.
- Fraud
- Fraudulent misrepresentation

MaST training and professional development

The costs associated with the provision of agreed ongoing learning and development including mandatory (MaST) training will be met by NHSE.

100% compliance is required by all staff for the MaST training detailed below:

Equality, Diversity and Inclusion

As part of the system leadership arrangements for the NHS, we recognise the importance of becoming a role model for the rest of the NHS in respect of issues relating to equality, diversity, and inclusion in the workplace.

Fraud Awareness

This course focuses on providing you with awareness of the key aspects of fraud and corruption in the NHS and help you know your responsibilities to combat it.

Data Security Awareness

This course focuses on the importance of data security in health and social care. It will help you understand how to comply with the law, define potential threats and how to identify and avoid breaches.

Health and Safety

This course focuses on health and safety in the workplace. You will gain an understanding for responsibilities under Health and Safety Law, different types of safety signage, basic fire safety principle, basic moving, and handling techniques and why incident reporting is so important.

Safeguarding Children & Adults at Risk of Harm or Abuse

This course introduces safeguarding children and adults at risk of harm or abuse. It focuses on safeguarding in the NHS, data sharing, domestic abuse, and associated legislation as well as what you can do when raising a concern.

Records Management

This course introduces you on the importance of records management, legal and contractual requirements, and guidance on how to keep information secure.

Patient Safety

This course introduces patient safety for all NHS staff. It focuses on the essentials for creating patient safety and helps recognise that the NHS is a system of essential and interconnected parts; a team with a common goal.

Appraisal and Dynamic Conversations

NHSE will meet all costs and requirements of ensuring all members of the have regular performance and development through regular Appraisal & Dynamic Conversations.

Appraisals are an opportunity for both line managers and team members to have meaningful, fluid, and organic 1:1s. Dynamic Conversations put wellbeing at the forefront of initial conversations and will help to support colleagues through change.

NHSE will ensure that monthly 1:1s with line managers are regularly scheduled.

(c) Freedom of Information and Parliamentary Requests

- (d) All Freedom of Information and Parliamentary Requests relating to Delegated Services should be forwarded to the NHSE commissioning team will ensure the appropriate handling, management, and response, ensuring where appropriate that ICBs are informed and engaged. The team will also ensure they provide reasonable support to ICBs in responding to freedom of information and parliamentary correspondence as required.

(e)

(f) Incident Response and Management

- (g) The NHSE commissioning team shall provide such reasonable support as required by an ICB in relation to local incident management for Delegated Services and NHSE commissioning services.

(h)

(i) Provider Selection and Procurement

- (j) The NHSE commissioning team shall act on instructions from the ICBs in relation to provider selection and procurement processes for the Delegated Services.

Escalations

If an ICB has cause to raise concerns regarding the performance, actions or conduct of a member of the Multi-Disciplinary Team the ICB will in the first instance contact by email the Director of Specialised & Collaborative Commissioning, who will where possible provide an acknowledgement within 7 days of receipt.

The Director of Specialised & Collaborative Commissioning will provide the ICB with feedback and action taken with 30 days.

If for any reason the ICB is unhappy with the response the concerns can be escalated to the NHS England Regional Director of Commissioning

Confidential information

The ICBs and NHSE shall always use its best endeavours to keep confidential and ensure that its employees and agents keep confidential any information in relation to the business and affairs of another Partner.

If the information referred to herein is subject to a freedom of information (FOI) or other request to share the data, then NHS England will be responsible for the fulfilment of the request, but will seek views from the ICBs before undertaking this in accordance with the Freedom of Information Code of Practice issued by the Cabinet Office under section 45 of the Freedom of Information Act 2000.

The ICBs and NHSE will not make any press announcements about this Agreement or publicise this Agreement or any of the terms in any way. The ICBs and NHSE shall ensure that any such information disclosed is solely for the purpose of performing its obligations under this Agreement.

Terms of Reference

Midlands Joint and Collaborative Committee

Introduction and purpose	The Joint & Collaborative Committee has been established by the ICBs & NHSE as listed: Cluster 1 (1) NHS Lincolnshire Integrated Care Board of Bridge House, The Point, Lions Way, Sleaford, NG34 8GG ("Lincolnshire ICB"); and (2) NHS Nottingham & Nottinghamshire Integrated Care Board of Sir John Robinson House, Sir John Robinson Way, Arnold, Nottingham, NG5 6DA ("Nottingham & Nottinghamshire ICB"); and (3) NHS Derby & Derbyshire Integrated Care Board of Cardinal Square, 10 Nottingham Road, Derby, Derbyshire, DE1 3QT ("Derby & Derbyshire ICB"). and Cluster 2 (4) NHS Leicester, Leicestershire & Rutland Integrated Care Board of Room G30, Pen Lloyd Building, County Hall, Glenfield, Leicester, LE3 8TB ("Leicester, Leicestershire & Rutland ICB"); and (5) NHS Northamptonshire Integrated Care Board of Haylock House, Kettering Parkway, Venture Park, Kettering NN15 6EY ("Northamptonshire ICB"); and Cluster 3 (6) NHS Birmingham & Solihull Integrated Care Board of Eighth Floor, Alpha Tower, Birmingham ("Birmingham & Solihull ICB"); and (7) NHS Black Country Integrated Care Board of Civic Centre, St Peters Square, Wolverhampton WV1 1SD ("Black Country ICB"); and Cluster 4 (8) NHS Herefordshire & Worcestershire Integrated Care Board of Kirkham House, John Comyn Drive, Perdiswell, Worcester, WR3 7NS ("Herefordshire & Worcestershire ICB"); and (9) NHS Coventry & Warwickshire Integrated Care Board of Shire Hall, Market Place, Warwick CV34,4RL ("Coventry & Warwickshire ICB"); and Cluster 5 (10) (NHS Shropshire, Telford & Wrekin Integrated Care Board of Halesfield 6, Halesfield, Telford, TF7 4BF ("Shropshire, Telford & Wrekin ICB"); and (11) NHS Staffordshire & Stoke-on-Trent Integrated Care Board of Stafford Education & Enterprise Park, Weston Road, Stafford, ST18 0BF ("Staffordshire & Stoke-on-Trent ICB") and (12) NHS England – Midlands Region, Cardinal Square, 10 Nottingham Road, Derby DE1 3QT

Introduction and purpose	The Committee has been established by the partners to fulfil the following core functions: • For the ICBs to jointly discharge commissioning responsibilities for Specialised Services that have been delegated to them by NHS England which NHS England requires them to exercise collaboratively • To act as a Collaborative forum for NHS England to discharge its retained Direct Commissioning responsibilities (including for retained Specialised Services, Health and Justice Services and Screening and Immunisation Services) in consultation with the ICBs. The Joint & Collaborative Committee will make decisions on the strategic planning and delivery, including resource allocation, oversight and assurance, to improve health and care outcomes and reduce health inequalities for services within its purview. The Joint & Collaborative Committee will establish sub-groups or sub-committees with such Terms of Reference and delegated responsibilities as it agrees.
The Terms of Reference	These Terms of Reference support effective partnership working between all Partners acting through this Joint & Collaborative Committee. They set out the role, responsibilities, membership, decision-making powers and reporting arrangements of the Joint & Collaborative Committee.
Statutory Framework	The Joint & Collaborative Committee is established pursuant to section 65Z6 of the NHS Act 2006. Apart from as set out in the Agreement, the Joint & Collaborative Committee does not affect, and must act in accordance with, the statutory responsibilities and accountabilities of the Partners.
Role of the Joint Committee	The Joint & Collaborative Committee and aligned subsidiary arrangements will be responsible for the safe, effective, efficient and economic discharge of the Joint Functions by the ICBs. It will also serve as a collaborative forum for NHS England to make decisions on retained Direct Commissioning services (Retained Specialised Services, Health and Justice Services and Immunisation and Screening services). This will involve the discharge of the following key responsibilities: Strategic Leadership: • Supporting setting the strategic direction for commissioning across the Midlands, ensuring clarity of purpose, outcomes and value for all services outlined in Schedule 3 of the Collaboration Agreement. • Oversight of the development and integration of Strategic Commissioning Frameworks for agreed Pan ICB commissioning across the Midlands. • Oversight of the development of system plans and strategies to enable the three shifts, with clear outcome metrics, financial sustainability, and public accountability for the defined population that are evidence based and responsive to population health needs. Population Health and Insight: • Oversight of work to ensure members have a deep understanding of population health needs through advance analytics, predictive modelling, and citizen insight. • Ensuring that there is effective use of robust, high-quality data and insight in the development of evidence-based prioritization frameworks aligned to value and equity. • Ensuring that there is alignment with other relevant plans and strategies including Integrated Care Strategies, Joint Strategic Needs Assessments and Health and Wellbeing Strategies. Value, Prioritisation and Investment: • Approving system-wide commissioning priorities based on value, equity, and outcomes to support investment and disinvestment decision making.

	- Developing subsidiary arrangements to enable effective and efficient operational decision making arrangements that will support the exercise of the Joint Functions by sub-groups and/or staff working on behalf of the partners Innovation and Delivery: - Supporting the development of strategies including setting expectations for outcome-based commissioning. - Oversight of collaborative commissioning across the Midlands for all services within its scope with other ICBs and NHS England. - Acting as a forum for discussion and making recommendations on issues where further joint action or working between ICBs and NHSE commissioners would be of benefit outside the arrangements delegated to it
Accountability and reporting	The Joint & Collaborative Committee will be formally accountable to the Boards of the ICBs for the functions delegated by them to the Joint & Collaborative Committee through their Schemes of Reservation and Delegation (SORDs). The Joint & Collaborative Committee operates as the collaborative body for NHS England to make decisions on direct and retained services in consultation with the ICBs through its accountable officers to NHS England's Regional Director and National Directors in line with NHSE the Scheme of Reservation and Delegation (SORDs). The Joint & Collaborative Committee may also report to NHS England's Delegated Commissioning Group (DCG) for Specialised Services on its proceedings and decisions relating to Specialised Services. The Chair (or, at their discretion, another member) may also attend the DCG to present reports on behalf of the committee. Where an ICB Board or National or Regional Directors requests that the Joint & Collaborative Committee provides information or reports on its proceedings or decisions, the Partners must comply with that request within a reasonable timescale.
Membership	<u>ICB Membership</u> The core voting membership of the Committee will be made up of one Authorised Officer (who must be the CEO or their nominated representative) from each of the ICB Clusters. Each of the ICB Clusters must ensure that the members nominated on their behalf are of a suitable level of seniority and duly authorised to act on its behalf and to agree to be bound by the final position or decision taken at any meeting of the Joint & Collaborative Committee. The Authorised Officers may nominate a named substitute who may attend meetings on their behalf with the same decision-making authority. <u>NHSE Membership</u> The NHSE Regional Director of Commissioning (or their nominated representative) will attend meetings of the Committee to take decisions in relation to the retained services in consultation with the wider committee. <u>Other Participants</u> Each of the Partners may be represented at meetings by representatives who may observe proceedings and contribute to the deliberations as required, but these will not have the right to vote. The Partners may also identify individuals or representatives of other organisations that may be invited to observe proceedings and contribute to the Joint &

	Collaborative Committee's deliberations as required. These representatives will not have the right to vote. <u>Term of Membership</u> Members (and any substitutes appointed) will hold their appointment until the partner they represent nominates an alternative member or they cease to hold their substantive role with the relevant partner. <u>Membership Lists</u> The Chair (or in the absence of a Chair, the Partners themselves) shall ensure that there is prepared (and updated from time to time) a list of the members and named substitutes and that this list is made available to the Partners. <u>Other Attendees</u> The Joint & Collaborative Committee will be supported by a Secretariat, who will be provided by the Office of Pan ICB Commissioning.
Chair	The Joint & Collaborative Committee will appoint two of the Authorised Officers as Co-Chairs of the Joint & Collaborative Committee. The Co-Chairs will serve as Strategic leads for Specialised Services and Health & Justice/Screenings & Immunisation respectively. The Joint & Collaborative Committee will confirm or appoint new Co-Chairs at the first meeting of each financial year.
Meetings	The Joint Committee shall meet at least quarterly. At its first meeting (and at the first meeting following each subsequent anniversary of that meeting) the Joint & Collaborative Committee shall prepare a schedule of meetings for the forthcoming year ("the Schedule"). The Co-Chair(s), or in the absence of a Chair, the Partners themselves, shall see that the Schedule is notified to the members. Any of the Partners may call for a special meeting outside of the Schedule as they see fit, by giving notice of their request to the Co-Chairs. The Co-Chairs may, following consultation with the Partners, confirm the date on which the special meeting is to be held and then issue a notice giving not less than four weeks' notice of the special meeting.
Quorum	A Joint & Collaborative Committee meeting will be quorate if at least one authorised representative member (or substitute) from each ICB Cluster is in attendance. Attendance at meetings by telephone/video conferencing will count towards the quorum.
Decisions and veto.	The Joint & Collaborative Committee must seek to make decisions relating to the exercise of the ICB Cluster Joint Functions on a consensus basis. The Partners must ensure that matters requiring a decision are anticipated and that sufficient time is allowed prior to Joint & Collaborative Committee meetings for discussions and negotiations between Partners to take place. Where it has not been possible, despite the best efforts of the Core Membership, to come to a consensus decision on any matter relating to ICB Cluster Joint Functions put before the Joint & Collaborative Committee, the Chair of Part may require the decision to be put to a vote. Where such a vote is required, each Authorised Officer will have one vote, per cluster ICB, with decisions being made by a simple majority of those voting. Any disputes will be resolved using the dispute resolution process outline in section 21 of the Collaboration agreement.

Conduct and conflicts of interest	Members will be expected to act consistently with existing statutory guidance, NHS Standards of Business Conduct and relevant organisational policies. The NHS Standards of Business Conduct policy is available from: https://www.england.nhs.uk/publication/standards-of-business-conduct-policy/ Members should act in accordance with the Nolan Principles (the Seven Principles of Public Life): https://www.gov.uk/government/publications/the-7-principles-of-public-life Members should refer to and act consistently with the NHSE guidance: <i>Managing Conflicts of Interest in the NHS: Guidance for staff and organisations</i>. See: https://www.england.nhs.uk/ourwork/coi/
Confidentiality of proceedings	The Joint & Collaborative Committee is not subject to the Public Bodies (Admissions to Meetings) Act 1960. Admission to meetings is at the discretion of the Partners. All members in attendance are required to give due consideration to the possibility that the material presented to the meeting, and the content of any discussions, may be confidential or commercially sensitive, and to not disclose information or the content of deliberations outside of the meeting's membership, without the prior agreement of the Partners.
Publication of notices, minutes and papers	The Office of Pan ICB Commissioning shall provide sufficient resources, administration and secretarial support to ensure the proper organisation and functioning of the Joint & Collaborative Committee. The Chair(s), with the support of the Secretariat Lead, shall see that notices of meetings, together with an agenda listing the business to be conducted and supporting documentation, is issued to the Partners one working week (or, in the case of a special meeting, three calendar days prior to the date of the meeting). The proceedings and decisions taken shall be recorded in minutes, and those minutes circulated in draft form within one week of the date of the meeting. The Joint & Collaborative Committee shall confirm those minutes at its next meeting.
Review of the Terms of Reference	These terms of reference will be reviewed in six & twelve months of the Joint & Collaborative Committee establishment and then at least annually thereafter. Any changes to the Joint & Collaborative Committee decision-making membership or core functions must be approved by the partners. Other changes to the terms of reference may be agreed by the Joint & Collaborative Committee and reported to the Partners for assurance.
Date of Approval of Terms of Reference	TBC

The secretariat can be contacted on jomelling@nhs.net

Enclosure No: 08

Report to:	Integrated Care Board						
Date:	26 March 2026						
Title:	5 Year Strategic Commissioning Plans – NHS Shropshire Telford and Wrekin ICB and NHS Staffordshire and Stoke on Trent ICB						
Presenting Officer:	Dr Lorna Clarson, Chief Officer for Strategy and Improving Outcomes						
Author(s):	Gemma Smith, Director of Commissioning, NHS STW ICB and Vicki Inch, Associate Director of Planning and Intelligence, NHS SSOT ICB						
Document Type:		Action Required (select):					
Report	☐	Business Plan	☐	Information (I)	☐	Discussion (D)	☐
Strategy	☒	Policy	☐	Assurance (S)	☐	Approval (A)	☒
Other	☐	(please describe)		Ratification (R)	☐	(check as necessary)	
Is the decision within SOFD powers & limits				Yes	☒	No	☐
Any potential / actual Conflict of Interest?				Yes	☐	No	☒
<i>If Y, the mitigation recommendations:</i>		N/A					
Any financial impacts: ICB or ICS?				Yes	☐	No	☒
Any impacts on ICB Undertakings?				Yes	☐	No	☒
Appendices:	Appendix 1 – NHS Shropshire, Telford and Wrekin ICB 5 Year Strategic Commissioning Plan, Appendix 2 – NHS Staffordshire and Stoke on Trent ICB 5 Year Strategic Commissioning Plan						

(1) Purpose of the Paper:

The purpose of this paper is to present the Five-Year Strategic Commissioning Plans 2026/27–2030/31 for NHS Shropshire, Telford and Wrekin (STW) and Staffordshire and Stoke on Trent (SSoT) for Board approval.

(2) History of the paper

Extraordinary Board Meeting in Common for D

Date

9/2/2026

(3) Implications:

Legal / Regulatory	The Five-Year Strategic Commissioning Plans have been developed in line with the ICB's statutory duties under the Health and Care Act 2022, including responsibilities to improve quality, reduce health inequalities, involve patients and the public in decision-making, ensure safeguarding, and secure continuous improvement in outcomes and efficiency. The plans align with the regulatory expectations set out by NHS England, including requirements for Integrated Impact Assessments (IIAs), Equality Impact Assessments (EQIAs), Core20PLUS5 inequalities duties, compliance with national patient safety and quality frameworks, and adherence to the Gunning Principles for consultation. The plans also strengthen regulatory assurance through improved data quality, contract compliance, provider oversight, and structured quality and inequalities governance, ensuring that statutory obligations are embedded throughout transformation and service redesign
CQC / Patient Safety	The Five-Year Strategic Commissioning Plans embed quality and safety as a core, cross-cutting requirement across all commissioning intentions and system shifts. The plans ensure compliance with national frameworks, and establish clear mechanisms for improving safety, outcomes, and experience across all providers. It reinforces the ICB's duty to secure high-quality care through robust oversight, integrated clinical leadership in commissioning, and targeted action on unwarranted variation.
Financial (CFO-assured)	The Five-Year Strategic Commissioning Plans have been developed within the constraints of both systems financial position and explicitly aligns with the System Financial Strategy, Financial Recovery Plan, and statutory Revenue and Capital Resource Limits. They prioritise investment based on value and population impact, directing resources toward prevention, neighbourhood-based care, digital enablement and productivity improvements, while ensuring that all commissioning intentions undergo robust cost assessment and affordability checks through the Strategic Decision-Making Framework and the Capital Prioritisation Framework. It also incorporates national funding streams and gainshare approaches where available, with clear recognition of cost pressures and the need for rigorous financial oversight through the System Finance Committee and Strategic Commissioning and Transformation Committee.

Sustainability	A system wide shift toward community-based and digitally enabled care supports long term sustainability by reducing reliance on hospital settings, lowering travel and emissions, and improving resource use. Financial sustainability is also strengthened through value based commissioning, productivity improvements and targeted investment in prevention, ensuring a resilient, future proof health and care system.
Workforce / Training	The Five-Year Strategic Commissioning Plans have significant workforce implications, as delivery of neighbourhood-based care models, expanded community services, digital transformation, prevention programmes and pathway redesign all require a workforce with the right capacity, capability and support. Training and development needs will be addressed through enhanced leadership development, workforce upskilling for neighbourhood teams, digital literacy improvements, and support for staff wellbeing and culture, reinforced by governance structures such as the System People Committee. The plans also highlight resource requirements linked to workforce transformation, including the need for sufficient programme capacity within the ICBs and partners, strengthened establishment controls, and coordinated system-wide action to mitigate shortages and build a sustainable, resilient workforce.
Equality & Diversity	The plans align with the regulatory expectations set out by NHS England, including requirements for Integrated Impact Assessments (IIAs), Equality Impact Assessments (EQIAs), Core20PLUS5 inequalities duties, compliance with national patient safety and quality frameworks, and adherence to the Gunning Principles for consultation.
Due Regard: Inequalities	The plans respond directly to the ICB's statutory duties to involve patients and the public, including marginalised and Core20PLUS populations, through the proposed and planned use of structured engagement mechanisms such as routine public meetings, Integrated Impact Assessments, and programme-specific engagement led by the ICBs. The plans also align with the regulatory expectations set out by NHS England, including requirements for Integrated Impact Assessments (IIAs), Equality Impact Assessments (EQIAs), Core20PLUS5 inequalities duties,

Due Regard: wider effect

The plans demonstrate clear due regard for improving health and wellbeing through a strong focus on prevention, neighbourhood-based care and targeted action to reduce inequalities, particularly for Core20PLUS5 populations. They embed robust quality governance, standardised pathways and the Patient Safety Incident Response Framework to ensure consistently high-quality, safe care.

Efficiency is advanced through value based commissioning, digital transformation, community delivered models, and system wide productivity measures designed to reduce duplication, streamline flow and shift resources toward prevention and early intervention. Together, these approaches ensure a balanced emphasis on better outcomes, safer care and sustainable use of resources.

(4) Statutory Dependencies & Impact Assessments:

	Completed?			If N - N/A, Rationale	If Y, Outcome / Date Reported & Signed off
	Yes	No	N/A		
DPIA	☐	☐	☒	Please note that DPIA's will be undertaken on an individual service/pathway basis as models are developed.	<i>Reported to IG Committee:</i> Click or tap to enter a date.
EIA	☐	☐	☒	Please note that EIA'S/IIA's will be undertaken on an individual service/pathway basis as models are developed.	<i>Outcome and date of completion:</i> Click or tap here to enter text.
QIA	☐	☐	☒	Please note that QIA's/IIA's will be undertaken on an individual service/pathway basis as models are developed.	<i>SRO sign-off, outcome & date of completion:</i> Click or tap here to enter text.
Has there been Public / Patient Involvement?	☐	☒	☐	Work will commence with comms and engagement colleagues to map out the requirements over the 5-year period by	

programme area to identify the engagement required in addition to any potential for full Public Consultation. Plans are also in place to discuss via the Health and Wellbeing Boards, and all engagement will be built into the refreshed programme moving forwards.

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

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

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

The development of the Five Year Strategic Commissioning Plans is required under NHS England's Planning Framework for 2026/27–2030/31, which shifts the NHS away from short term annual cycles and towards rolling, medium term planning to deliver the transformation set out in the 10 Year Health Plan. The guidance highlights that credible five-year plans are essential to achieving the national three shifts from hospital to community, analogue to digital, and sickness to prevention while providing clear commissioning intentions that enable coherent, system wide planning and delivery.

As part of our medium term planning, we have sought to develop our 5 Year Strategic Commissioning plans that includes an assessment of population need incorporating the Integrated Strategic Needs Assessment (ISNA), Population Health Improvement Plan (PHIP), and Clinical Strategy. Alongside this, we have clearly articulated our long term ambitions for improving outcomes, reducing health inequalities, improving access, commissioning for outcomes, approach to financial sustainability, and the digital and workforce requirements and interfaces needed to deliver change.

The Five Year Strategic Commissioning Plans are also the mechanism through which the ICBs will demonstrate how they will lead transformation, coordinate partners and deliver nationally mandated improvements over the medium term.

In summary, our plans focus on the following:

- Developing and expanding our neighbourhood-based models of care, expanding community capacity, modernising primary care and delegated functions, and ensuring earlier intervention for priority population groups. It sets out a phased shift of activity from acute hospitals into community and neighbourhood settings through full implementation of Integrated Neighbourhood Teams for adults and children, expansion of Urgent Community Response and Virtual Wards, development of community diagnostic and elective pathways, and a unified Flow Centre.
- Significant transformation is planned across mental health, learning disability and autism, children and young people's services, women's health, elective care, cancer and diagnostics. This includes reducing out-of-area placements, developing a Psychiatric Intensive Care Unit (PICU) within Shropshire, Telford and Wrekin, delivering a redesigned CAMHS model, improving SEND pathways, shifting gynaecology and long-term condition management into community settings, increasing early cancer diagnosis, and expanding digital outpatient and diagnostic models. Prevention is a core theme, with targeted action on smoking, obesity, alcohol-related harm, vaccinations and screening, hypertension, respiratory disease and early years outcomes, aligned to Core20PLUS5.
- Digital and data-enabled transformation underpins all intentions, including wider use of shared care records, AI-enabled triage, remote monitoring, adoption of the Federated Data Platform, and expanded NHS App functionality.
- Primary care will be modernised through improved digital access, greater diagnostic capability in practices, Pharmacy First and Optometry First pathways, and preparation for full delegation of dentistry and optical services in 2027. We will modernise primary care access, expand Pharmacy First and Optometry First, strengthen urgent care navigation and flow, improve elective and diagnostic performance to national standards, and reduce waiting times across mental health, SEND and children's services.
- System productivity will be driven through value-based commissioning, pathway standardisation, medicines optimisation, improved theatre and outpatient utilisation, strengthened financial stewardship, and aligned contracting to support sustainable system delivery.
- Overall, the 5 Year Strategic Commissioning Plans provide a clear roadmap for shifting to a more proactive, integrated, digitally enabled and financially sustainable health and care system that improves outcomes and reduces inequalities across Shropshire, Telford & Wrekin and Staffordshire and Stoke on Trent.

The 5 Year Plans are presented to the Board in Common today for approval to ensure that the ICB's are able to publish by the 1st April 2026 in line with our statutory duty in regard to the publication of the Joint Forward Plan.

The Board are asked to note that there is further work ongoing to meet this deadline which includes the development of an accessible public facing version and that will be released imminently.

In addition, the Board are asked to note that at the point of writing the plans, the Neighbourhood Health guidance was still awaited. Given that this was published on the 17th March 2026, our 5 Year plans will be further reviewed taking the guidance into account alongside any feedback that we get from NHSE, and incorporated into a future iteration.

(7) Recommendations to Board:

The Boards are asked to

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

Main Body of the Report

2.1 Introduction

- 2.1.1 This report presents the Five-Year Strategic Commissioning Plans for Shropshire, Telford and Wrekin (STW) and Staffordshire and Stoke on Trent (SSOT), outlining the system's long-term approach to improving population health, reducing inequalities, modernising access, and ensuring financial and operational sustainability.
- 2.1.2 The plans set out how the ICBs will deliver the three major national system shifts of Hospital to Community, Analogue to Digital, and Sickness to Prevention alongside local priority areas of focus in Improving Access and Improving Productivity, supported by strengthened neighbourhood working, digital innovation, improved workforce capability, and closer partnership between the STW and SSOT ICB's ahead of the planned 2027 merger.
- 2.1.3 The Board is asked to consider the strategic direction, the enablers required for delivery, and the risks and mitigations associated with implementing these plans over the next five years.

2.2 Background

- 2.2.1 The development of the Five-Year Strategic Commissioning Plans takes place during a period of significant challenge and transition for the NHS. Shropshire, Telford and Wrekin (STW) face a distinct combination of demographic pressures, rising demand, persistent inequalities, and financial constraints. Telford and Wrekin continue to experience rapid population growth and increasing diversity, while Shropshire's predominantly rural and ageing population requires greater support for long-term conditions, frailty and access to services. For Staffordshire and Stoke-on-Trent (SSoT) our population of 1.18 million is growing, ageing, and becoming more diverse, with marked variations in deprivation, particularly in Stoke-on-Trent, where over half of residents live in the most deprived areas nationally. These demographic and socio-economic patterns drive higher levels of long-term

conditions, rising emergency admissions, complex frailty and persistent health inequalities across all age groups, intensifying pressure on urgent and emergency care, community services, primary care and mental health provision.

- 2.2.2 The plans are built on a comprehensive and robust evidence base, including the Joint Strategic Needs Assessments, the Integrated Strategic Needs Assessment (ISNA), the Population Health Implementation Plan (PHIP), and the STW Clinical Strategy. This intelligence highlights trends in long-term conditions, variation in screening and immunisation uptake, rising mental health and SEND demand, and gaps in diagnostic, community and prevention services. It also points to the need for strengthened neighbourhood models, improved digital maturity, and a more proactive approach to prevention. Population health intelligence shows widening gaps in outcomes, variation in screening and immunisation uptake, and a growing prevalence of long term conditions. These challenges collectively underline the need for a fundamental shift in how the system plans, commissions and delivers care.
- 2.2.4 Financial pressure remains a significant challenge across both systems. The Medium-Term Financial Plan sets out a route to sustainability that depends on delivering productivity improvements, reducing variation, shifting investment toward prevention and community-based care, and embedding a value-based approach to commissioning. The commissioning plan therefore integrates financial strategy with service transformation, workforce development and digital investment to create a coherent approach to long-term sustainability.
- 2.2.5 Taken together, this context provides a strong rationale for a strategic plan that is ambitious, evidence-driven and system-wide. It positions the ICBs to meet statutory duties, deliver national priorities, strengthen financial resilience, and improve health outcomes across STW and SSOT over the next five years.

2.3 Main Body of report

- 2.3.1 The Five-Year Strategic Commissioning Plans articulate three overarching system shifts that will guide all commissioning decisions and transformation activity. The first, the shift from hospital-based to community-based care, seeks to rebalance activity through the establishment and expansion of integrated neighbourhood multidisciplinary teams, covering both adults and children. This includes scaling urgent community response and virtual ward capacity, enhancing intermediate care pathways, and enabling a greater proportion of diagnostics and elective activity to be delivered in community settings. Strengthened access to primary care, supported by modernised pharmacy, dental and optometry offers, will underpin this transformation, alongside neighbourhood-led approaches for mental health, SEND and long-term condition management.
- 2.3.2 The second, the shift from analogue to digital, reflects the need to modernise care pathways and ensure the system is equipped to meet the expectations and needs of a digitally enabled population. This includes establishing a fully interoperable digital infrastructure through the Shared Care Record, electronic patient records and the Federated Data Platform; expanding

remote monitoring, digital triage, NHS App utilisation and AI-enabled tools; and embedding digital pathways across primary, community, elective, mental health and cancer services. Central to this shift is the commitment to digital inclusion, ensuring that technological improvements enhance access and outcomes for all communities and do not exacerbate existing inequalities.

- 2.3.3 The third shift focuses on moving from reactive sickness treatment to proactive prevention and population health management. The plan prioritises targeted interventions across major drivers of poor health including smoking, obesity, hypertension, respiratory disease and mental health. Screening, immunisation and vaccination programmes will be strengthened, and early years and family support will be enhanced through Family Hubs and Best Start pathways. A structured population-health-management approach, including focused action on Core20PLUS5 cohorts, will be embedded across all commissioning activity to ensure resources are directed to the groups and places with the greatest need. Prevention will be systematically built into all pathways, including long-term conditions, women's health, children's services and mental health.
- 2.3.4 Aligned to these system shifts, the plan sets out comprehensive commissioning intentions across all major programmes. This includes a redesigned urgent and emergency care pathway that strengthens demand management, improves patient flow, reduces avoidable admission and shortens length of stay; modernised primary care access supported by multidisciplinary teams and digital tools; and improved elective and diagnostic performance through straight-to-test models, expanded Community Diagnostic Centres and greater use of AI and cancer services will focus on improving early diagnosis, standardising best practice and addressing inequality gaps in screening and outcomes. Mental health commissioning will enhance neighbourhood-based provision, strengthen crisis alternatives, reduce reliance on out-of-area placements and deliver the new CAMHS model. Commissioning for children and young people prioritises earlier intervention, increased delivery in schools and improved neurodevelopmental pathways. Women's health and maternity services will be strengthened through more integrated neighbourhood-based models that enhance safety and continuity and focus on equity. Long-term conditions pathways will adopt proactive, personalised and multidisciplinary approaches centred on prevention and optimisation.
- 2.3.6 Achieving these ambitions requires a robust and sustainable financial approach. The financial strategy sets out a path to sustainability through a minimum 2% annual efficiency and 2% productivity improvement; prioritised investment in prevention, community-based care and digital transformation; and adoption of value-based commissioning informed by health economic analysis. Financial governance, risk management and collaborative decision-making will be strengthened to ensure resources are allocated transparently and in alignment with system priorities. Central to the financial approach is the recognition that shifting activity away from hospital-based care towards prevention and neighbourhood based models is essential to long-term sustainability.
- 2.3.7 The plans also acknowledges that workforce is a critical enabler of system transformation. It outlines the development of integrated neighbourhood workforce models, increased primary and community care workforce capacity, and a systemwide pharmacy strategy. It also sets out the workforce requirements for mental health, learning disabilities, autism, children and

young people's services, and elective and diagnostic pathways. A sustained focus on wellbeing, retention, leadership development and cultural improvement is essential to maintaining workforce resilience. Preparations are underway to align system workforce planning with the forthcoming National Long Term Workforce Plan.

- 2.3.8 A number of cross-cutting enablers are essential to delivering the plans, including digital and data maturity; modern, fit-for-purpose estates; a strong and embedded approach to equality, diversity and tackling health inequalities; a strengthened research, innovation and improvement culture; robust safeguarding arrangements; and enhanced system emergency preparedness and resilience. The plans also identify a series of strategic risks, financial, workforce, digital, performance and inequality related and sets out the governance and mitigation arrangements that will ensure progress is monitored and sustained.

2.4 Conclusion

- 2.4.1 The Five-Year Strategic Commissioning Plans set out a comprehensive, evidence-driven and future-focused blueprint for the transformation of health and care across STW and SSOT. They articulate a clear and ambitious strategic direction that balances the need for long-term system change with the realities of operational, workforce and financial pressures facing the local system.
- 2.4.2 The plans provide a coherent framework for commissioning over the next five years, supported by clear priorities across urgent and emergency care, primary care, mental health, children and young people, elective and diagnostic services, women's health, and long-term conditions. They also embeds the financial discipline and value-based approach required to restore long-term sustainability. Strong governance arrangements and a maturing operating model across the Cluster will ensure the system has the oversight and accountability necessary to deliver the scale of change required.
- 2.4.3 However, it is important for the Boards to note that the successful delivery of this plan will require sustained commitment across all partners. Effective implementation will depend on the continued alignment of commissioning, provider delivery, workforce planning, digital investment, and financial ownership. It will also rely on close collaboration with Local Authorities, the voluntary and community sector, provider collaboratives, neighbourhood teams and population groups experiencing the poorest outcomes. Strong leadership, coherent programme management and a systemwide approach to improvement will be essential to maintaining momentum and responding to emerging risks.
- 2.4.4 Workforce capacity, capability and wellbeing will remain critical dependencies, as will the ability of the system to manage financial pressures while continuing to invest in prevention and community-based models of care. Digital maturity and data quality must continue to improve to enable the analytical capability, interoperability and insight required for modern commissioning and population health management.
- 2.4.5 Overall, these plans provide a credible and deliverable route to a more sustainable, integrated and prevention-focused health and care system across STW and SSOT. With collective leadership, disciplined delivery and sustained collaboration, the strategic aims set out within

it can be realised, improving outcomes, experience and equity for our population over the next five years.

2.5 Recommendation(s)

2.5.1 The Boards are asked to:

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



Shropshire, Telford
and Wrekin

Five Year Strategic Commissioning Plan

April 2026



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Section 1 – Executive Summary

Chair and CEO Foreword

We are pleased to introduce this ambitious Five Year Strategic Commissioning Plan, which sets out how we will shape the future of health and care across Shropshire, Telford and Wrekin at a time of significant challenge, change and opportunity. Our population is growing and ageing, our communities experience some of the most striking inequalities in the region, and demand for services continues to rise year on year. Yet we also see extraordinary strengths in our neighbourhoods, our partnerships and our workforce. This plan is our commitment to harnessing those strengths to build a healthier, fairer and more sustainable future for the people we serve.

The next five years will mark a decisive shift in how we work. We are moving purposefully from a system centred around hospitals and reactive care to one that focuses on prevention, early help and support delivered much closer to home. Our integrated neighbourhood teams, strengthened community services, modernised primary care and expanding digital capabilities will together create a model of care that is more responsive to people's needs and more aligned to where they live their lives. This shift which is supported by improved population health data, stronger clinical leadership and new ways of commissioning – will help reduce avoidable pressure on urgent and emergency care (UEC) to free up capacity for those who genuinely need hospital treatment. While we are committed to this shift and focus on integrated community-based care, we will continue to develop hospital services that are there when patients need them and are responsive to that need. Our collective 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.

We know that inequalities in access and outcomes remain one of our most urgent challenges. Too many residents face poorer health simply because of where they live, their background, or the barriers they encounter navigating the health and care system – simply, this is unacceptable. Tackling these inequalities is central to this plan. With our partners across local government, the voluntary sector and communities, we will expand targeted prevention, strengthen early years support, improve access to screening and immunisation, and ensure that those with the greatest needs benefit first from new models of care. Our work with children and young people – including those with Special Educational Needs and Disabilities (SEND) – is especially important, and we remain committed to delivering earlier, more coordinated, and more effective support for families. We will be relentless in our drive to improve the mental health offer for local people and will build on the relationships and services that are offered locally.

Digital innovation will underpin much of this transformation. Better connected records, AI-enabled triage, remote monitoring and virtual wards will improve how people access services, support clinicians to make decisions and reduce duplication across the system. These tools will also help us anticipate need sooner, and design services around real-time insight. Importantly, our commitment to digital inclusion means ensuring people who cannot or do not wish to use digital routes still receive equitable and timely care.

Financial sustainability is essential to delivering our ambitions. Both Shropshire, Telford and Wrekin and our partner system in Staffordshire and Stoke-on-Trent face longstanding financial pressures, intensified by rising demand. This plan sets out a responsible, value-based approach to stewardship – directing investment towards prevention, neighbourhood models and digital transformation, reducing unwarranted variation, and embedding productivity and efficiency throughout the commissioning cycle.

By 2027, as we move towards a merged single organisation across Shropshire, Telford and Wrekin and Staffordshire and Stoke-on-Trent, we will strengthen our collective ability to manage resources fairly, transparently and for maximum population benefit.

None of this change is possible without our workforce. Across every service and profession, colleagues continue to demonstrate extraordinary commitment despite real pressures. This plan sets out how we will support their wellbeing, enable new roles and ways of working, and build the skills, confidence and leadership needed for the future. We want our system to be a place where staff feel valued, where teams can innovate, and where the culture enables people to thrive.

Above all, this plan is about being ambitious in our unrelenting focus on improving the lives of the people and communities we serve. It reflects the voices of our partners, our clinicians, our voluntary sector, our staff and, most importantly, our residents. Over the next five years, we will keep those voices at the heart of our decisions through meaningful engagement and co-production. We will ensure transparency in how we prioritise, invest and measure progress. We will continue to champion a system that is compassionate, inclusive and focused on what matters most.

We are grateful to everyone who has contributed to shaping this ambitious plan. We look forward to working with you as we deliver it, together, on behalf of our communities.

Ian Green OBE

ICB Cluster Chair
NHS Shropshire, Telford and Wrekin
NHS Staffordshire and Stoke-on-Trent

Simon Whitehouse

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

Executive Summary

Over the next five years, NHS Shropshire, Telford and Wrekin will transform how health and care is planned and delivered, creating a system that is more proactive, more preventative, and more responsive to the diverse needs of our population. Our ambition is to shift the balance of care closer to home, reduce inequalities, modernise access through digital innovation, and ensure services remain financially and clinically sustainable. As we develop a joint operating model with Staffordshire and Stoke-on-Trent, this plan lays the foundations for a single strategic commissioning approach ahead of merger in 2027 – strengthening consistency, shared decision making and long-term system resilience.

Shropshire, Telford and Wrekin face a unique combination of challenges – rapid growth and diversity in Telford and Wrekin, an ageing and increasingly frail population across rural Shropshire, and persistent inequalities that shape health outcomes and access. Rising demand in mental health, SEND, urgent care and long-term conditions reinforce the need for a different way of working. This plan responds to that reality by embedding the principles of neighbourhood-based, multidisciplinary care, stronger prevention, and the smarter use of data and digital tools.

We will strengthen our integrated neighbourhood teams for adults and children, ensuring more people receive joined-up care in their communities – supported by urgent community response, virtual wards, intermediate care and improved care coordination. The aim is to reduce avoidable hospital use, improve flow for those who do require acute care, and support faster, safer discharge. Alongside this, primary care will modernise through improved digital access, expanded clinical services in GP practices, pharmacy and optometry, and better integration across pathways such as diagnostics, women's health and long-term conditions. Dentistry and optometry will evolve as full delegated functions transfer locally, expanding access and supporting preventive care.

Mental health, learning disability and autism services will be strengthened through more timely community support, reduced out-of-area placements, expanded support in schools, and trauma-informed approaches for children, families and those with complex needs. We will also prioritise earlier help for children and young people with SEND – improving access to therapies, reducing diagnostic waits, and delivering more support in schools and local settings. Across cancer, elective care and diagnostics, we will redesign pathways so that more activity is delivered in the community, waits are reduced, and patients experience faster, more personalised journeys from referral to treatment.

A core theme throughout the plan is prevention. Working with local authorities, the voluntary sector and communities, we will focus on improving lifestyles, tackling smoking and obesity, expanding health checks and screening, reducing alcohol-related harm, and improving early years and family support. Using population health data and the Core20PLUS5 framework, we will target the people and places most affected by poor outcomes – ensuring our system's efforts genuinely narrow inequalities.

Digital, data and technology will underpin the changes ahead, with the Shared Care Record, Federated Data Platform, remote monitoring, AI-supported diagnostics and NHS App functionality enabling more integrated, efficient and personalised care. These tools will help clinicians make better decisions, reduce duplication, and improve the experience of people navigating between services.

Delivering this transformation requires a sustainable financial position and a workforce with the right skills, capacity and support. Over the next five years, we will stabilise system finances through value-based decision making, better productivity, outcomes-based contracting and a clear shift of investment towards prevention and community-based care. At the same time, we will focus on recruitment, retention, wellbeing and leadership development across the workforce, building a resilient and capable system able to deliver new models of care.

This plan sets a clear direction for the future – a health and care system that is more joined up, digitally enabled, neighbourhood-focused and financially sustainable. Most importantly, it is a system designed around what matters to local people – supporting them to live healthier lives, accessing the right care at the right time, and experiencing equitable, high-quality services wherever they live.

DRAFT

Section 2 – Who we are, our partnerships and our five-year ambition

Who we are

Shropshire, Telford and Wrekin Integrated Care Board (ICB) is the statutory NHS body responsible for planning, commissioning and overseeing health services for a population of around 509,200 people across a diverse rural and urban landscape. The ICB is responsible for commissioning services for our population while working closely with our partners, which consist of NHS providers, local authorities, primary care, independent providers and the voluntary sector, to improve outcomes, reduce inequalities and ensure sustainable, high-quality care.

Across the area there are 50 GP practices organised into nine Primary Care Networks (PCNs). The ICB also commissions community optometry and NHS dental services, delivered through a broad network of local practices. This integrated commissioning role enables the ICB to shape our services and develop wider system coordinated delivery plans that reflect the needs of our diverse population.

As part of the ICB's Planning Requirements, this Five Year Strategic Commissioning Plan sets out a clear, long-term vision for improving health and healthcare across Shropshire, Telford and Wrekin. It aligns closely with the wider ICS Strategy, local Health and Wellbeing Board priorities and the three strategic shifts of the national 10 Year Plan – moving care from hospital to community, accelerating digital transformation, and strengthening prevention.

The plan is firmly outcome-focused, committing to measurable improvements in population health, reduced inequalities and better experience of care. It also connects the system's long-term ambitions already set out within the Joint Forward Plan and the NHS Long Term Plan, ensuring coherence between strategic direction and operational delivery.

In addition, the commissioning approach is designed to align with provider trust strategies and neighbourhood-level plans, creating a unified, system-wide framework that supports integrated, place-based models of care and setting the scene for shared accountability for improving outcomes.

Purpose and role

The ICB acts as a strategic commissioner focused on:

- Improving population health outcomes
- Reducing inequalities
- Ensuring financial sustainability.

Core functions:

- Translating national/local priorities into commissioning intentions
- Convening system partners for integrated care
- Providing assurance on quality, performance, and finance.

Principles and approach to strategic commissioning

As a strategic commissioner, the ICB plays a pivotal role in shaping a health and care system that meets the long-term needs of our population. Our remit extends beyond service planning – it includes providing strategic leadership for population health, addressing inequalities, and ensuring that resources are deployed to deliver the greatest value and impact for our communities. To fulfil this responsibility, we must continue to strengthen our skills, capabilities, and ways of working, building the foundations that enable us to lead the system with confidence and effectiveness.

Delivering and evolving our Strategic Commissioning Plan will require an ambitious and forward-looking approach. This involves strong clinical and professional leadership, high-quality data and analysis, fair and transparent decision making about the use of NHS resources, meaningful engagement with our communities, and a commitment to continually improving how we work. The Strategic Commissioning Framework outlines the key areas of focus that will help ensure we plan and organise health and care services in the most effective way for the people we serve.

As such, we will use a simple, continuous cycle to guide how we plan and improve services:



- 1. Strategic planning** – We assess local population needs, review evidence, and draw on insight from people and communities. This intelligence informs the design of appropriate support and helps us set clear commissioning priorities.
- 2. Procuring and organising services** – We ensure that the most suitable organisations deliver the care our population requires. This includes developing robust contracts, monitoring quality, and ensuring services provide value for money.
- 3. Monitoring, evaluation and improvement** – We assess performance, gather feedback, and use this learning to refine and improve services, ensuring they remain effective, responsive and continuously improving over time.

How we work together across Shropshire, Telford and Wrekin

Shropshire, Telford and Wrekin have a long-standing commitment to strong strategic partnerships that improve health and wellbeing outcomes for their diverse communities. Effective collaboration with local authorities, NHS providers, the voluntary, community and social enterprise (VCSE) sector, and local people is fundamental to creating a system that is responsive, sustainable and genuinely person-centred.

At the core of our local approach is a shared commitment to working together. This is reflected in well-established, formalised relationships between local authorities, NHS trusts and our wider provider networks, PCNs, VCSE organisations and communities. These partnerships are built on mutual trust, shared priorities and a collective ambition to reduce health inequalities, strengthen prevention and deliver high-quality, integrated care. They are supported by several key system structures:

Health and Wellbeing Boards

The Health and Wellbeing Boards in both Shropshire and Telford and Wrekin provide a crucial strategic forum where system leaders come together to shape shared priorities for improving population health and wellbeing. Operating at the interface between the NHS, local authorities, and wider public services, the Boards enable partners to jointly develop long-term strategies, align commissioning intentions, and oversee progress against system-wide outcomes. They play an essential role in promoting integration by bringing together statutory health and care bodies, the VCSE sector, and representatives of local communities to ensure that decisions are informed by lived experience and reflect local need. Through their focus on prevention, early intervention and tackling health inequalities, the Boards help to create the collective conditions required to deliver sustainable improvements across neighbourhood, place, and system levels, reinforcing their position as a key governance mechanism within the commissioning landscape.

Place-based partnerships

The Shropshire Integrated Place Partnership (ShIPP) and the Telford & Wrekin Integrated Place Partnership (TWIPP) play a central role in shaping and delivering this plan by bringing together local partners – across the NHS, local authorities, public health, the VCSE sector and wider community services – to collaboratively design services that reflect the unique needs, assets and priorities of their local populations. Through a place-based approach, these partnerships enable decisions to be made closer to communities, ensuring that interventions are informed by local data, lived experience, and a deep understanding of neighbourhood-level variation.

ShIPP and TWIPP act as engines for innovation, co-producing solutions with residents, supporting prevention and early intervention, and driving the left-shift towards integrated, community-delivered care. Their work strengthens alignment between system strategy and delivery on the ground, ensuring that commissioning intentions translate into responsive, person-centred models of care that improve outcomes, reduce inequalities and build long-term resilience within each place.

Provider collaboratives

NHS trusts and wider system providers are increasingly collaborating to plan and deliver services in a way that reflects the realities of shared workforce pressures, rising urgent care demand, and the ongoing requirement to recover and stabilise elective services. Over the next five years, this collective approach will be critical to delivering the commissioning plan's aims of improving resilience, reducing unwarranted variation, and creating seamless pathways across organisational boundaries.

The evolving group model between Shrewsbury and Telford Hospital NHS Trust (SaTH) and Shropshire Community Health NHS Trust (SCHT) represents a significant step towards deeper integration, creating opportunities for shared clinical leadership, aligned workforce planning, and more coordinated patient pathways across acute, community and intermediate care. The continued collaboration with The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJA) can genuinely transform the way that musculoskeletal and orthopaedic services are delivered across our geography. There should be no limits to our ambition in this area to be the leading system, given the expertise, clinical leadership and innovation being demonstrated daily.

Alongside this, the cluster arrangements between Shropshire, Telford and Wrekin ICB and Staffordshire and Stoke-on-Trent ICB will further strengthen cross-system collaboration, supporting enhanced clinical networks between SaTH and University Hospitals of North Midlands NHS Trust (UHN) and enabling closer alignment with Midlands Partnership University NHS Foundation Trust (MPFT) for mental health and learning disability services. Together, these developments foster a more coherent, system-wide operating model capable of pooling expertise, sharing resources, and jointly tackling pressing system challenges, ensuring that the commissioning intentions of the Five Year Plan can be delivered at scale and with greater impact for local communities.

Joint Commissioning Boards

Joint commissioning between local authorities and the ICB is a fundamental enabler of the Five Year Strategic Commissioning Plan, ensuring that resources are used in a more coordinated and strategic way to meet the needs of people with complex, long-term or multiple conditions. By working collaboratively, Shropshire Council, Telford & Wrekin Council and the ICB can align priorities, reduce duplication and design integrated pathways that span health, social care, housing and the voluntary and community sector. Strong governance arrangements underpin this partnership approach – supporting shared accountability, transparent decision-making and the ability to take a system-wide view of demand and capacity across both places.

Pooled budgets, enabled through the Better Care Fund and Section 75 agreements, provide a flexible commissioning framework that allows investment to shift upstream into prevention, early intervention and community-based support. This improves outcomes and independence for residents while reducing reliance on acute services, supporting the wider system goals of improving flow, reducing pressure on UEC and enabling the left-shift central to this plan. Over the next five years, these joint commissioning arrangements will be critical to delivering sustainable models of care, supporting market stability, and creating a more integrated, person-centred offer across Shropshire and Telford and Wrekin.

Involving people and communities

Involvement is central to how we work and is a core principle underpinning the Five Year Strategic Commissioning Plan. By meaningfully involving local people in the design, delivery and evaluation of services, we ensure that care is shaped by what matters most to residents and reflects the diverse needs of our communities. Working closely with the VCSE sector and a broad range of community organisations ensures that voices from all parts of the population, including those who are seldom heard, inform and influence decision-making.

Our commitment to engagement is strengthened through a wide range of mechanisms such as citizens' panels, focus groups, parent carer forums, community forums and targeted outreach, helping to build transparency, trust and shared ownership across the system. Over the next five years, this approach to co-production will be instrumental in shaping preventative, community-based models of care, tackling health inequalities, improving population health

outcomes, and ensuring that commissioning decisions remain rooted in the lived experience and priorities of local people.

Specialised commissioning

To support the government's 10 Year Plan ambition to establish ICBs as strategic commissioners, current NHS England (NHSE) specialised commissioning functions and services are expected, subject to legislation, to transfer from NHSE Specialised Commissioning to ICBs from April 2027 with only a small number of services retained at a national level by exception.

Throughout 2026/27, the ICB will continue to work closely with NHSE Specialised Commissioning Leads and regional commissioning teams to ensure a smooth transition of commissioning responsibilities. This includes active engagement in the development of the Offices for Pan-ICB Commissioning (OPICs), which will support ICBs across each NHS region to commission specified services efficiently and effectively, including commissioning at scale where this will improve patient outcomes.

As part of supporting system-wide pathway redesign, we will work with providers and NHSE specialised commissioning teams, as appropriate, to strengthen the continuity, quality, and sustainability of services. This will be underpinned by robust contracting arrangements with a strong focus on value, timely access to appropriate treatment, and improved outcomes for patients.

Cluster working and future merger

During 2026/27, Shropshire, Telford and Wrekin ICB will begin working as a cluster alongside Staffordshire and Stoke-on-Trent ICB – laying the foundations for a future full merger by 2027. Over the coming years, the two ICBs will increasingly operate through shared planning, joint decision making and coordinated delivery, beginning with the bringing together of a single Five Year Strategic Commissioning Plan by April 2027.

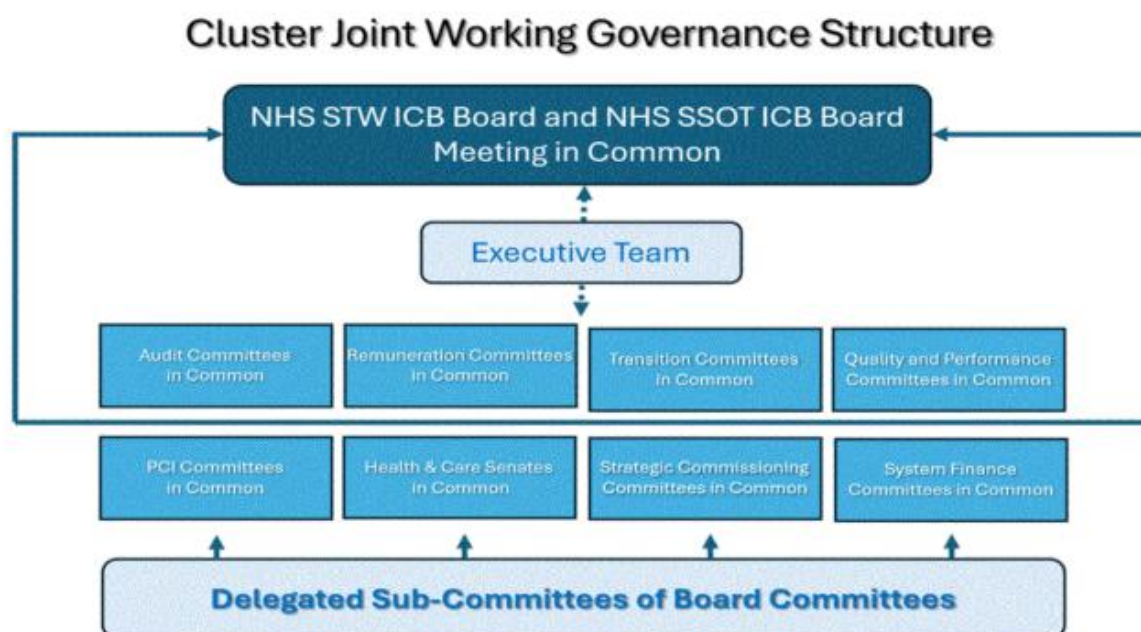
Governance arrangements, outcomes frameworks and assurance processes will be progressively aligned to support consistent, system-wide oversight and reduce duplication. Provider collaboratives will also be brought into closer alignment – enabling more integrated service planning, shared workforce approaches and streamlined pathways across the wider geography. This phased approach will ensure that, by the time of formal merger, the system is already functioning as a coherent, unified commissioning footprint focused on improving outcomes and value for the populations it serves.

Governance and accountability

The Five Year Strategic Commissioning Plan replaces the previous Joint Forward Plan by providing a more comprehensive, long-term and system-wide approach to planning, prioritisation and delivery. While the Joint Forward Plan set out annual operational intentions, this new plan fulfils the ICB's statutory duty to produce a clear, strategic commissioning plan that reflects population needs, aligns with national requirements and demonstrates how the system will improve outcomes, quality and value over time. It brings together intelligence, clinical priorities, financial strategy and partnership commitments into a single framework that guides decision making across the whole commissioning cycle.

In doing so, it ensures the ICB meets its legal responsibilities for transparency, public involvement and integrated system leadership, while providing a stable foundation for long-term transformation across Shropshire, Telford and Wrekin.

The ICBs are moving to a shared transitional clustering governance structure in anticipation of merger in April 2027. The structure, which is set out below, seeks to provide a transparent, streamlined assurance and decision-making process for both ICBs to deliver their respective five-year plans while they remain two separate statutory organisations. It will also allow a single staff structure to support it in the most efficient and effective way. The Boards of both ICBs are now meeting in common with new committees and sub-committees in common being created, which will move to joint committees as soon as is appropriate.



Key enablers

System leadership for population health

Effective leadership across the entire health and care system is critical to improving population health and reducing inequalities. Leaders across the system must understand how services interconnect, draw on robust data and insight, and work confidently with a wide range of partners to deliver improvements for the benefit of the population.

Population health leadership requires uniting organisations around shared priorities, emphasising prevention, and directing support to communities with the greatest need. It also involves influencing change without always having formal authority and balancing collaborative approaches with the responsibility to ensure quality, value for money, and decisions that serve the whole population rather than individual services or organisations. This is a significant shift in the way in which we must work as a system.

In Shropshire, Telford and Wrekin, our approach to population health is underpinned by robust system governance led by our Directors of Public Health and ICB population health management experts, feeding into system commissioning decisions and supporting robust evaluation of impacts. This will be further developed as part of the Cluster Operating Model.

Clinical and professional leadership

Clinical and professional leadership is vital at every stage of strategic commissioning. This will ensure that clinical expertise is embedded and that commissioning decisions are grounded in evidence and best practice, support care that delivers the best outcomes, improve outcomes for the whole population, and support the effective use of resources. Through our existing Clinical Advisory Groups, leaders from across different clinical backgrounds provide expert oversight, shape our Clinical Strategy, champion value-based healthcare, and help identify clinical priorities using robust data and intelligence.

Over the next five years, we will build on and strengthen clinical and professional leadership at every level (including the expansion of the Health and Care Senate into Shropshire, Telford and Wrekin) to enable the commissioning and delivery of integrated and outcome-focused models of care aligned to the three shifts of the 10 Year Plan.

Throughout the life of this plan, clinical and professional leaders will drive service transformation by:

- Developing our Clinical Strategy and identifying clinical priorities using data and population health insight alongside ongoing evaluation of health outcomes
- Leading the top clinical priorities across the health and social care system
- Building leadership capability for commissioning
- Providing system leadership and fostering effective partnership working
- Embedding a culture of collaboration and stewardship.

Our commitment to high-quality, safe care

High-quality, safe care underpins our commissioning approach across both ICBs. Over the next five years, our strategic commissioning will remain focused on improving outcomes, reducing avoidable harm, enhancing patient experience, and minimising unwarranted variation across all services.

This commitment is grounded in our statutory responsibilities and national expectations, including the NHS Constitution, the NHS Long Term Plan, the NHS Patient Safety Strategy and the Patient Safety Incident Response Framework (PSIRF). Quality and safety will be embedded in every commissioning decision, transformation programme and service model we develop.

Our vision is for a health and care system where:

- Avoidable harm is minimised, with proactive risk identification embedded in everyday practice
- Outcomes are consistently high across all providers, geographies and population groups
- Inequalities in access, quality and experience are eliminated, ensuring fairness for the most disadvantaged communities.
- Learning is shared rapidly and consistently across organisational boundaries
- Patients, service users, carers and communities shape improvement, with lived experience central to decision making
- Providers operate within strong quality governance, supported by robust commissioning oversight and assurance.

How we will deliver this

Quality governance and oversight

We will maintain a transparent and effective system of quality assurance that reflects our role as a strategic commissioner.

ICB Quality and Performance Committee

The Committee will continue to provide oversight and assurance across:

- Safety, effectiveness and experience
- Compliance with statutory duties
- PSIRF implementation and learning
- Provider quality risks and improvement plans
- Safeguarding
- Inequalities in outcomes, access and experience.

Shared system quality model

Across the emerging cluster, we will develop a shared quality governance framework that:

- Aligns quality surveillance processes
- Aligns with national Quality Strategy
- Enables joint thematic deep dives
- Strengthens cluster-wide escalation routes
- Uses shared data and intelligence
- Supports integrated responses to risk.

Provider assurance

We will hold all commissioned providers to account through:

- Quality review meetings
- Contractual quality schedules
- Quality indicators and outcome measures
- Joint Quality Visits and service level assurance
- The Quality Framework for commissioned services
- Safeguarding and SEND Partnership Arrangements.

Patient safety – embedding PSIRF

We will fully embed PSIRF across all providers, establishing a learning-focused, systems-based approach to incident response.

Our priorities include:

- Ensuring providers deliver PSIRF-compliant incident response and annual safety improvement plans
- Improving the quality, timeliness and impact of investigations
- Strengthening triangulation of safety intelligence (patient safety investigations, complaints, claims, mortality reviews, workforce data and soft intelligence)

- Supporting providers to develop mature safety cultures based on openness and continuous improvement
- Developing system-level learning networks to share insights and good practice.

This will shift the system from reactive responses to proactive risk reduction, making patient safety a visible and integral part of everyday care.

Clinical effectiveness

High-quality commissioning requires a strong focus on outcomes and evidence-based practice.

Over the next five years, we will:

- Commission services aligned to national best practice, NICE guidance and Modern Services Frameworks
- Reduce unwarranted clinical variation through standardised pathways
- Implement outcomes-based commissioning where feasible
- Apply Quality Impact Assessments (QIAs) and Integrated Impact Assessments (IIAs) consistently across transformation, disinvestment and redesign
- Develop our health economic outcomes research approach for evaluating local health outcomes
- Strengthen clinical leadership across commissioning portfolios and provider collaboratives
- Embed personalised care and shared decision making in pathway design.

Patient and carer experience

Patient and carer experience will be treated as a core indicator of quality.

We will:

- Strengthen systematic collection and analysis of experience data
- Ensure insights directly influence commissioning decisions and service specifications
- Prioritise improvements in communication, access and navigation
- Amplify the voices of seldom-heard communities through targeted engagement
- Work with VCSE partners to develop accessible, culturally competent feedback routes
- Embed co-production in all major service redesign programmes.

Reducing inequalities in quality and outcomes

Reducing inequalities is a statutory duty and a central component of quality.

We will:

- Embed Core20PLUS5 across commissioning intentions
- Ensure that the ICB and provider trusts are compliant with the SEND Code of Practice (2015) and pending SEND reforms (2026)
- Use data and our population health management approach to identify variation in outcomes, experience and safety
- Commission targeted interventions for underserved groups
- Routinely apply Equality Impact Assessments (EIAs) and Integrated Impact Assessments (IIAs)

- Require providers to demonstrate reductions in variation across protected characteristics and deprivation
- Strengthen monitoring of access and waiting times for disadvantaged populations.

Quality in new models of care and system shifts

a. Hospital to community ('left shift')

We will ensure safer care through:

- Reliable escalation routes
- Safe discharge processes and intermediate care pathways
- Reduced harm from long stays and delayed discharge
- Strong governance for neighbourhood health models and virtual wards
- Measurable outcomes
- Seeking patient and carer experience.

b. Analogue to digital

Digital transformation will enhance quality and safety through:

- Shared care records to reduce duplication and error
- Improved clinical decision making through better data
- Safety-tested digital triage and remote monitoring tools
- Digital inclusion initiatives to reduce inequality.

c. Sickness to prevention

As preventing deterioration is a key safety intervention, we will prioritise:

- Early detection of long-term conditions
- Proactive management of high-risk groups
- Improved uptake of screening, immunisation and prevention programmes
- Community-based models that reduce avoidable harm.

Safeguarding

We will meet all statutory safeguarding duties for adults and children by:

- Maintaining robust safeguarding commissioning standards, statutory guidance and legislation
- Ensuring provider compliance with national frameworks
- Improving identification of exploitation, domestic abuse, neglect and mental capacity concerns
- Improving early identification of need to prevent escalation and higher-level intervention
- Implementing the Family First Partnership programme
- Working in partnership with local authorities and safeguarding boards across both ICB areas
- Ensuring ICB and provider compliance with the planning and implementation of guidance and legislative changes related to the Families First Partnership reforms.

Quality risks and early warning

We will maintain a proactive approach to identifying emerging risks through:

- Cluster-wide quality surveillance
- Soft intelligence and whistleblowing routes
- Real-time data (urgent and emergency care, staffing, acuity, complaints)
- Mortality surveillance and learning
- Horizon scanning for national and local risks.

Clear escalation processes will ensure timely action and support for providers.

Quality improvement

We will foster a culture of continuous improvement through:

- A system-wide approach aligned with PSIRF learning
- Provider collaboratives sharing expertise and resources
- Clear definitions of 'what good looks like' through outcomes dashboards
- Targeted support for high-risk or challenged services
- Workforce capability building in quality improvement and human factors.

Measuring progress

We will monitor quality through a structured, data-driven approach, including:

- Portfolio-level quality dashboards
- Outcome measures for commissioning intentions
- Safety indicators (such as harm reduction goals)
- Patient experience metrics
- Inequalities monitoring
- Quarterly thematic reviews.

Data, analytics, and technology

Data, analytics and technology are integral in supporting ICBs to become strategic commissioners – enabling evidence-based, data-driven decision making. Advanced analytical tools, linked datasets and real-time intelligence allow commissioners to understand need, demand and outcomes and surface inequalities at a far deeper level than traditional activity reporting ever allowed.

The NHS Federated Data Platform provides a vehicle to strengthen this capability by securely connecting data across providers, care settings and geographies, giving a single, consistent view of the system. This supports everything from pathway redesign and resource allocation to early identification of risk, unwarranted variation and opportunities for prevention. When combined with digital tools, shared care records and automated reporting, commissioners can model future scenarios, evaluate impact, assess outcomes and design services that are more integrated, efficient and responsive to population needs.

Intelligent payor capabilities

Intelligent payor capabilities mean being a smart commissioner - knowing what works, what does not work, and how to spend resources wisely to improve care.

Intelligent payor capabilities are a critical component of modern strategic commissioning and central to delivering the ambitions of this plan. By strengthening our ability to use robust data, insight and population-level analytics, we can better understand demand, capacity, outcomes and provider performance across the system. This will enable us as commissioners to act proactively – shaping markets, managing resources and influencing provision towards high-quality, sustainable models of care that meet the needs of different population groups.

As we move towards more Place-based and neighbourhood-level delivery, intelligent payor functions will underpin multi-neighbourhood contracting approaches – allowing us to commission at scale where appropriate while tailoring services to the distinct characteristics and priorities of local communities. These arrangements create the flexibility to align funding with local need, support targeted interventions for complex populations, and incentivise collaboration across providers working within and across neighbourhood footprints.

The development and implementation of sophisticated contracting models – such as outcomes-based contracts, alliance agreements and blended payment mechanisms – will further enable integration by fostering shared accountability and incentivising partners to work collectively towards agreed system outcomes. Embedding these models within multi-neighbourhood contracts will allow for shared risk and reward, support innovation, and encourage providers to focus on prevention, personalisation and improved population health rather than activity alone.

Payment reform plays a key role in this shift by aligning financial incentives with the broader goals of the Five Year Strategic Commissioning Plan including reducing health inequalities, supporting early intervention, and ensuring resources flow into community-based, preventative models of care. Taken together, these capabilities allow commissioners to operate strategically, deploying resources in ways that maximise impact, reduce variation, promote collaboration and secure long-term sustainability across neighbourhood, place and system levels.

Organisational development and capability building

Organisational development and capability building are fundamental to enabling the ICB to operate as an effective strategic commissioner over the next five years. As the system continues its shift towards long-term population health improvement, prevention, and integrated models of care, the ICB must invest in the skills, behaviours and structures required to lead this transformation confidently and consistently. This includes strengthening analytical capability to support population health management and predictive modelling, enhancing commercial skills to negotiate complex contracts and shape local markets, deepening clinical leadership to ensure commissioning decisions are grounded in evidence and outcomes, and expanding programme and change management expertise to drive delivery at scale. Building confidence and competence in data-led decision making is central to this – enabling teams to use insight to prioritise investment, improve productivity, and identify unwarranted variation.

Over the next five years, developing strategic commissioning leadership at every level within the ICB, across providers, and through place-based partnerships, will be essential to develop a workforce able to work across organisational boundaries.

Alongside this, a structured approach to talent development, skills frameworks and leadership pipelines will support workforce resilience and succession planning. By investing in these organisational capabilities, the ICB will build a confident, adaptive and high-performing

commissioning function that can deliver high-quality, value-driven, integrated care and ensure the long-term sustainability of the system for the populations of Shropshire, Telford and Wrekin.

Working with people and communities in strategic commissioning

We have a clear statutory responsibility to involve people and communities in the planning, development and delivery of health services. Under Section 14Z45 of the Health and Care Act 2022, ICBs must ensure that individuals – and their carers or representatives – are involved in the planning of commissioning arrangements, the development and consideration of proposals for change, and decisions that affect how those arrangements operate. This duty is central to our role as a strategic commissioner and will shape how we plan, prioritise and commission services over the next five years.

The NHS Constitution reinforces this obligation by emphasising public ownership of the NHS and accountability to the patients, communities and populations it serves. Meaningful involvement is therefore a core component of high-quality commissioning and effective system leadership.

Strategic commissioning shaped by people and communities

As strategic commissioners, we are responsible for ensuring that services are planned, organised, funded and commissioned to meet the current and future needs of our population. Achieving this requires working in genuine partnership with the people who live in Shropshire, Telford and Wrekin, those who use services now and in the future, and those who care for others.

Engagement with people and communities will be embedded throughout the commissioning cycle

Insight from patients, carers, staff and communities will inform population health needs assessments, service design and redesign, commissioning intentions and specifications, implementation and mobilisation, and ongoing review and improvement. We recognise that lived experience brings essential insights, which will help us to innovate and to design services that are accessible, equitable and capable of improving outcomes and reducing inequalities.

Working in partnership to reduce inequalities

Reducing health inequalities is a core objective of this commissioning plan. Our approach to involvement will therefore prioritise inclusive, two-way engagement with diverse and seldom-heard communities, asset-based approaches that build on community strengths, and the removal of barriers that prevent people from influencing decisions. Partnership with the VCSE sector will be central to this work – particularly in reaching communities experiencing the poorest outcomes and embedding lived experience into service design.

Our approach to involvement across the commissioning cycle

To meet our statutory duties and strategic ambitions, we will apply a consistent approach to informing, involving, engaging and consulting people and communities.

- **Inform** – We will provide clear, timely and accessible information about commissioning plans, service changes and opportunities to be involved, using multiple channels and formats that meet diverse needs.

- **Involve** – We will involve patients, service users, carers and community representatives early in shaping commissioning decisions, ensuring that feedback is acknowledged and its influence clearly demonstrated.
- **Engage** – We will maintain ongoing dialogue with communities about health needs, priorities and experiences. Insight gathered will directly inform commissioning intentions, resource allocation and service improvement, with a strong focus on reducing inequalities.
- **Consult** – Where significant service changes are proposed, we will undertake formal consultation in line with statutory requirements, ensuring clarity of purpose, inclusivity and transparency in how responses inform final decisions.

Embedding involvement in governance and delivery

The ICB has established clear principles for working with people and communities, supported by a local strategy within our Governance Handbook. These principles will be embedded across this Five Year Strategic Commissioning Plan, annual commissioning intentions, service specifications, transformation programmes, and all governance, assurance and decision-making processes.

We will monitor and evaluate the effectiveness of our involvement activity using both qualitative and quantitative measures. We will also publish information on how people and communities have influenced commissioning decisions and report progress through our annual reporting and assurance mechanisms.

Hospital Transformation Programme

The SaTH Hospital Transformation Programme (HTP) represents a pivotal opportunity for the system to deliver safer, more efficient, and clinically sustainable acute services over the next five years. For the ICB, the success of the HTP is inseparable from achieving a meaningful left shift, strengthening prevention, early intervention, and community-based care to reduce avoidable demand on acute hospitals. Embedding this shift within the commissioning plan will enable the system to rebalance resources, prioritise population health outcomes, and ensure that acute capacity is protected for the most seriously ill patients.

By commissioning integrated pathways across primary care, community services, mental health, social care, and the voluntary sector, the ICB can create the conditions needed for the left shift to be realised at scale. This approach not only supports delivery of the HTP but also underpins long-term financial sustainability, workforce resilience, and improved patient experience across Shropshire, Telford and Wrekin.

In summary, this transformation is about much more than a 'hospital', it is the opportunity for healthcare transformation across our geography, and it is our collective responsibility to deliver on this for our residents.

Looking ahead (five-year maturity)

Over the next five years, the ICB's evolution, initially within a cluster arrangement with Staffordshire and Stoke-on-Trent ICB and progressing towards a planned full merger, will enable the system to operate with coherence, consistency and efficiency across a broader geographical footprint. This transition provides the foundation for a more unified commissioning approach

allowing the ICB to streamline functions, reduce duplication and strengthen its strategic influence while preserving local autonomy where it adds value.

As the system matures, greater independence will be devolved to neighbourhoods and provider collaboratives enabling them to innovate, shape local delivery models and respond more dynamically to population need, supported by clear frameworks, enabling governance and proportionate oversight.

Strengthening joint commissioning with local authorities will continue to be a priority, particularly as the focus shifts further towards prevention, community resilience and addressing the wider determinants of health. By aligning local priorities and statutory duties, the ICB and local authorities will be able to drive a more coherent, whole-system response to issues such as housing, employment, education, family support and environmental factors. This will help ensure commissioning decisions are grounded in a deep understanding of what shapes people's health and wellbeing. Enhanced governance arrangements will underpin this, ensuring clarity of accountability, constructive challenge and timely decision making, while enabling the system to accelerate transformation and deliver improvements in productivity and quality.

As additional delegated responsibilities transfer to the ICB such as specialised commissioning, immunisations and vaccinations, screening programmes and the full spectrum of primary care, the organisation will move towards truly end-to-end commissioning. This will allow the ICB to set clearer standards across pathways, drive more consistent outcomes, and embed a system-wide commitment to equity, quality and value. Ensuring that these functions integrate seamlessly into existing structures will be central to creating a commissioning function that is modern, responsive and capable of supporting the long-term ambitions of the system.

Through this forward-looking approach, the ICB will create the environment needed for integrated, preventative and community-centred models of care to flourish, ensuring the system is prepared not only for current challenges but for the changing landscape of the next five years.

Section 3 – Commissioning intentions, transformation and new care models

Commissioning intentions for 2026/26 to 2030/31

This section sets out our Integrated Strategic Needs Assessment (ISNA), which helps us understand the health needs, inequalities and changing population trends across Shropshire, Telford and Wrekin. Understanding these needs, both now and in the future, is essential. It allows us to see which communities need more support, what is driving poor health, and where we should focus our resources to make the biggest difference. This insight is a vital part of our role as a commissioner, helping us plan the right services for our citizens and ensure they meet the needs of our population.

The section also outlines our commissioning plan for the period 2026/27 to 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, and productivity and efficiency. Together, these shifts will help us move towards a more proactive, joined-up and community-focused health and care system.

Population overview

Shropshire, Telford and Wrekin ICB covers two distinct but inter-connected local authority areas with different demographic profiles and growth patterns. Together, they form a population of just over 520,000 residents, characterised by a mix of rural communities, market towns and a rapidly growing urban centre.

Shropshire is a predominantly rural county with a steadily growing but ageing population. Recent estimates show the population increased from 329,558 in 2023 to 332,455 in 2024 – a rise of 0.9% driven largely by inward migration rather than natural growth. The county has a significantly older age profile, with higher demand for services related to long-term conditions, frailty and social care. Rurality also creates challenges around access, transport and digital connectivity.

Telford and Wrekin is one of the fastest-growing areas in the West Midlands. Between the 2011 and 2021 censuses, the population grew by 11.3% – rising from around 166,600 to 185,500. More recent estimates show continued growth, reaching 195,952 in 2024 – an increase of 1.8% in a single year. The area has a younger demographic profile, higher birth rates and greater ethnic diversity compared with Shropshire.

Across the ICB footprint, our challenges can be summarised as follows:

- Population growth is strong, particularly in Telford and Wrekin – creating rising demand for maternity, children's services and primary care.
- Ageing is a major driver of need, especially in rural Shropshire – increasing pressure on community services, urgent care and adult social care.
- Health inequalities vary significantly – with pockets of deprivation concentrated in parts of Telford and Wrekin, while rural isolation affects access and outcomes in Shropshire.
- Migration patterns differ, with Shropshire seeing more inward migration of older adults, while Telford and Wrekin attracts younger families and has a more diverse population.

Together, these dynamics shape the commissioning priorities for the ICB – requiring a balanced approach that supports both an ageing rural population and a growing, diverse urban community.

JSNAs, ISNA, PHIP and their relationship to the Shropshire, Telford and Wrekin Clinical Strategy

Joint Strategic Needs Assessments

The Joint Strategic Needs Assessments (JSNAs) produced by local authorities provide the foundational, place-based understanding of population health needs, inequalities and wider determinants across Shropshire, Telford and Wrekin. They draw on local data, community insight and statutory public-health intelligence to describe need at a granular level, informing local planning and resource allocation.

Telford and Wrekin JSNA

The Telford and Wrekin JSNA identifies a fast-growing and increasingly diverse population, with significant variation in health, deprivation and need across the borough. Population growth of 11.4% makes it one of the fastest-growing areas in the West Midlands, driven particularly by increases in children and young people aged 0–25. Around 17% of residents live in neighbourhoods among the most income-deprived nationally, contributing to marked inequalities in health outcomes and life chances.

The JSNA highlights rising diversity – 26% of school-aged children identify as non-White British. There is also increasing demand for support relating to Special Educational Needs and Disabilities (SEND), affecting 17.9% of children – above the national average. Key needs include moderate learning difficulties, speech and language challenges, and social, emotional and mental health issues.

Overall, the Telford and Wrekin JSNA provides a high-level picture of trends, inequalities and emerging pressures, supporting partners to plan services, target resources and address the wider determinants of health.

Shropshire JSNA

The Shropshire JSNA presents a detailed assessment of the county's health, wellbeing and wider determinants. As a largely rural area, Shropshire faces challenges related to an ageing population, access to services, transport, digital connectivity and social isolation. Despite overall affluence, pockets of deprivation persist – with some communities experiencing significantly poorer outcomes.

The JSNA highlights rising need across children's emotional wellbeing, SEND and school readiness. The SEND population has grown rapidly, increasing by 32% post-pandemic, with a particularly sharp rise of 78% in children with Education, Health and Care Plans (EHCPs).

For adults, the JSNA highlights pressures associated with long-term conditions, mental health, employment, and lifestyle-related risks. Wider determinants such as housing, the local economy and community infrastructure are also examined given their influence on inequalities. In addition, Shropshire's 18 place-based JSNAs provide deeper insight into local priorities, assets and variation at neighbourhood level.

ISNA

The ISNA incorporates intelligence from the JSNAs from both local authorities, integrating them with NHS datasets to produce a system-wide assessment of current and future health needs. It combines demographic trends, disease patterns, service-use data, workforce pressures and wider determinants to provide a comprehensive and comparable picture of need and health inequality headlines across the ICS.

We have taken a pragmatic approach to its first ISNA (used to inform this plan) based on the data and intelligence available. We will develop this over time using analytical methods such as segmentation, cohort modelling, cost-pressure forecasting and inequality analysis to identify variation in outcomes, unmet needs, system inefficiencies and capacity-demand mismatches. Scenario modelling will also allow commissioners to test the implications of population change, long-term condition prevalence and service redesign.

The ISNA will also incorporate qualitative insight from patients, clinicians, local authorities and voluntary partners to enrich and enhance the quantitative analysis. This combined evidence will enable us to identify priority cohorts, set transformation goals, target resources effectively and evaluate to ensure commissioning aligns with future need and statutory duties around equality and prevention.

In essence, the ISNA provides the overarching insight that makes the Five Year Strategic Commissioning plan robust, data-driven and aligned with population health management principles.

Population Health Implementation Plan (PHIP)

The Population Health Implementation Plan (PHIP) sets out how the system will utilise population health intelligence based on the ISNA findings to inform a practical and sequenced set of ambitions over a rolling five-year period. The plan outlines an associated programme of interventions over the same commissioning timeframe that will aim to deliver these ambitions.

Technically, the PHIP acts as the delivery blueprint to improve the health of the local population. It outlines the key metrics that the ICB has prioritised with system partners identified by the ISNA, along with the high-level aims and objectives of each programme of interventions. It uses a prioritisation matrix to identify the health metrics that will enable the ICB to effectively measure the impact of the programmes on the population's health.

Overall, the PHIP combines population-health intelligence with targeted, actionable programmes, ensuring the Five Year Strategic Commissioning Plan is coherent, data-driven and capable of driving meaningful population-level health improvement. At present the PHIP is a work in progress and still requires formal sharing and agreement with both Health and Wellbeing Boards. It will evolve over time to provide impactful interventions for all the key population needs and health inequalities for the people of Shropshire, Telford and Wrekin identified by the ISNA.

Clinical Strategy

The ISNA provides the core analytical foundation for the Shropshire, Telford and Wrekin Clinical Strategy which in turn provides the strategic context for the PHIP. The Clinical Strategy provides the vision to enable the ICB to commission for the area's specific challenges, including rurality, an ageing population and persistent health inequalities.

The strategy is a prevention-focused, community-centred approach across the life course – Start Well, Grow Well, Live Well, Age Well and End Well.

Ultimately, the ISNA and PHIP ensure that the Clinical Strategy is both evidence-led and delivery-ready. Based on our clinical priorities in population need, it provides a structured, data-driven framework for implementing interventions that reduce inequalities, improve outcomes and support integrated, sustainable models of care.

All of the above have been developed and form a coherent approach to the ultimate development of the Five Year Strategic Commissioning Plan.

Core20PLUS5 Framework

The Core20PLUS5 Framework is an NHS England approach designed to reduce healthcare inequalities. It focuses action within the NHS towards supporting population groups which are nationally recognised as being more likely to experience health inequality.

This includes:

- The most deprived 20% of the population (otherwise known as the Core20), as defined by the Index of Multiple Deprivation (2025)
- Locally defined PLUS groups (such as minoritised ethnic groups and people with learning or physical disabilities, amongst others) and inclusion health groups.

Within Shropshire, Telford and Wrekin, inclusion groups include:

- People experiencing homelessness
- Those affected by drug and alcohol dependence
- Vulnerable migrants and refugees
- Gypsy, Roma and Traveller communities
- People in contact with the justice system
- Victims of exploitation, and other marginalised or seldom-heard groups.

These communities often face significant barriers to accessing care, contributing to poorer health outcomes and reduced life expectancy. By embedding Core20PLUS5 principles across all programmes, the ICB aims to improve access, experience and outcomes through targeted interventions and strengthened partnerships with local authorities, the VCSE sector and wider public services to address the broader determinants of health.

The framework also identified 10 priority clinical areas:

- Maternity services
- Serious mental illness
- Chronic respiratory disease
- Cardiovascular disease
- Early cancer diagnosis
- Children and young people's asthma
- Children and young people's epilepsy
- Children and young people's diabetes
- Children and young people's mental health
- Children and young people's oral health.

To support our strategic planning process, a full review of data metrics aligned to [NHS England's Healthcare Inequality Priorities](#) and the Core20PLUS5 Framework has been completed. Where data is available, the analysis demonstrates variation between Core20PLUS groups and the general population. It also indicates trends of improvement in reducing known inequality gaps between population groups in access to, experience of, and outcomes from healthcare services.

It should be noted that several areas (marked with an asterisk*) cannot be fully analysed at this time due to limited data availability. There are further data quality implications relating to ethnicity data due to limitations in the completeness and accuracy of local ethnicity recording.

Priority area	Metrics	Variation/gap (Latest performance where disaggregated data is unavailable)	Trend period	Trend
Data quality	Percentage of records with valid ethnic codes, including not stated and not known	92.19% (variable by provider)	2024/25 – 2025/26	No change
Smoking cessation	Inequalities in smoking prevalence in adults (18+)*	Higher in Core20	2022 – 2023	Gap widening
Smoking cessation	Inequalities in smoking at time of delivery (SATOD) status	Higher in Core20	2024/25 – 2025/26	Gap reducing
Alcohol and drug use	Number of hospital admissions for alcohol-attributable conditions	Higher in Core20	2022/23 – 2024/25	No change
Obesity	Inequalities in percentage of adults classified as overweight or obese*	Higher in Telford and Wrekin	2022/23 – 2023/24	Increasing
Obesity	Variation between percentage of referrals to the National Diabetes Prevention Programme (NDPP) from the most deprived quintile and percentage of Type 2 diabetes population from the most deprived quintile*	Lower in Core20	2024/25 – 2025/26	Not available
Elective care	The size of the waiting list and observed inequalities in waiting times across different population groups (18-	No variation between Core20PLUS groups	2024/25 – 2025/26	No change

	week and 52-week waits)			
Elective care	Inequalities in rates of 'Did Not Attend'/'Was Not Brought' across services	Higher in Core20 Higher in minoritised ethnic groups	2024/25 – 2025/26	No change
Urgent care	Emergency admissions (age-standardised)	Lower in rural populations	2024/25 – 2025/26	N/A
Urgent care	Emergency admissions (all ages)	Higher in Core20	2024/25 – 2025/26	Gap reducing
Urgent care	Emergency admissions (all ages)	Higher in minoritised ethnic groups	2024/25 – 2025/26	Gap widening
Urgent care	Emergency admissions (all ages)	Lower in rural populations	2024/25 – 2025/26	N/A
Urgent care	Emergency admissions (people aged 0–18)	Higher in Core20 and Higher in minoritised ethnic groups	2024/25 – 2025/26	Gap widening
Urgent care	Emergency admissions (people aged 0–18)	Lower in rural populations	2024/25 – 2025/26	N/A
Learning disability	Percentage of patients aged 14+ on GP learning disability registers who have had an annual health check*	33.1%	2024/25 – 2025/26	No change
Learning disability	Number of people in a mental health inpatient setting who have autism*	25.4 per million of the population	2024/25 – 2025/26	Increased
Learning disability	Number of people in a mental health inpatient setting who have a learning disability*	20.3 per million of the population	2024/25 – 2025/26	Decreased
Learning disability	Percentage of people with suspected autism	Higher in ages 0–18	2024/25 – 2025-26	Increased

	waiting more than 13 weeks for contact*			
Maternity	Deprivation and ethnicity gap in pre-term births	Lower rates from Core20	2023/24 – 2025/26	Gap widening
Maternity	Deprivation and ethnicity gap in pre-term births	Lower rates in Black/Black British populations	2023/24 – 2025/26	Gap reducing
Maternity	Inequalities in gestational age at booking (by 10 weeks)	Lower rates in Core20	2023/24 – 2025/26	Gap reducing
Maternity	Inequalities in gestational age at booking (by 10 weeks)	Lower rates in Black/Black British populations	2023/24 – 2025/26	Not available
Adult mental health	Inequalities in patients achieving reliable recovery from talking therapies	Higher in Core20	2023/24 – 2025/26	No change
Adult mental health	Inequalities in patients achieving reliable recovery from talking therapies	Higher in minoritised ethnic groups	2023/24 – 2025/26	Gap widening
Adult mental health	Inequalities in proportion of people with serious mental illness receiving a full annual health check*	September 2025 – 53%	2023/24 – 2025/26	No change
Adult mental health	Inequalities in rates of Mental Health Act detentions	Higher in Core20 Higher in minoritised ethnic groups	2024/25 – 2025/26	Gaps reducing
Adult mental health	Inequalities in rates of Mental Health Act detentions	Lower in rural populations	2024/25 – 2025/26	N/A
Adult mental health	Inequalities in use of restrictive interventions*	15 per 1,000 of the population	2024/25 – 2025/26	Decreasing

Chronic respiratory adult	Inequalities in pulmonary rehab completion rates *	89.9%	2024/25	Not available
Chronic respiratory adult	Inequalities in under-75 mortality rate from chronic lower respiratory disease	Higher in Core20	2023/24 – 2024/25	Gap reducing
Chronic respiratory adult	Inequalities in under-75 mortality rate from chronic lower respiratory disease	Lower in minoritised ethnic groups Lower in rural populations	2023/24 – 2024/25	N/A
Chronic respiratory adult	Inequalities in COVID-19 vaccination uptake	Lower in Core20 and minoritised ethnic groups	2023/24 – 2024/25	Gap reducing
Chronic respiratory adult	Inequalities in COVID-19 vaccination uptake	Higher in rural populations	2023/24 – 2024/25	Gap reducing
Chronic respiratory adult	Inequalities in flu vaccination uptake	Lower in Core20, Asian/Asian British and Black/Black British population groups	2024/25	Not available
Cancer	Premature mortality from cancer considered preventable	Higher in Core20	2023/24 – 2024/25	Gap widening
Cancer	Premature mortality from cancer considered preventable	Lower for minoritised ethnic and rural groups and Lower in rural populations	2023/24 – 2024/25	N/A
Cancer	Inequalities in percentage of cancers diagnosed at stage 1 and 2* (data is heavily caveated)	Higher in Core20	2023/24 – 2024/25	Gap reducing

Cancer	Cancer screening coverage – bowel cancer*	Similar in Telford and Wrekin compared to England Higher in Shropshire	2024	Not available
Cancer	Cancer screening coverage – breast cancer*	Similar in Telford and Wrekin compared to England Higher in Shropshire	2024	Not available
Cancer	Cancer screening coverage – cervical screening (people aged 25 – 49)*	Higher in Shropshire and Telford and Wrekin, compared to England	2024	Not available
Cancer	Cancer screening coverage – cervical screening (people aged 50 – 64)*	Similar in Shropshire and Telford and Wrekin, compared to England	2024	Not available
Cancer	Cancer screening coverage – targeted lung health checks*	Not available at the time of analysis	Not available at the time of analysis	Not available at the time of analysis
Cardiovascular disease (CVD) and adult diabetes	Premature mortality from CVD	Higher in Core20	2023/24 – 2025/26	Gap reducing
CVD and adult diabetes	Premature mortality from CVD	Lower in Minoritised Ethnic Groups	2023/24 – 2025/26	N/A
CVD and adult diabetes	Deprivation gap in myocardial infarction and stroke admissions	Higher in Core20	2024/25 – 2025/26	Gap reducing
CVD and adult diabetes	Deprivation gap in myocardial infarction and stroke admissions	Higher in Minoritised Ethnic Groups	2024/25 – 2025/26	Gap widening
CVD and adult diabetes	Inequalities in percentage of patients with CVD who have their cholesterol levels managed to NICE guidance	Higher in Core20, people with a learning disability and autism and people with serious mental illness	2024/25 – 2025/26	Gap reducing

CVD and adult diabetes	Inequalities in percentage of patients with CVD who have their cholesterol levels managed to NICE guidance	Lower in Black/Black British	2024/25 – 2025/26	Gap reducing
CVD and adult diabetes	Inequalities in percentage of hypertension patients treated to target	Higher in people with a learning disability and autism and with serious mental illness	2024/25 – 2025/26	N/A
CVD and adult diabetes	Inequalities in percentage of hypertension patients treated to target	Lower in Core20	2024/25 – 2025/26	Gap increasing
CVD and adult diabetes	Inequalities in percentage of hypertension patients treated to target	Lower in minoritised ethnic groups	2024/25 – 2025/26	Gap increasing
CVD and adult diabetes	Inequalities in rates of hypertension case finding	Lower in Core20	2024/25 – 2025/26	No change
CVD and adult diabetes	Inequalities in people with diabetes who have received all 9 of the care processes (including retinal screening)*	Data unavailable by demographic group	Data unavailable by demographic group	Data unavailable by demographic group
Children and young people's (CYP) mental health	Access rates to CYP mental health services by protected characteristic or demographic group (0–17)	Higher in Core20	2024/25 – 2025/26	Increasing
CYP oral health	Inequalities in elective admissions of hospital-based tooth extractions due to dental caries, commonly known as tooth decay	Higher in Core20	2024/25 – 2025/26	Gap widening

	Inequalities in elective admissions of hospital-based tooth extractions due to dental caries	Lower in rural populations	2024/25 – 2025/26	No change
CYP asthma	Inequalities in prevalence of childhood asthma (under-18)	Similar rates in Core20 and some minoritised ethnic groups	2025	Not available
CYP epilepsy	Access to epilepsy specialist nurses in the first year of care for CYP with a learning disability or autism*	100%	2023/24	Not available
CYP diabetes	Inequalities in percentage of CYP with diabetes receiving all the recommended NICE care processes	Lower in Core20	2025/26	Not available
CYP diabetes	Inequalities in percentage of CYP with diabetes receiving all the recommended NICE care processes	Similar in minoritised ethnic groups	2025/26	Not available
CYP diabetes	Inequalities in percentage of CYP on continuous glucose monitoring	No variation in access between Core20 groups	2025/26	Not available
CYP diabetes	Inequalities in percentage of CYP on insulin pump	No variation in access between Core20 groups	2025/26	Not available
CYP diabetes	Inequalities in percentage of CYP on hybrid closed-loop	No variation in access between Core20 groups	2025/26	Not available

We have drawn on all of the above complementary sources of evidence and strategic direction to shape our Five Year Strategic Commissioning Plan and Strategic Commissioning Intentions.

Together, the JSNAs, ISNA, PHIP, Clinical Strategy and the Core20PLUS5 Framework provide a coherent and aligned foundation that ensures our plan is evidence-led, population-focused and strategically positioned to deliver meaningful improvements in health outcomes, reduce inequalities and support long-term system sustainability.

Commissioning intentions

Overview

Our commissioning intentions for 2026/27–2030/31 outline how we will target resources, reshape models of care, and deliver the five key system shifts, hospital to community, analogue to digital, sickness to prevention, improving access, and productivity and efficiency. These intentions are informed by the ISNA, detailed population health analysis, and system performance baselines across Shropshire, Telford and Wrekin. They demonstrate how we will meet our statutory responsibilities to improve outcomes, tackle inequalities, secure value for money, and align with national priorities such as the NHS Long Term Plan, the 10 Year Plan and the Medium Term Planning Framework.

Principles

Our approach is guided by a set of core principles that shape how we plan, prioritise and commission services.

- **Resources will follow need**, with investment shifting from acute care towards prevention, community services and primary care where clinically appropriate.
- We will **standardise approaches wherever beneficial**, adopting a system-wide ‘do once’ methodology while maintaining flexibility at place and neighbourhood level.
- **Decisions will be made at the most appropriate level**, with greater delegation to neighbourhoods, places and provider collaboratives to support integrated, outcome-focused delivery.
- All pathways will **embed prevention, early identification and patient empowerment**.
- We will promote **integrated, multisector models of care**, encouraging co-produced pathways and seamless transitions between services.
- Commissioning decisions will be **driven by evidence and robust data**, including population health management, benchmarking and modern service frameworks.
- **Lived experience will be central**, informing service design, improvement and evaluation.
- We will prioritise **value and productivity**, reducing unwarranted variation, and supporting financial sustainability. Tackling inequalities will be a core requirement, with commissioning directly targeting variation in access, experience and outcomes in line with Core20PLUS5.
- We will **innovate in contracting**, expanding outcomes-based approaches, modern payment models and strategic prioritisation tools such as the Strategic Decision Making Framework.

Golden threads across all intentions

All commissioning intentions are anchored in the wider strategic framework of the system, aligning with key strategies including the NHS 10 Year Plan, the Medium Term Financial Plan, the Joint Forward Plan, and the Clinical Strategy. They are also informed by our:

- Frailty, urgent and emergency care, cancer, inpatient quality, digital, data and engagement strategies
- the SHIPP and TWIPP delivery plans
- the ICS Strategy and its four statutory aims – National Oversight and Performance Assurance Frameworks, Estates and Infrastructure Strategy, and the Prevention Strategy.

Together, these documents provide the strategic context that shapes our desired outcomes, investment decisions and transformation priorities.

Purpose of the commissioning intentions

The commissioning intentions are designed to translate the ISNA into clear priorities for 2026/27–2030/31 and to set out what is expected of providers, places, neighbourhoods and collaboratives. They guide decisions on where to invest or disinvest, support the shift towards a new system operating model – including neighbourhood working, provider collaboratives and emerging Integrated Health Organisations – and define the measurable outcomes and deliverables required across all pathways.

Through the delivery of these commissioning intentions, we aim to achieve measurable improvements in population health and significantly narrow inequalities in access, experience and outcomes. We will shift more care closer to home by strengthening neighbourhood and community-based services and build a digitally-enabled system that reduces unnecessary reliance on face-to-face and hospital-based care – where it is safe and appropriate to do so.

Our approach will prioritise prevention, early intervention and proactive management of long-term conditions – while driving productivity and efficiency to support long-term financial sustainability. Ultimately, we will enhance our effectiveness as a strategic commissioner, underpinned by clear accountability, strong assurance processes and aligned system governance.

Our ambitions are set out based upon the following model in line with the requirements of the 10 Year Plan.



Hospital to community

Planned timescales

- In **2026/27**, the system will continue to roll out Integrated Neighbourhood Teams (INTs), establishing neighbourhood multidisciplinary teams for both adults and children. Community-based diagnostic capacity will increase, and urgent community services, including virtual wards, Urgent Community Response (UCR) and intermediate care, will become the default response for individual's escalating needs.
- During **2027/28**, these models will expand, supported by stronger multidisciplinary working, simplified community access routes via the Integrated Care Coordination Centres, and the early rollout of community-based elective pathways in specialities such as ear, nose and throat (ENT), respiratory and gynaecology.
- By **2028/29**, neighbourhood health models will be fully embedded, with a growing proportion of elective, diagnostic, frailty and rehabilitation services delivered outside acute hospitals. Home-based cancer treatments, enhanced support for care homes and expanded community pathways for chronic conditions will become part of routine provision.
- From **2029/30 to 2030/31**, this shift will be consolidated. Hospital activity will increasingly reflect the left shift in care, with more preventative, proactive, and community-managed support leading to fewer admissions, shorter lengths of stay and greater resilience in out-of-hospital services. Neighbourhood teams will be strengthened through devolved budgets, pooled commissioning arrangements and expanded community capacity to ensure long-term sustainability.

Our overarching ambition

We are committed to developing neighbourhood-based health models in close collaboration with our two Places, shifting towards proactive, preventative approaches that support people with a wide range of physical and mental health needs. These partnerships are essential for understanding population needs, setting shared priorities and integrating health and care services. Strong governance arrangements ensure regular oversight, meaningful stakeholder engagement and alignment with national expectations.

Our neighbourhood models will reduce duplication, create a more seamless experience for patients, and place greater emphasis on prevention, early intervention and reducing deconditioning. We will equip people with the tools and confidence to manage their own health wherever possible. Investment in our INTs will enable more care to be delivered within communities and in people's usual places of residence, both face-to-face and digitally, helping to prevent avoidable escalation and unnecessary hospital use.

Neighbourhood delivery will be coordinated through place-based partnerships and accelerator groups, aligned with local authority boundaries and natural patient flows. Progress will be monitored against national metrics, including outpatient activity, emergency admissions, bed days, ambulance conveyances, A&E attendances, GP appointments, community pharmacy contacts and patient-reported outcomes. Workforce engagement and staff experience will also be tracked to ensure effective multidisciplinary working and strong team culture.

Transformation and new care models

Neighbourhoods and urgent and emergency care

The Hospitals Transformation Programme (HTP) is a key enabler of the system's commitment to shift care from hospital to community settings over the next five years. Recent system initiatives,

including the expansion of community-based rehabilitation services and the enhancement of the Urgent Community Response (UCR) service are already strengthening capacity to support people safely at home and reduce avoidable hospital admissions. These developments directly support the commissioning plan's priorities to embed prevention, improve flow, and grow integrated neighbourhood-level care models and provide a firm position on which to build upon as articulated within this plan.

We will continue to expand and embed our UCR offer delivered via SCHT, extending operating hours to midnight, seven days a week. This will increase access, reduce reliance on emergency departments (ED), and ensure vulnerable people receive timely intervention within their usual place of residence.

Virtual wards will remain a core element of the UEC pathway. We will further develop and optimise these models to support admission avoidance, earlier supported discharge and improved patient flow. Capacity will be aligned to system demand, with a particular focus on frailty, respiratory conditions, long-term conditions and stepdown from acute care. Virtual wards will contribute to reduced ED attendances, improved ambulance non-conveyance dispositions and more care delivered closer to home for high-risk and vulnerable groups. Integration with UCR, acute flow processes and neighbourhood teams will ensure a seamless, end-to-end pathway.

To simplify access and improve consistency for the public, we will standardise urgent care entry points by embedding Urgent Treatment Centre (UTC) models where appropriate and strengthening NHS 111 as the default route into urgent care. This will include enabling bookable arrival times into UTCs and Same Day Emergency Care (SDEC), where feasible.

We will designate and commission UTCs in line with national standards (or agreed exemptions), ensuring a consistent and reliable 'front door' for urgent care. This will divert appropriate activity away from Type 1 EDs, improve patient navigation and choice, and ensure equitable access across the system. Robust patient engagement will inform future service design and commissioning decisions.

We will build on our Single Point of Access (SPA) and Care Coordination Centre (CCC) by embedding these functions within the System Flow Centre (SFC), enabling a 24/7 service. Electronic referrals for urgent community services will be implemented for health and social care professionals, reducing duplication and multiple referral routes. The CCC will provide triage, coordination and, where clinically appropriate, direct case management to avoid ED attendance, ambulance conveyance and readmission. It will proactively utilise community services, expand community pathways and share data to inform future commissioning and service development. Through the SFC, we will better understand how to further expand Intermediate Care, UCR, virtual wards and SDEC to meet population needs in alternative settings, initially focusing on priority cohorts. Streamlined access to urgent services will also support greater efficiency and flexibility across the system.

We will align demand and capacity across intermediate care services to support more people at home and reduce reliance on bed-based care. This will improve flow, reduce length of stay, decrease the number of patients with no criteria to reside, and support timely discharge. Through place-based governance, including the Better Care Fund, we will further integrate social care, pharmacy, the voluntary sector and primary care. Neighbourhood health models and community hospitals will be used to deliver a fluid step-up and step-down model across the community pathway, supporting both discharge and alternatives to hospital admission.

The National Neighbourhood Health Implementation Programme (NNHIP), launched in October 2025, is a 12-month accelerator involving 43 sites, including Shropshire. Its first phase focuses on combining the NHS biomedical model with a psycho-social approach, enabling holistic care and addressing wider barriers to health.

INTs are being established across five neighbourhoods, prioritising adults with complex long-term conditions and those at escalating risk. Delivery plans are informed by population health data and co-designed with stakeholders. The model emphasises co-management of long-term conditions, moving away from single condition pathways and drawing on trusted expertise within communities.

Although the national programme is centred on Shropshire, learning and opportunities are being mirrored in Telford and Wrekin. Alignment across the cluster is at an early stage, but the approach will be streamlined as the cluster matures. Neighbourhood health teams will become the default model for proactive urgent care and admission avoidance. They will deliver anticipatory care planning for high-risk cohorts, including frailty, multimorbidity, high-intensity users and care homes. Working alongside the CCC, they will provide rapid review of deteriorating patients and strengthen links with wider partners such as the VCSE sector and local authority services. This aligns with national neighbourhood health guidance and the broader national agenda.

This will be achieved through:

- Using population health management segmentation and risk stratification to identify at-risk cohorts and develop proactive intervention plans for priority groups.
- Embedding multidisciplinary huddles and care coordination meetings at neighbourhood level, linked to the ICC for urgent escalation.
- Standardising anticipatory care planning and escalation plans for high-priority cohorts, including medication optimisation, and access to remote clinical support.
- Implementing a 'no wrong door' referral approach and using shared care records as a core multidisciplinary team tool to reduce duplication and delays.

Dementia

We will continue to aim to ensure that people living with dementia, and their carers, have the support they need post diagnosis including the knowledge and strategies to avoid going into crisis through a combination of specialist nursing and dedicated link workers.

We will ensure that dementia models of care are embedded in our emerging neighbourhood models of delivery. In 2026/27, we will implement across all our neighbourhoods the successful Dementia Multidisciplinary Team approach designed and piloted in South East Shropshire, which provides proactive identification, assessment and multi-agency coordination and management of people with dementia to reduce the risk of exacerbation and deterioration.

General practice

We will continue to work closely with general practice deliver left shift through a portfolio of locally-commissioned services designed to increase access to diagnostics such as electrocardiogram (ECGs), spirometry and fractional exhaled nitric oxide (FeNO) in primary care. We will also provide the clinical management and disease monitoring currently provided in acute settings.

In addition, to support our clinical strategic priorities, we will develop and implement a Quality Improvement Framework with a focus on early identification of diabetes, cardiovascular and renal disease to improve clinical management aiming to prevent further deterioration or complications.

We will commission these services with a design aimed to promote collaborative delivery focused around our neighbourhoods.

Community pharmacy

We will continue to work closely with community pharmacy as part of our delegated commissioning responsibilities, and in preparation for the full transfer of functions from NHS England on 1 April 2027. Community pharmacy will play an increasingly central role in delivering the left shift set out in the NHS 10 Year Plan – supporting a system where more care is delivered in community settings and fewer people need to attend hospital or general practice for routine or manageable conditions.

Community pharmacy will continue its transformation and integration journey, with a focus on expanding both new and existing clinical services. This will include broadening the scope of Pharmacy First into additional clinical areas, enabling pharmacists to manage a wider range of minor and acute conditions and reducing pressure on general practice and urgent care. We will also support the development of new services linked to prevention, early detection and screening, including cardiovascular risk checks, respiratory case finding, and targeted health promotion for high-risk groups.

In line with national expectations, community pharmacy will take on an enhanced role in medicines optimisation, including structured support for polypharmacy, reducing overprescribing, and improving adherence for people with long-term conditions. This will be aligned with further delegated functions and integrated into primary care pathways, ensuring pharmacists are fully embedded within neighbourhood teams and multidisciplinary models of care.

We will work with pharmacy providers to maximise the impact of Pharmacy First, ensuring it is consistently available, well publicised, and effectively linked to NHS 111, general practice, urgent care and digital triage systems. Community pharmacy will also contribute to anticipatory care, personalised care planning and proactive management of long-term conditions, supporting earlier intervention and reducing avoidable escalation.

Dentistry

We will continue to work closely with community dentistry as part of our delegated commissioning responsibilities, and in preparation for the full transfer of functions from NHS England on 1 April 2027.

Optometry

We will continue to work closely with community optometry as part of our delegated commissioning responsibilities, and in preparation for the full transfer of functions from NHS England on 1 April 2027.

Following the five-year Eyecare Transformation Programme (2021–25), the new Optometry First service launched in Shropshire, Telford and Wrekin in July 2025, will continue to deliver a range of integrated eye care services at neighbourhood level. The service is delivered across a wide geographical area through a network of local optical practices, coordinated by a single lead organisation (the Prime Provider) that oversees delivery and quality. It also includes a telemedicine hub, which acts as one central point of contact where patients and professionals can access advice, support, and specialist review remotely.

The Optometry First model supports the left shift of eye care from acute to community and incorporates first-contact care and monitoring low-risk eye conditions deemed suitable within primary care. The model utilises technology, imaging and diagnostics within the pathways to provide care closer to home and improves integration and delivery of local care. It supports prevention of sight loss through early intervention and timely treatment. Productivity is increased through the utilisation of skills, equipment, technology and estates that already exist in primary care optometry.

The success of this redesign programme has been underpinned by collaborative local working between primary care optometry and secondary care ophthalmology. The ongoing development over many years of local eye care networks has provided a foundation for education, peer support and an appetite for collective problem solving and improvement. It is anticipated that this culture of collaboration will encourage further innovation to build on the Optometry First model over the next five years.

We will be work with Business Intelligence (BI) colleagues to better understand data around eye health and sight loss from a population health perspective, so that the impact of interventions can be understood and provide insight for future planning.

In addition, core NHS sight testing services will continue to be provided locally for eligible patients through the General Ophthalmic Services (GOS) contract both within optometry practices and through domiciliary services. Alongside this, during 2026/27, it is anticipated that annual sight tests in special educational settings will be commissioned via GOS as per the national NHS England specification.

Mental health, learning disabilities and autism

Working with MPFT and our wider network of mental health providers, we will support the co-location of mental health teams within the Type 1 ED at the Royal Shrewsbury Hospital. This development will be informed by a system-wide needs assessment undertaken between 2026 and 2029. The aim is to shift away from reactive emergency mental health care within ED settings by diverting individuals to more appropriate specialist services, enabling Type 1 EDs to focus on physical emergencies and improving patient flow.

A review of current service provision will identify opportunities for efficiency and model optimisation. Delivery will be supported through resource realignment and national funding. These models will contribute to improved UEC performance and patient experience, including A&E four-hour and 12-hour metrics, ensuring people receive timely care that better meets their needs.

We will develop and embed 24/7 Mental Health Neighbourhood Models to ensure people experiencing poor mental health can access timely, local support as part of a wider multidisciplinary team. This approach will improve access and patient experience, strengthen integration with primary and social care, and reduce waiting times for individuals requiring immediate intervention.

We will further enhance the Mental Health Crisis offer by incorporating peer support and exploring opportunities to expand community crisis bed provision. This will create an integrated VCSE–NHS pathway with a preventative focus, simplified access routes, and a broader range of alternatives to A&E attendance and inpatient admission.

In partnership with system colleagues, we will continue to transform and commission services under the Inpatient Quality Transformation Programme (IQTP). This work will ensure that inpatient care is personalised, admissions are timely and purposeful, hospital stays are therapeutic, and discharge is effective. The programme will strengthen system-wide coordination,

proactively address health inequalities, and drive continuous improvement across the inpatient pathway.

We will continue to implement the child and adolescent mental health services (CAMHS) Three Year Transition Plan following the re-procurement of the service. This includes embedding prevention, needs-led and trauma-informed practice, establishing a single point of access, developing clear pathways for children and young people (CYP) requiring mental health support, and reducing waiting times. The new service model will expand digital support options and improve access to early help information, tools, guidance and signposting.

It will fully embed the iThrive principles:

- common language
- needs-led care
- shared decision making
- proactive prevention and promotion
- partnership working
- outcomes-informed practice
- reduced stigma
- improved accessibility.

Through this transformation, we expect to see reduced symptom acuity and escalation, improved resilience among CYP and families, and reductions in crisis presentations, admissions and A&E attendances. We will also prioritise Core20PLUS5 deliverables to reduce inequalities in access and outcomes across protected and underserved groups aged 0–17.

We will expand Mental Health Support Teams (MHSTs) in schools and colleges to achieve full national coverage by 2029. Full coverage means providing MHST support to all children and young people aged 5–18 in mainstream education – including primary, secondary, post-16, special schools, alternative provision, faith and independent schools, and pupil referral units. CYP who are temporarily absent or persistently/severely absent will also be within scope.

For eating disorder services, we will prioritise early identification, rapid access and needs-based care. Over the next five years, the ICB will ensure consistent, equitable access to specialist community eating disorder services, strengthen referral routes from schools, primary care and wider partners, and build a trained multiagency workforce able to recognise early signs and intervene promptly. Commissioning will focus on expanding capacity within Community Eating Disorders Service for Children and Young People (CEDS–CYP), improving support for a broader range of presentations including Avoidant/restrictive food intake disorder (ARFID), and embedding trauma-informed, preventative approaches to reduce crisis escalation, hospital admissions and long-term harm. Our ambition is to shift from late, acute responses to proactive, community-based support that improves outcomes and reduces avoidable demand across the system.

Special educational needs and disabilities (SEND) 0–25 years

When considering services commissioned for CYP with SEND there will be a continued drive to move care delivery closer to home, and in familiar and accessible settings such as schools. Based on local learning from the national [Early Language Support For Every Child](#) Speech and Language Therapy (SLT) programme, services such as SLT typically yield more positive outcomes when they are delivered in schools and early years settings rather than clinics.

This shift to work within school and early years settings results in better join up between education and health which is necessary to maximize the impact of services for CYP with SEND. Furthermore, the learning from the delivery of the cross-partnership programme for Partnership for Inclusion of Neurodiversity in Schools (PINS) reinforces the necessity of delivery of health services in schools, taking a system-wide approach.

This model of delivery is also evident in the nationally mandated Mental Health Support Teams service offer delivered by CAMHS. In line with the pending Schools White Paper (February 2026) which will set out SEND reforms, it is anticipated that one of the fundamental principles will be services delivered locally. This will further engender children's health services to be delivered closer to home. Additionally, the Family First Partnership programme, which serves the SEND population amongst other vulnerable groups, sets out the requirement for Family Help to be delivered in the heart of the community by multidisciplinary teams and the Family Hubs agenda requires accessible support in the community.

Electives and diagnostics

For elective services, we will begin a phased transformation programme to shift appropriate activity into community settings, starting with ENT, gastroenterology, respiratory, urology, cardiology and gynaecology. This will include implementing a consistent model of collective care approaches, standardising referral criteria across the system, maximising the use of Advice and Guidance, and introducing clinical triage standard operating procedures for high-volume specialities. These changes will support the development of fully integrated, end-to-end pathways, reduce unwarranted variation, and shorten waiting times in line with the ambitions of the NHS 10 Year Plan. The programme will also incorporate digital pathway optimisation, increased use of remote monitoring where clinically appropriate, and the expansion of community-based elective hubs to deliver high volume, low complexity procedures outside acute hospitals.

We will continue to invest in our Community Diagnostic Centre (CDC) to expand access, streamline pathways and reduce reliance on hospital-based diagnostics, supporting the wider shift of care closer to home. This will include developing strategies to reduce geographic variation in access, ensuring equitable provision for underserved groups, including vulnerable and rural communities. Our aim is to improve patient experience through simplified and faster diagnostic journeys, increase the number of straight to test pathways where clinically appropriate, and enhance GP direct access to diagnostics. In line with national expectations, we will extend CDC operational hours to 12 hours a day, seven days a week, increase capacity for imaging, physiological measurement and pathology, and strengthen digital interoperability to ensure results flow seamlessly into primary and secondary care systems. This will support earlier diagnosis, reduce bottlenecks in elective pathways, and contribute to the national ambition to diagnose more cancers at stages 1 and 2.

In musculoskeletal and orthopaedics, we will work with our RJA, SaTH, SHT and our wider provider network to transform the way that local services are delivered. Using the expertise and clinical leadership in our system this is an area where our ambition is to be class leading. There is no reason why this cannot be achieved within the timescale of this plan.

Women's health

We will deliver a system-wide transformation in women's health and perinatal services that improves outcomes, reduces inequalities and ensures women and girls can access safe, high-quality care across the life course. Building on the ambitions of the 2022 Women's Health Strategy and the Maternity and Neonatal Three-Year Delivery Plan, we will reduce fragmentation

between perinatal, gynaecology and wider women's health services by embedding women's health within neighbourhood models and aligned commissioning programmes. Priority action will focus on shifting high-volume, low-complexity pathways into community settings, reducing elective gynaecology waits and unwarranted variation, and strengthening continuity and coordination across reproductive health, pregnancy, postnatal and women's health needs at all life stages. Our ambition is that Women's Health Hubs will be scaled and embedded within neighbourhood teams to provide integrated, multidisciplinary support including group consultations, where appropriate, covering menstrual health, menopause, contraception, pelvic health, urogynaecology and preconception care, supported wherever possible by Advice and Guidance, Community Diagnostic Centres (CDCs) and community pharmacy.

Reducing inequalities in women's health and perinatal outcomes will be a core system priority. A comprehensive Women's Health Needs Assessment, drawing on local intelligence, population health data and lived experience, will identify high-impact action areas across the life course and inform commissioning priorities, pathway redesign and improved ways of working across the women's health system. We are committed to listening to women and girls, families and communities, particularly those least well served by current services, and using their insight to shape service design, delivery and improvement. This intelligence-led and co-produced approach will focus effort where it will have greatest impact, including women from deprived communities, minority ethnic groups, rural populations and those with complex social factors. In perinatal services, this will include delivery of national safety and quality improvement programmes, embedding equity and anti-discrimination approaches, strengthening perinatal mental health, pelvic health and bereavement pathways, and improving access, experience and outcomes across the perinatal pathway.

Analogue to digital

This section sets out how we will modernise health and care by expanding the use of digital technology across pathways and services. Digital tools already help people manage appointments, monitor their health, receive care at home and stay informed about their treatment. As demand and expectations continue to rise, the role of digital solutions will grow further, while we continue to protect and value the importance of face-to-face care for those who need or prefer it.

Digital technology is reshaping how people live, work and access services, and health and care are no exception. In recent years, digital innovations have made it easier for individuals to navigate the system, access timely support and take a more active role in managing their own health. As our population ages and the complexity of need increases, digital transformation will be essential to delivering faster, safer and more coordinated care.

When used effectively, digital tools reduce delays, support earlier intervention, and allow staff to spend more time with patients by streamlining administrative processes. They also improve the secure flow of information across teams and organisations, enabling more joined up decision making and reducing the need for people to repeat their story. Expanding digital capability will help us deliver more personalised care, improve access for underserved communities, and support the shift of care closer to home.

The ICB will strengthen and expand assertive and intensive outreach provision for adults with the most complex and enduring mental-health needs, ensuring timely, flexible and community-based support that reduces reliance on inpatient care and crisis services. Commissioning will prioritise multi-disciplinary teams able to deliver proactive, trauma-informed intervention for individuals who struggle to engage with traditional services, including those experiencing repeated crises, co-occurring conditions or significant social vulnerability. Over the next five years, the ICB will

develop a consistent system-wide model that integrates with primary care, community mental-health services, police and justice services, housing, social care and the voluntary sector, enabling rapid response, continuity of care and personalised support. This approach aims to stabilise need earlier, prevent avoidable admissions, reduce out-of-area placements and improve long-term outcomes for adults with the highest levels of complexity.

Our overarching ambitions

Neighbourhoods and urgent and emergency care

The Care Coordination Centre (CCC) will play a central role in driving digital transformation by ensuring full interoperability across systems, enabling the seamless transfer of patients into the right services at the right time. This will reduce unnecessary reliance on clinical capacity and streamline operational processes. The CCC will draw on regional and national best practice in care coordination to embed consistent standards, improve information flow, and support real time decision making across the system.

New models of care will increasingly use technology to deliver hybrid, flexible and accessible services. Our hybrid pulmonary rehabilitation programme already demonstrates this approach by combining digital platforms with face-to-face sessions to improve access, adherence and outcomes for respiratory patients. For people living with long-term conditions, we will expand the use of remote monitoring, virtual consultations and data-driven insights to support personalised, proactive care. This includes scaling digital blood pressure monitoring, glucose monitoring, virtual cardiac rehabilitation and other remote clinical tools that help people manage their conditions safely at home.

In palliative and end of life care, we will strengthen digital integration through shared electronic records, Digital ReSPECT, and virtual multidisciplinary team meetings to ensure coordinated, compassionate and timely support. For people living with frailty, we will implement the wider actions set out in the Shropshire, Telford and Wrekin Frailty Strategy to promote independence and reduce avoidable deterioration.

Across all pathways, digital solutions will be used to support earlier intervention, improve continuity of care, and reduce duplication. This includes expanding digital triage, improving access to online information and self-management resources, and ensuring that digital tools are accessible and inclusive for underserved communities.

General practice

We will deliver the key digital developments required in General Practice, aligned to national expectations set out in the NHS 10 Year Plan and the GP Contract. This will include:

- **Delivering My NHS GP**, using AI-enabled triage and data-driven clinical pathways to guide people rapidly to the most appropriate service. This will ensure those who need an appointment can book one directly, while others are safely directed to selfcare, pharmacy, community services or urgent care as appropriate.
- **Transforming Planned Care**, giving patients a single digital space to manage all appointments, referrals, diagnostics and communications. This will streamline administrative processes, reduce referral to- treatment- times, and support more efficient coordination between primary and secondary care.
- **Managing My Health**, empowering people to manage their own health and the health of dependants by providing targeted access to prevention services, personalised health information, and digital tools that help reduce future demand before illness develops or worsens.

- **Prioritising Advice and Guidance (A&G)** before, or instead of, a planned care referral where clinically appropriate (excluding urgent suspected cancer). We will move towards all referrals in the 10 highest volume specialties going through A&G first, ensuring patients are managed in the right place and reducing unnecessary outpatient activity.
- **Expanding access to specialist advice and diagnostics**, working with system partners to increase direct access for general practice. When aligned with neighbourhood models, this will enable GPs to manage more patients without referral, support earlier diagnosis, and reduce pressure on hospital services.
- **Deploying ambient voice technologies** to reduce administrative burden and free up clinical time. Time released through automation and AI supported documentation will be reinvested into direct patient care, supporting improved access and continuity.
- **Implementation of Child Protection Information Sharing System (CP-IS) phase 2** to be implemented following the national work undertaken to create a more universal application programme interface between the National Summary Care Record and common Electronic Patient Records used within primary care. Further national work is being undertaken for EMIS and System1 (overseen by NHSE) for full integration of CP-IS which will require implementation locally.

In addition to these commitments, we will also deliver the wider digital requirements of the NHS 10 Year Plan and GP Contract, including:

- **Modern General Practice Access** – ensuring all practices have digital telephony, cloud-based clinical systems, and care navigation that directs patients to the right service first time.
- **Improved interoperability** – enabling seamless information sharing between primary care, community services, urgent care, mental health and hospitals.
- **Expansion of online services** – including prescription management, test results, appointment booking and personalised care plans.
- **Enhanced digital inclusion** – ensuring that digital tools are accessible to underserved groups, with alternatives available for those who cannot or prefer not to use digital channels.
- **Support for continuity of care** – using digital tools to identify and prioritise patients who benefit most from ongoing relational continuity.
- **Strengthening data quality and population health management** – enabling proactive identification of high-risk cohorts and targeted intervention at neighbourhood level.

Through these developments, general practice will become more accessible, efficient and proactive, supporting the left shift into community settings, improving patient experience, and ensuring digital transformation directly contributes to better outcomes for the population of Shropshire, Telford and Wrekin.

Pharmacy

We will deliver key digital advancements in community pharmacy in line with national expectations, ensuring pharmacy is fully integrated into the wider digital ecosystem of primary and community care. This will include the development and rollout of the Single Patient Record, enabling pharmacists to access and contribute to real time clinical information. This will support safer prescribing, reduce duplication, improve medicines optimisation- and strengthen continuity of care across pathways.

We will implement national booking standards, enabling patients to book pharmacy services directly through digital channels, including the NHS App. This will support the expansion of Pharmacy First, contraception services, blood pressure checks and other clinical pathways, ensuring patients can access timely care without unnecessary GP or hospital attendance.

We will support the adoption of ambient AI technologies within community pharmacy to reduce administrative burden, improve documentation accuracy and free up pharmacist time for clinical care. This aligns with the national ambition to modernise the pharmacy workforce and enable pharmacists to operate at the top of their licence.

Digital enablement through the NHS App will be strengthened, ensuring patients can view pharmacy services, manage prescriptions, receive notifications, access test results and engage with personalised medicines information. This will also support digital inclusion by providing clear, accessible information for people managing long-term conditions.

In addition, we will deliver the wider digital commitments for pharmacy set out in the NHS 10 Year Plan and national guidance, including:

- **Full digitisation of pharmacy clinical services** – ensuring structured data flows into GP and hospital systems to support shared decision making.
- **Expansion of electronic prescribing and dispensing** – including increased use of EPS for acute prescriptions and improved digital repeat dispensing.
- **Improved interoperability** – between pharmacy, general practice, urgent care, community services and hospitals to support seamless care transitions.
- **Digital tools for medicines optimisation** – including polypharmacy reviews, adherence monitoring and personalised medicines support for high-risk cohorts.
- **Enhanced digital safety systems** – including clinical decision support tools, allergy alerts and automated safety checks.
- **Support for remote clinical services** – such as virtual consultations, digital follow-up and remote monitoring for long-term conditions.
- **Better use of population health data** – to identify patients who would benefit from pharmacy-led interventions such as cardiovascular risk management or inhaler optimisation.

Optometry

We will promote the implemented regional Electronic Eyecare Referral system within local optometry practices – enabling a more efficient, digital referral process between optometry and ophthalmology. This replaced a historical paper referral system via general practice. Clinical information can be transferred electronically, with the capability to send full volumetric Optical Coherence Tomography (OCT) images.

We will encourage use of and continue to improve Optometry First services which includes a range of diagnostic tests and imaging, so these can be undertaken prior to referral. This will enable more rapid specialist clinical input from ophthalmology, where referral is required, avoid duplication of tests and avoid unnecessary referrals where they are not required. Referral pathways are more streamlined and efficient, and this digital capability will continue to be embedded in new pathways.

In addition, we will deliver the wider digital commitments for optometry in line with the aspirations of the NHS 10 Year Plan.

- We will introduce optometry independent prescribing into commissioned pathways, where appropriate to reduce demand on general practice and secondary care.

- We will expand community optometry roles within Optometry First pathways, commissioning digitally-enabled services (urgent/minor eye conditions, cataract postop checks, glaucoma monitoring) to shift care closer to home and relieve hospital eye service capacity.
- We will expand the use of imaging and diagnostics (for example – OCT, fundus photography) within commissioned Optometry First services to enable secure transmission, viewing and virtual review by ophthalmology clinicians.
- We will use data to manage and improve eye care pathways, establishing dashboards and reporting for referral volumes, waiting lists, A&G uptake, and outcomes, consistent with NHS data and digital transformation priorities.

Mental health, learning disabilities and autism

Digital transformation in mental health, learning disabilities, and autism will play a central role in delivering the ambitions of the NHS 10 Year Plan, improving access, personalisation, and the quality of care. National guidance emphasises the expansion of digital tools that support early intervention, reduce crisis escalation and enable more joined-up, person-centred pathways. This includes wider use of shared electronic care records, digital care plans and real time information sharing across mental health, primary care, social care and education to ensure people do not have to repeat their story. We will look to expand the use of remote monitoring, virtual consultations and digital therapies will increase choice and flexibility, particularly for people who face barriers to attending in-person appointments.

For people with learning disabilities and autistic people, we will look to implement digital solutions which will support reasonable adjustments, communication preferences, sensory-friendly care and improved access to specialist advice. Enhanced use of digital decision support tools, risk stratification and population health data will help identify individuals at rising risk earlier, enabling proactive support and reducing avoidable crisis presentations.

Together, these developments will create a more inclusive, accessible and proactive model of care that improves outcomes and reduces inequalities for people with mental health needs, learning disabilities and autism.

Special educational needs and disabilities (SEND) 0–25 years

As for the mental health and learning disability and autism population, the requirement for digital transformation of services and support for CYP with SEND is essential. As technology develops children with SEND can be better supported to meaningfully engage in the world around them.

As an example, there is valuable impact of electronic Augmentative and Alternative Communication (AAC) devices. The AAC Speech and Language Therapy service has seen a significant rise in demand for electronic AAC devices as the needs and complexity of our CYP population increases. Further to this, the use of electronic devices to support CYP with mental health needs are increasing, for example the use of AV1 Robots to support CYP who are experiencing emotionally-based school avoidance has proven effective to enable connectivity with school and classroom while a CYP is at home. These examples emphasise the need for digital innovation for CYP with SEND to be prioritised as a system.

Delivery of digital integrated record systems are essential to delivering the required progress for CYP with SEND. As set out in the Key Principles of SEND Reform (2025), shared systems will result in better care and better outcomes. We will endeavour to implement the digitisation of shared record systems – including Education, Health and Care Plans – to deliver on the pending SEND reforms and the Family First Partnership programme.

Further work is required to utilise digital systems effectively to manage data to inform commissioning and service delivery. Current information sharing processes rely on manual reporting. However, more advanced digital data systems which can consider place-based needs at a neighbourhood level would enable smarter use of public resources – as well as more effective forecasting of service needs for CYP with SEND.

Elective and diagnostics

We will continue to work closely with our providers to expand and enhance the use of patient-initiated follow-up (PIFU), ensuring patients have a wider range of responsive and accessible follow-up options. This will include standardising remote consultations, remote monitoring and digital support tools across all major specialities. These developments will be supported by the introduction of AI-enabled triage, automated reminders, digital symptom tracking and other emerging technologies that help patients manage their own care and reduce unnecessary outpatient demand.

We will further roll out Advice and Guidance (A&G) to ensure referrals are consistently optimised through timely specialist advice and effective clinical triage. This will increase the proportion of patients managed in the most appropriate care setting and reduce avoidable outpatient appointments. In line with national guidance, we will work towards ensuring that the highest volume specialities routinely use A&G as the default route prior to referral – except where urgent suspected cancer pathways apply.

We will continue to deliver our outpatient transformation programmes, expanding the use of virtual appointments, digital preassessment, and community-based clinics supported by alternative technologies. This will include wider adoption of digital consent, online preoperative information, automated follow-up scheduling and personalised digital care plans. These changes will support the NHS 10 Year Plan ambition to modernise outpatient care, reduce unnecessary face-to-face activity and improve patient convenience.

We will accelerate innovation and technology adoption in diagnostics, implementing cutting-edge tools across the system. This includes evidence-based use of AI and machine learning to support image interpretation, pathology automation, risk stratification and earlier detection of disease. We will also expand the use of digital triage and straight-to-test pathways, ensuring patients move more quickly through diagnostic stages of their care.

In line with national diagnostics guidance, we will strengthen the use of the NHS App for diagnostics – enabling patients to receive real-time updates, manage appointments online, access test results more easily and receive personalised information about their diagnostic journey. This will improve transparency, reduce administrative burden and support more efficient patient flow.

We will also:

- Expand interoperability between diagnostic systems, primary care and acute providers to ensure results are available in real time across the system.
- Support the development of digital clinical decision support tools to improve referral quality and reduce unwarranted variation.
- Increase the use of remote diagnostic technologies, such as home spirometry and ambulatory ECG monitoring.
- Strengthen digital inclusion initiatives to ensure all patients can benefit from digital elective and diagnostic innovations, including those in our rural or underserved communities.

Through these developments, we will create a more efficient, digitally-enabled elective and diagnostic system that improves access, reduces waiting times, and supports the wider left shift of care into community settings.

Cancer

We will harness technological innovation to transform the prevention, diagnosis and treatment of cancer. This is in line with national ambitions to diagnose more cancers at stages 1 and 2, and to deliver faster, more personalised care. This includes expanding the use of robotic-assisted surgery – enabling greater precision, shorter recovery times and improved outcomes. We will also scale the use of AI and machine learning to increase diagnostic capacity, support faster image interpretation, reduce reporting backlogs, and improve the accuracy of cancer detection across radiology, pathology and genomics.

Improving data sharing and interoperability will be central to this transformation. We will strengthen real-time information flow between primary care, diagnostics, acute providers and specialist cancer services – ensuring clinicians have access to complete and up-to-date records. Patients will increasingly use the NHS App to track symptoms, manage appointments, receive test results, access personalised information, and engage in remote monitoring during and after treatment. This will support earlier escalation, improved safety and more convenient follow-up.

A key enabler of this digital transformation is Cancer 360, the national centralised cancer data platform designed to support patient tracking, treatment planning and pathway oversight. In 2025/26, Cancer 360 moved from pilot to initial adoption and expansion, with the intention that it will be rolled out across all NHS trusts. This will provide a single, integrated view of each patient's cancer journey, improve MDT coordination, support personalised stratified follow-up, and enable more accurate performance monitoring and pathway optimisation.

In addition, we will adopt wider digital innovations recommended in national cancer guidance, including:

- **Digital pathology networks** to support rapid image sharing and AI-enabled analysis.
- **Remote monitoring platforms** for people living with and beyond cancer – enabling personalised follow-up and reducing unnecessary outpatient visits.
- **Genomic decision support tools** to guide targeted therapies and precision medicine.
- **Digital risk assessment tools** to support earlier identification of high-risk individuals.
- **Enhanced screening informatics** to improve uptake and reduce inequalities.

Maternity

Providers will continue to strengthen digital maturity in maternity and neonatal services in line with national standards – ensuring that women and birthing people can access joined-up, user-friendly digital information throughout their maternity journey. This includes delivering interoperable maternity records, enabling real-time data sharing across providers, and supporting digital tools for personalised care planning, risk assessment and safety monitoring.

Providers will also be expected to improve data quality, contribute to system-wide dashboards, and adopt innovations that enhance safety, reduce variation and improve the experience of families and staff.

Sickness to prevention

We want to ensure that everyone in Shropshire, Telford and Wrekin has a fair opportunity to live a healthy, fulfilling life. We know that health inequalities persist across our area, and these differences have a real impact on people and communities. We will continue to work with partners to tackle what is unfair and preventable, focusing on the wider factors that shape health as well as the services people receive.

Improving health and wellbeing will come not only from high-quality, accessible care, but also from preventing illness, strengthening resilience and supporting people to live well in the places they call home. We recognise that many of the barriers to good health sit beyond traditional health and care services, and we are committed to working alongside local authorities, the voluntary and community sector, and our residents to understand these challenges and create the conditions for healthier lives across Shropshire, Telford and Wrekin.

Our approach to prevention

The NHS 10 Year Plan sets out a clear ambition to shift from reactive care to prevention, expand community and mental health services, reduce health inequalities, and embrace digital innovation.

These priorities align closely with the health needs of Shropshire, Telford and Wrekin and our challenges which can be summarised as follows:

- **Rurality and access** – A large rural geography means many residents face barriers to accessing timely care, creating demand for innovative, locally delivered services.
- **Ageing population** – Higher proportions of older adults lead to increased prevalence of multiple long-term conditions, frailty, and complex care needs.
- **Inequalities** – There are marked differences in health outcomes and life expectancy across the area, particularly between more deprived urban communities and rural localities.
- **Workforce pressures** – National and local challenges in recruiting and retaining clinical staff require more integrated, flexible and sustainable service models.
- **System transformation** – Delivering the neighbourhood health model and strengthening primary care are essential to reducing hospital demand and improving patient outcomes.

Prevention and the shift to prevention has been a consistent theme in the Strategic Direction across Shropshire, Telford and Wrekin with our collective vision being that we 'Focus on developing strong communities where we can reduce inequalities, build the resilience of vulnerable people and families, and concentrate on driving system change so that every area has joined up, efficient local services which are able to identify people and families in need and provide the right support at the right time'. Prevention is also firmly embedded in our Clinical Strategy.

Our jointly agreed key priorities that we will work collectively to deliver are as follows:

- Ensure residents can access information, advice, and support on healthy lifestyles and self-care.
- Expand community prevention Healthy Lifestyles, community and workplace health checks and social prescribing offer – smoking, healthy weight etc.
- Further develop community support for emotional wellbeing and mental health, including social prescribing.
- Best Start in Life – healthy pregnancy, women's hubs, oral health promotion etc.
- Enable and develop strong integrated neighbourhoods including community hubs and spokes.

- Enable communities and the VCSE sector to take more of central role in place-based prevention programmes.
- Bolster community and VCSE infrastructure to unleash the power of communities, health champions and volunteers, business social responsibility, resource communities.
- Integrated community hubs, including Family Hubs.
- Embed person-centred care and approach across all organisations and partners.
- Develop and train front line workforce to ensure we make every contact count – communities, primary and secondary care.
- Expand social prescribing support and tackle inequalities in access and provision.
- Deliver NHS prevention programmes (with effective targeting of inequalities Core20PLUS5 programmes).
- Develop Alcohol Care team and Tobacco Dependency team (maternity, inpatients, serious mental illness), NHS weight management.
- Deliver national screening and immunisation programmes.
- Promote annual health checks for people with learning disabilities, and physical health checks for those with serious mental illnesses.
- Focus prevention activities to reduce inequalities – working across the system to support those in need.
- Intelligence-led targeting of the 'core 20' and 'PLUS' populations in NHS prevention programmes (see above).
- Develop a health literacy programme, including training and awareness raising for staff, linked to the digital exclusion agenda.
- Improve access to NHS dentistry and early access to maternity.
- Prioritise early detection and treatment for long-term conditions.
- Deliver community blood pressure checks, NHS Health Check, targeted lung health checks, early detection of cancer.
- Improve GP management of long-term conditions (such as diabetes care processes) which will evolve over the coming years to include key roles for community pharmacy in managing these patients.

The impacts of our ambitions will be measured by:

1. Reviewing our systems approach to child and adult obesity including community level interventions, NHS programmes and new pharmaceutical interventions to **reduce the number of children and adults classified as obese.**
2. Reducing the smoking prevalence in adults, by **increasing the number of people who successfully stop smoking** with a particular focus on smoking in pregnancy, routine and manual workers, inpatients, and people with learning disabilities and mental illness and through the lung health screening programme.
3. **Decreasing the number of people drinking to harmful and hazardous levels** by improving identification and access to brief interventions and treatment, support and recovery.
4. **Improving the identification and management of hypertension** optimising clinical and non-clinical prevention treatment pathways. Our aim will be to increase the number of people identified with hypertension (BP>140/90) and the percentage of these who are treated to target.
5. **Improving respiratory outcomes by increasing uptake of flu vaccination** with a particular focus on older people and adults with pre-existing health conditions and targeting low uptake groups through neighbourhood approaches.
6. Prioritising access to and quality of health checks for people with learning disabilities and autism, and serious mental illness.

7. **Accelerating plans to tackle adverse infant outcomes** by focusing on women with existing health conditions and those less likely to access services early – to ensure that there is good access to pre-conception advice, early booking and screening.
8. **Accelerating the take up of all childhood immunisations** including MMR – with a particular focus on reducing inequalities in low uptake areas.
9. Taking steps to **improve the oral health of children by maximising** public health interventions and access to NHS dentistry.
10. **Improving early diagnosis of cancer** by commissioning a deep dive on local cancer screening uptake and performance as well as reviewing diagnosis with symptoms. This will set system baselines prior to any delegation of screening responsibilities.
11. Ensuring **early help for those with mental health conditions** by improving access to talking therapies and CYP tier 1 and 2 services.
12. **Reducing drug-related deaths** by optimising access to and benefit from treatment and recovery.
13. Collaborating with the local authorities and VCSE organisations on the **best start in life delivery plans** aimed at improving the good level of development of children at the end of Reception.

Vaccinations, immunisations and screening

Across Shropshire, Telford and Wrekin, joint working between the ICB, provider organisations, local authorities and the voluntary and community sector will be essential to deliver high-quality vaccination, immunisation and screening programmes. A coordinated, system-wide approach will ensure that services are accessible, equitable- and aligned to national expectations.

As part of this approach, we will:

- **Increase uptake of vaccinations and immunisations** by expanding delivery in convenient local settings, enabling individuals and families to receive multiple vaccinations in a single visit. This will be supported by targeted outreach to underserved and high-risk populations to reduce inequalities in uptake.
- **Maximise the digital capabilities of national programmes**, using digital reminders, improved data flows, and NHS App functionality to support practices, streamline administration and increase population uptake across both immunisation and screening services.
- **Prepare for the transfer of commissioning responsibilities** from NHS England to ICBs from April 2027 – ensuring vaccinations, immunisations and screening services are commissioned responsibly, sustainably and in line with national standards.
- **Review and develop screening services** to improve uptake by ensuring capacity is located in the most appropriate and accessible settings, reducing barriers for eligible individuals across rural and urban communities.
- **Establish system-wide governance structures by April 2027** for immunisation and screening programmes, ensuring transformation aligns with the NHS Vaccination Strategy, national service requirements and financial allocations.
- **Participate in the regional strategic review of tuberculosis (TB) management**, due for completion in December 2026, to strengthen cross system approaches to TB prevention, detection and treatment.

Obesity

We will continue to develop our commissioning approach to obesity services in line with NICE guidance, which sets out a whole-system, tiered approach to prevention, early identification and treatment. This includes timely assessment, behavioural interventions, dietary support, physical

activity programmes and access to pharmacological or surgical options where clinically appropriate.

We will initially focus on the commissioning of pathways for targeted groups at higher risk of obesity, including children, young people and underserved communities in line with the whole-system approach and Healthy Weight Strategy in our two Places. We will ensure strong links between primary care, community services, public health and specialist providers – with clear referral criteria, robust outcome monitoring and a focus on reducing health inequalities. Through this approach, we will deliver safe, effective and equitable obesity services that improve long-term health outcomes and reduce preventable disease across our population.

Perinatal, maternity and neonatal services

Our aim in Shropshire, Telford and Wrekin is to ensure that all women and birthing people, babies and families can access high-quality and compassionate maternity and neonatal care. Services will be family-centred, culturally-sensitive and focused on reducing inequalities, improving outcomes and supporting positive experiences for every family.

We will continue to manage clinical quality risks and maintain strong oversight of maternity and neonatal outcomes. This includes monitoring performance, identifying areas for improvement and ensuring providers deliver safe, effective care.

To support this, a clear quality and safety framework will be in place across Shropshire, Telford and Wrekin:

- **Maternity dashboards** – Providers will maintain a maternity dashboard showing key safety and performance indicators, reviewed monthly to identify trends and trigger action where needed. Wider maternity and neonatal performance dashboards will also support system oversight.
- **Incident reporting and investigation** – All incidents, near misses and complaints will be reported and reviewed. Serious incidents including maternal deaths, neonatal deaths and severe brain injuries will be referred to the Maternity and Newborn Safety Investigations (MNSI) programme, with providers required to implement any recommendations. Internal reviews using the Perinatal Mortality Review Tool will include parent involvement and follow national standards.
- **Escalation protocols** – Clear escalation processes will be in place for times of pressure or reduced capacity, following the **ICB maternity escalation framework** and ensuring safe decision making and communication across the system.
- **Workforce governance and culture** – Providers will monitor midwifery, obstetric and neonatal staffing using Birthrate Plus and take action to address gaps, in line with national recommendations including the Ockenden Review. Providers will foster an inclusive, respectful and psychologically safe workforce culture, in line with national recommendations. They will support multidisciplinary teamwork, enable staff to speak up, and embed compassionate leadership. Actions to strengthen staff wellbeing, supervision and collaboration will be required to ensure a positive culture that underpins safe, high-quality care.
- **Service user voice** – Feedback from families, including through the Maternity and Neonatal Voices Partnership, will be central to service improvement and co-design.
- **Benchmarking and external review** – Providers will implement all applicable national recommendations and essential actions, including those from Ockenden, MBRRACEUK and regulatory requirements. They will maintain robust governance systems to track compliance, provide assurance of progress, and implement any required service changes at pace. Providers will also be expected to embed newly issued safety standards, national recommendation, update pathways in line with national updates, and demonstrate improvements through their quality reporting and safety dashboards.

- **Reducing inequalities** – The provider will commit to a population health management approach to maternity care – using data, intelligence and partnership working to understand population needs, target interventions and reduce inequalities. The provider will implement the Continuity of Carer and/or Enhanced Continuity of Carer model – embedding the Core20PLUS5 Framework and expanding community-based maternity care.

Through this approach, Shropshire, Telford and Wrekin will continue to strengthen maternity and neonatal services – ensuring they are safe, equitable and responsive to the needs of local families now and into the future.

Long-term conditions and multi-morbidity pathways

Across Shropshire, Telford and Wrekin, we will continue to prioritise alongside our strengthened approach on prevention, proactive and personalised care for people living with long-term conditions. Our approach will build on the ambitions set out in our Clinical Strategy while moving over the next five years towards a fully integrated model for prevention and chronic disease management. This model reflects the principles of international best practice, including the National Framework for the Integrated Prevention and Management of Chronic Disease.

Our programme of work will be underpinned by the following priorities:

- **Promoting prevention first** – Reducing lifestyle and other modifiable risk factors, working in a more systematic way across public health services and the NHS.
- **Proactive and preventative care** – Earlier identification of risk, systematic risk stratification and strong health promotion activity to prevent deterioration and reduce avoidable illness.
- **Person-centred care planning** – Care plans developed with individuals and their families, supported by digital tools that enable self-management, remote monitoring and personalised advice.
- **Integrated and coordinated care** – Multidisciplinary teams working through neighbourhood models to deliver joined-up support closer to home, reducing fragmentation and improving continuity.
- **Evidence-based clinical management** – Consistent application of NICE guidance across diabetes, respiratory disease, cardiovascular disease and other long-term conditions to ensure high-quality, standardised care.
- **Medication optimisation** – Regular structured reviews to reduce polypharmacy, minimise harm, and ensure treatments remain effective and appropriate.

This integrated model of care will align closely with our new approaches to frailty, palliative, and end of life care. By bringing together ‘teams of teams’ across primary care, community services, acute providers and the voluntary sector, we will create a seamless, end-to-end system for chronic disease management. Our aim is to support people to live well for longer, reduce inequalities, and ensure that care is accessible, coordinated and centred around what matters most to individuals and their families.

Cardiovascular and renal metabolic (CVRM)

We will shift CVRM care from late, reactive treatment to early, proactive prevention through commissioning integrated, neighbourhood-based pathways that identify risk earlier, treat to target, and manage multimorbidity across cardiovascular disease, chronic kidney disease, diabetes, obesity and heart failure. This requires strengthened primary and community capacity to systematically case-find and optimise high-impact interventions – supported by essential diagnostics and consistent clinical standards.

Multidisciplinary hubs will reduce unwarranted variation across practices and rural communities, with Core20PLUS5 ensuring a sharp focus on inequality reduction. The goal is better, not more activity – fewer major cardiovascular events, reduced progression to end-stage kidney disease, and lower system pressure. Local modelling shows that improved secondary prevention could avert hundreds of events within three years and deliver a strong return on investment.

CYP asthma

The CYP asthma pathway will provide a clear, consistent and evidence-based approach to the identification, diagnosis and management of asthma for children and young people. The pathway will include a standardised diagnostic process incorporating FeNO testing, spirometry and clinical assessment to ensure early and accurate diagnosis. A robust risk stratification tool will be embedded within General Practice to proactively identify high-risk CYP and ensure timely intervention.

For children with severe or complex asthma, multidisciplinary team reviews will be established to coordinate specialist input and optimise treatment. The pathway will be delivered in partnership with neighbourhood teams, Family Hubs, PCNs and wider community services to ensure support is accessible close to home.

To build a sustainable, skilled workforce, we will support multidisciplinary work and roll out asthma training across the system. We will also broaden engagement with training to ensure all professionals working with CYP, including schools, primary care, residential care settings and voluntary sector partners, have the knowledge and confidence to recognise and respond to asthma needs.

Preventative activity will be a core focus, with targeted work in areas of greatest need and attention to environmental triggers that contribute to poor asthma control. We will review data from the Digital Health Passport and explore opportunities for local implementation to support personalised care, symptom tracking and improved self-management.

The pathway will align with the five national priorities for CYP asthma – reducing environmental impact, ensuring early and accurate diagnosis, delivering effective preventative medicine, improving management of exacerbations and strengthening care for severe asthma. Primary care will be supported to deliver high-quality asthma reviews, personalised action plans and proactive follow-up.

CYP epilepsy

The CYP epilepsy pathway will provide a comprehensive, proactive and equitable approach to the diagnosis, management and long-term support of children and young people living with epilepsy. A core component of the pathway is a strengthened risk management approach to mortality, including SUDEP (Sudden Unexpected Death in Epilepsy) – ensuring that CYP and families receive clear information, personalised risk assessments and timely access to epilepsy-specific services.

To build a skilled and confident workforce, we will deliver ongoing education and training for system partners, alongside practical resources for practitioners who come into contact with CYP living with epilepsy. This will increase awareness across schools, primary care, community services and social care, ensuring that epilepsy is recognised early and managed consistently.

The pathway will expand access to high-quality epilepsy care closer to home, supporting the left shift from hospital to community settings.

Cancer

Our overarching ambition is to reduce the number of lives lost to cancer. This will be driven by three core goals – improving cancer survival, consistently meeting Cancer Waiting Time (CWT) standards, and enhancing patient experience and quality of life during and after treatment.

To achieve earlier diagnosis and deliver faster elective cancer pathways – supporting the national ambition for 75% of cancers to be diagnosed at Stage 1 or 2 – we will:

- **Commission faster, more efficient diagnostic and treatment pathways** – including one-stop or minimum stop clinics and straight-to-test models wherever possible. This will shorten time to diagnosis and treatment, improve outcomes, and reduce inequalities. We expect this to increase the proportion of cancers diagnosed at Stage 1 or 2, ensure compliance with the 28-day Faster Diagnosis Standard and the 31- and 62-day treatment standards, and reduce variation in early diagnosis by deprivation and geography.
- **Work closely with general practice to implement Jess's Rule** – supporting GP teams to reflect, review and rethink when a patient presents three times with the same or worsening symptoms, ensuring timely referral and reducing missed opportunities for early diagnosis.
- **Prioritise Core20PLUS5 populations** – with targeted screening, outreach and diagnostic access for deprived, rural and underserved communities. We will use Core20PLUS5 data to identify the lowest performing cohorts and focus on narrowing the gap between the least and most deprived. Cancer mortality remains significantly higher in Core20 groups, and screening uptake is notably lower in Telford and Wrekin compared with Shropshire.
- **Increase HPV vaccine uptake across Shropshire, Telford and Wrekin** – working with local authorities and education partners to support the national ambition to eliminate cervical cancer by 2040.
- **Expand access to cervical screening self-sampling kits** – to improve convenience and uptake, particularly for groups who face barriers to traditional screening routes.

We will standardise cancer pathways using national Best Practice Pathways and embed National Best Practice Timed Cancer Pathways across elective services. This will improve productivity, reduce unwarranted variation, and ensure faster, more consistent and patient-centred care. Benefits will include shorter referral-to-treatment times, fewer unnecessary outpatient appointments, improved patient experience, and more equitable outcomes. We will monitor pathway performance by deprivation, ethnicity and age to maintain a strong focus on reducing inequalities.

We will also commission a range of best practice pathways, including the Non-Specific Symptoms (NSS) Cancer Pathway, nurse-led Local Anaesthetic Trans Perineal (LATP) biopsy, pathways for unscheduled bleeding in women on hormone replacement therapy (HRT), breast pain clinics, continued expansion of the faecal immunochemical test (FIT) and ongoing use of patient-initiated follow-up.

To improve outcomes and system flow, we will commission personalised cancer care, ensuring equitable access to psychosocial support, prehabilitation and survivorship services. These interventions will reduce complications, unplanned care and length of stay, while improving treatment tolerance and quality of life. We will strengthen patient activation, shared decision making and personalised navigation through cancer pathways. In addition, we will begin developing our approach to using genomic insights to inform individual risk scores and guide treatment decisions.

Mental health, learning disabilities and autism

A shift from sickness to prevention in mental health, learning disabilities and autism is central to NHS priorities. In Shropshire, Telford and Wrekin, this means acting earlier, intervening sooner and creating the conditions for people to stay well in their communities. Our focus will be on strengthening early identification of need, using population health data to spot rising risk groups, and expanding access to preventative support such as digital self-help tools, community-based wellbeing programmes, and proactive outreach for those most at risk of poor mental health.

For people with learning disabilities and autistic people, prevention also means ensuring timely annual health checks, personalised care plans, reasonable adjustments and improved access to physical health screening to reduce avoidable illness and premature mortality. We will work with schools, primary care, social care and the voluntary sector to build supportive environments that reduce crisis escalation, improve resilience and promote emotional wellbeing from childhood onwards. By embedding prevention across all pathways, we aim to reduce inequalities, avoid unnecessary hospital admissions and ensure people receive the right support as early as possible, enabling them to live healthier, more independent lives.

Special educational needs and disabilities (SEND) 0–25 years

Early identification is fundamental to the prevention of escalation of need, it is noted locally that we are currently lacking diagnostic pathways for certain clinical areas. Therefore, the following areas will be prioritised for action over the coming five years.

- Learning disability
- Foetal alcohol spectrum disorder
- Functional neurological disorder
- Tics and Tourette's.

As identified in the recent Shropshire SEND Joint Strategic Needs Assessment, there is a high occurrence of obesity, or being underweight for children and young people with learning disabilities in our area. It is also acknowledged that there is not currently a public health preventative nursing model delivering care into some of our largest Special Schools (Severndale and The Bridge). Further consideration needs to be given to the model of nursing delivery in these settings.

In line with the Schools White Paper (published February 2026) which sets out the need for early, local, effective and shared care for CYP with SEND, we have a duty locally to focus efforts on preventative care to reduce escalation of need. When these needs are met early, there is a significant reduction in more intensive need required later – noting that the needs of the family holistically must be considered when addressing the needs of the CYP.

Much of the focus of the children's health workforce supporting CYP with SEND is ensuring that adults who spend the most time with CYP can utilise strategies of support to deliver positive outcomes. This is the case for children's therapies, nursing services and increasingly mental health support services. Therefore, it is essential that children's health services effectively utilise training and coaching approaches to ensure effective upskilling of families and education staff who support CYP with SEND.

It is essential that the children's health workforce are adept at upskilling partners to deliver effective outcomes for CYP. Health coaching approaches need to be formalised and considered meaningful contacts in the delivery of high-quality care.

This preventative-based approach will be a golden thread through the SEND and Families First Partnership programme.

Dementia

Research shows more than 944,000 people in the UK have dementia – which is one in 11 people over the age of 65. This number is increasing because people are living longer – by 2030, the number is estimated to be more than 1 million. It is also estimated that more than one third of the population with the condition do not have a formal diagnosis.

Although there is no cure for dementia at the moment, an early diagnosis means its progress can be slowed down in some cases, so the person may be able to maintain their mental function for longer. A diagnosis helps people with dementia get the right treatment and support. It can also help them, and the people close to them, to prepare for the future.

We will continue to embed our dementia vision which focuses on supporting:

- Early help
- Assessment and diagnosis
- Living well
- When circumstances change.

We will aim to continue to identify people living with dementia as early as possible and increase the rate of diagnosis and the number of people who are living with dementia who have a tailored holistic Live Well care plan. We will ensure that their care plan is reviewed annually to ensure it reflects any changes in needs.

Women's health

We will prioritise prevention and early intervention through strong partnership working and strategic alignment across the system – recognising the shared gains that can be achieved when common outcomes and high-impact action areas are identified across programmes. By aligning women's health and perinatal priorities with neighbourhood health, public health and wider system transformation programmes, we will maximise collective impact, reduce duplication and accelerate improvement.

This approach will support improved uptake of screening, preconception care, smoking cessation, weight management and pelvic health support, delivered through neighbourhood health teams and community partners. Workforce development, robust system governance and ongoing engagement with women, girls and communities will underpin delivery.

Through this integrated, intelligence-driven and person-centred approach, women's health and perinatal services will be embedded as a core component of neighbourhood care – supporting safer outcomes, reduced inequalities and sustainable system flow.

Children in care

Children in care experience significantly higher levels of mental health need than their peers – driven by trauma, abuse, neglect and disrupted attachments. Statutory guidance (2015, updated 2022) requires ICBs, local authorities and NHS England to ensure that the health and wellbeing of looked-after children is prioritised, with sufficient resource allocated to meet their needs, including those placed in-area by other authorities.

Unmet mental health need leads to poorer long-term outcomes, increased crisis presentations, placement instability and escalating system costs. A shift from reactive, diagnosis-driven

responses to proactive, trauma-informed support is essential to improve outcomes and reduce avoidable demand across health and care.

The ICB will invest in and expand trauma-informed, psychologically-led provision for care-experienced children and young people across Shropshire, Telford and Wrekin including those hosted from other areas to:

- Improve emotional wellbeing and mental health outcomes
- Reduce crisis escalation, placement breakdown and hospital admissions
- Strengthen multi-agency coordination and decision-making
- Ensure statutory compliance and equitable access for all looked-after children.

Delivery will be achieved through a coordinated suite of programmes:

- Children in care with complex needs.
- NHSE CYP Developmental Service Specification implementation.

These programmes will enhance access to evidence-based therapeutic interventions, increase specialist capacity and embed trauma-informed practice within care settings.

Children with complex needs often require bespoke, multi-agency arrangements beyond standard commissioned provision. To ensure timely, clinically informed decisions, the ICB will:

- Establish a single consolidated process for all individualised commissioning decisions, including continuing healthcare, complex needs panels and EHCP-related funding.
- Strengthen clinical leadership, accountability and alignment across health, education and social care.
- Ensure consistent, transparent and timely decision-making for high-needs cases.

It is anticipated that this will result in:

- Earlier intervention and reduced crisis demand
- Improved placement stability
- Reduced high-cost out-of-area placements
- Better long-term outcomes for care-experienced children and young people
- More efficient use of system resources.

Improving access

This section outlines our system-wide ambition to guarantee timely, equitable and consistent access to high-quality care across all major pathways – including mental health, children and young people's services, primary and community care, urgent and emergency care, elective services and cancer.

Our focus is on reducing long waits, strengthening digital routes into care, expanding early help and preventative support, and addressing the inequalities experienced by those who face the greatest barriers to accessing services.

Overall ambition

Our overarching ambition is to ensure that people across all our care pathways including mental health, children and young people's services, community services, urgent and emergency care, elective care and cancer, receive timely, fair and consistent access to high-quality support. We

aim to meet or exceed national standards by cutting long waits, increasing early intervention and prevention, enhancing digitally enabled access, and prioritising action to reduce inequalities for those with the highest levels of need.

General practice

We will work closely with our GP practices to deliver the requirements of the 2026/27 GP contract from April, ensuring that patients can access care easily and reliably – whether by phone, online or in person during core hours. A key expectation is that every patient will know on the day how their request will be managed, alongside increasing opportunities for people to see their preferred healthcare professional.

To support this, we will implement action plans that strengthen contract oversight, commissioning and transformation across primary care. This includes tackling unwarranted variation, identifying practices that need additional support to meet access or other contractual requirements, and ensuring that extra capacity is commissioned to meet demand during out-of-hours periods and seasonal surges, including bank holidays and weekends.

We will also maintain a strong focus on GP recruitment and retention to improve access to general practice. This will include:

- **ICB funded leadership roles** such as the GP Recruitment and Retention Lead, GP Marketing Lead, GP Trainee Differential Attainment Lead and First 5 GP Lead (supporting GPs in their first five years post CCT).
- **Four funded GP network groups** – First 5s, Mid-Career, Wise 5s and Sessional/Locum GPs – providing regular educational and networking opportunities.
- **An ICB-funded GP locum booking platform** to support retention by making it easier for locum GPs to find work.
- **Delivery of the GP Fellowship Scheme** for newly-qualified GPs, which has been shown to prevent early workforce attrition.
- **Targeted marketing and outreach** to Foundation Year doctors, medical students and sixth form students to promote general practice as a career.
- **A regular GP newsletter** to strengthen professional community and connection.
- **A funded scheme encouraging sessional or salaried GPs to become GP partners**, supporting long-term workforce stability.
- **A funded support and development programme for newly-qualified GPs** in their first post-qualification year.
- **Collaboration with local NHS trusts** to help recruit GPs into specific posts, including funding for associated training.
- **Support for PCNs** in recruiting ARRS-funded GPs.
- **Development of dedicated GP resources** on the Shropshire, Telford and Wrekin Training Hub website.
- **Surveying sessional and locum GPs** to understand under-employment and ensure better utilisation of this workforce.

Through this comprehensive programme, we aim to strengthen the resilience, capacity and sustainability of general practice, ensuring patients receive timely, high-quality care and that the GP workforce is supported to thrive.

Dental

We will work closely with dental practices across Shropshire, Telford and Wrekin to deliver our contribution to the government's commitment to provide an additional 700,000 urgent dental appointments nationally, measured against the July 2023 to June 2024 baseline. Alongside this,

we will support the implementation of post consultation dental reforms to ensure services are modernised, accessible and sustainable and meet pre-COVID routine access for adults and children.

We will also design and implement locally-led quality improvement approaches for dentistry – supported by strong clinical leadership and active communities of practice. These will help improve access, strengthen pathways for patients with high or complex needs, and ensure consistent standards of care. To underpin this work, a dental investment plan has been agreed, including targeted measures to increase capacity in priority areas such as urgent appointments.

Our recurrent commitments include:

- 1) **Expanding the Shropshire and Staffordshire Oral Health Improvement Team** to deliver more targeted preventative programmes such as Brilliant Brushers to tackle the high rates of hospital tooth extraction in children.
- 2) **Providing dental checks in special educational settings** to improve access for children and young people with additional needs.
- 3) **Commissioning additional recurrent Unit of Dental Activity (UDAs)** in local dental access hotspots where poor delivery by existing providers is limiting availability.
- 4) **Commissioning UDAs within existing orthodontic contracts** to ensure patients receiving orthodontic treatment can access the full range of dental services they require.

Optometry

We will continue to embed and expand our Optometry First approach, which provides a framework for commissioning and designing services that respond to rising demand in a sustainable way. This model establishes a coordinated, comprehensive primary eye care service as part of an integrated eye care system, enabling the primary eye care workforce to act as first contact practitioners and broadening the scope of care delivered outside hospital settings.

This approach ensures that patients are appropriately navigated away from other parts of primary care or redirected from hospital eye services, with referrals to secondary care made only when clinically necessary. It also enables patients currently on routine follow-up pathways in hospital or community ophthalmology services to be safely transferred to primary care, delivering faster, high-quality care closer to home and improving overall access.

Our priorities include:

2026/27–2027/28

- Completing phased roll out of Optometry First and embedding all pathways including cataract, glaucoma, medical retina, paediatric eyecare and the community urgent eyecare service (CUES).
- Incorporating optometry independent prescribing into CUES pathway to streamline and reduce demand on general practice and urgent eye clinic where prescribing is needed.
- Exploring potential for Single Point of Referral for eyecare referrals.

2028/29 onwards

- Ongoing cycle of continuous improvement using service user and clinical feedback to improve Optometry First Service.
- Scope potential to further shift services from acute to primary care via Optometry First – for example dry eye, medical contact lens fitting, direct listing for cataract surgery and low vision services.

- Scope potential for further digital innovation using diagnostics and imaging with emerging technology across pathways of eye care.

In addition, core NHS sight testing services will continue to be provided locally for eligible patients through the General Ophthalmic Services (GOS) contract both within optometry practices and through domiciliary services. During 2026/27, it is anticipated that annual sight tests in SEND settings will be commissioned via GOS, as per the national NHS England specification. This work is being led by Office of West Midlands on behalf of the six West Midlands ICBs.

Community pharmacy

Ongoing development and transformation of the community pharmacy sector has already delivered significant improvements in access, outcomes and patient experience across our population. Building on this progress, we will continue to work in close partnership with community pharmacies to strengthen primary care access and expand the role they play within the wider system.

Our priorities include:

- 1) **Embedding pharmacy-first approaches** – ensuring patients can access timely advice and treatment directly from community pharmacies.
- 2) **Strengthening relationships between general practice and community pharmacy** – to support seamless access to pharmacy services and improve patient navigation.
- 3) **Introducing prescribing-based services in community pharmacies during 2026/27** – enabling pharmacists to manage a wider range of conditions and reduce pressure on general practice.
- 4) **Expanding access to emergency contraception** – through community pharmacies to improve convenience and reduce barriers to timely care.
- 5) **Maximising uptake of the Discharge Medicines Service** – helping to reduce medicines-related harm and prevent avoidable hospital readmissions.
- 6) **Making HPV vaccination available in pharmacies** – for women and young people who missed vaccination in school settings.
- 7) **Ensuring all community pharmacies enable prescription tracking via the NHS App** – giving patients real-time visibility of their medicines.
- 8) **Ensuring all primary care services support online medicines requests and management** – improving convenience and reducing administrative burden.
- 9) **Transitioning all messaging to NHS Notify** – with NHS App push notifications becoming the default method of communication.

Through these actions, community pharmacy will continue to play an increasingly central role in delivering accessible, preventative and patient-centred care.

Elective services and diagnostics

Over the next five years, our ambition for elective services alongside our providers is to deliver faster, more reliable and more equitable access to planned care, ensuring patients receive high-quality treatment within clinically appropriate timeframes. We will focus on eliminating long waits, sustaining 65-week and then 52-week compliance, and reducing unwarranted variation across specialities. Elective pathways will become increasingly efficient through greater use of digital tools, streamlined triage, straight-to-test models and expanded use of patient-initiated follow-up.

We will strengthen community-based and virtual outpatient models to free up hospital capacity and improve patient convenience. Diagnostics will continue to expand through Community

Diagnostic Centres, and the adoption of AI-enabled technologies to speed up reporting and improve accuracy. Our ambition is that, by the end of this period, elective services will be more resilient, more productive and more personalised, with improved patient experience, reduced inequalities and consistently strong performance across all key national standards.

We will be aiming to meet the national standards for elective care and diagnostics as outlined in the Medium Term Planning Framework – delivering change together 2026/27–2028/29:

Success measure	2026/27 target	2028/29 target
Improve the percentage of patients waiting no longer than 18 weeks for treatment	Minimum of 7% improvement or 65% whichever is greater	92%
Improve performance against the DM01 diagnostics 6-week wait standard	Minimum of 3% improvement or 20% whichever is better	1%

Cancer

Over the next five years, our ambition for cancer services is to deliver earlier diagnosis, faster and more consistent pathways, and better outcomes for everyone, with a particular focus on reducing inequalities. We will work towards achieving the national goal of diagnosing 75% of cancers at Stage 1 or 2 by expanding one-stop and straight-to-test models, strengthening primary care referral quality, and embedding Best Practice Timed Pathways across all major tumour sites. Performance against the Faster Diagnosis Standard and the 31-day and 62-day treatment standards will be stabilised and improved through increased diagnostic capacity, more efficient elective pathways and targeted action in specialities with the longest waits.

We will also expand personalised cancer care, ensuring people have access to prehabilitation, psychosocial support and survivorship services that improve quality of life and reduce avoidable complications. Alongside this, we will intensify efforts to close the gap for deprived, rural and underserved communities by improving screening uptake, outreach and access to diagnostics. By the end of this period, cancer services will be more equitable, more responsive and more integrated, with measurable improvements in early diagnosis, treatment timeliness, patient experience and long-term survival.

We will be aiming to meet the national standards for cancer services as outlined in the Medium Term Planning Framework – delivering change together 2026/27–2028/29:

Success measure	2026/27 target	2028/29 target
Improve performance against cancer constitutional standards – Faster Diagnosis Standard	80%	80%
Improve performance against cancer constitutional standard – 31-day standard	94%	96%
Improve performance against cancer constitutional standard – 62-day standard	80%	85%

Urgent and emergency care (UEC)

UEC performance across Shropshire, Telford and Wrekin remains among the most challenged in the country. Rising demand, an ageing and increasingly frail population, workforce shortages, limited community capacity and ongoing delays in discharge have created entrenched flow issues across the entire system. These pressures are reflected in poor emergency department performance, extended ambulance handover delays, high numbers of patients with no criteria to reside, and avoidable non-elective admissions.

Incremental improvements will not be enough. Sustainable recovery requires a fundamental redesign of the end-to-end UEC pathway, moving away from a hospital-centric, reactive model towards one that is proactive, neighbourhood-led and focused on flow. Restoring UEC performance is therefore a critical enabler for the wider elective, neighbourhood and productivity ambitions set out in this plan.

Over the next five years, UEC commissioning will prioritise whole-system flow from first contact through to discharge and recovery at home. All commissioning decisions will be tested against whether they improve flow, reduce avoidable admissions, shorten length of stay or accelerate safe discharge.

The system will adopt a 'home first' approach, treating admission avoidance and early supported discharge as core UEC functions rather than optional add-ons.

Expected outcomes over five years

System performance and flow

- Sustained improvement against national ED standards, including reductions in long-stay breaches.
- Reduced average ambulance handover times.
- Improved Category 2 ambulance response times.
- Fewer non-elective admissions per 1,000 population.

Acute flow and discharge

- Reduction in average length of stay.
- Reduced time on no criteria to reside list.
- Increased proportion of discharges via Pathway 0 and Pathway 1.

Community substitution

- Greater use of urgent community response, virtual wards and neighbourhood-based alternatives.
- Reduced ED attendances and ambulance conveyances for cohorts supported by neighbourhood teams.

Patient experience and equity

- Improved patient experience across urgent care pathways.
- Reduced variation in access and outcomes for Core20PLUS5 populations.

Delivery and phasing

UEC recovery will be treated as a system-wide priority. The pace and sequencing of broader transformation will reflect the need to stabilise urgent care flow and release acute capacity first. Commissioning decisions will be aligned to this principle, recognising that sustainable improvements in elective care, productivity and neighbourhood development depend on a functioning and resilient UEC system.

Community services

Over the next five years, community services will be expected to deliver consistently strong performance that supports earlier intervention, reduces pressure on hospitals and improves outcomes for people with complex or long-term needs. This includes meeting clear standards for timely access to community nursing, therapies, rehabilitation and reablement, with measurable reductions in waiting times and unwarranted variation across localities. Services will need to demonstrate improved productivity through better use of digital tools, streamlined pathways and more effective multidisciplinary working within neighbourhood teams.

Performance expectations will also focus on preventing avoidable admissions, supporting safe and timely discharge, and delivering high-quality care at home or close to home. Community services will be required to show year-on-year improvements in patient experience, equity of access and clinical outcomes, particularly for people with frailty, disabilities or multiple long-term conditions. By the end of the five-year period, we will expect community services to be more proactive, more integrated and more responsive, with clear evidence of their impact on population health and system flow.

We will be aiming to meet the national standard for community services waiting times as outlined in the Medium Term Planning Framework – delivering change together 2026/27–2028/29:

Success measure	2026/27 target	2028/29 target
Improve the percentage of patients waiting no longer than 18 weeks for community services	78%	80%

Learning disabilities and autism (LDA)

Our ambition for LDA services over the next five years is to ensure timely, equitable and high-quality support across the whole pathway, with a strong focus on prevention, early intervention, and reducing avoidable hospital admissions.

We will undertake a full assessment of the actions required to improve access and outcomes for adults with a learning disability and/or autistic adults, supported by clear commissioning and service delivery plans. Delivery will rely on close partnership with local authorities and mental health providers, particularly in relation to housing, social care, community support and specialist health provision.

We will work collectively with system partners to reduce admission rates for children under 18, recognising that current numbers are very low. Our ambition is that any admission is an absolute exception, with all children supported safely in the community wherever possible. Local authorities and mental health providers will play a central role in delivering this ambition through strengthened early help, crisis support, and wrap-around care.

We will strengthen partnership working to ensure timely, safe and person-centred discharge for individuals who require an inpatient stay. This includes coordinated working between inpatient services, Community Learning Disability Teams, local authorities and the Transforming Care

team. Our aim is to avoid unnecessary delays, prevent deterioration and ensure people return to the least restrictive setting as soon as clinically appropriate. This will include compliance with national requirements for Care (Education) and Treatment Reviews (C(E)TRs) and maintaining an accurate Dynamic Support Register (DSR) for adults and children at risk of admission.

We will continue to increase uptake of annual health checks (AHCs) for people aged 14+ with a learning disability, alongside ensuring completion of Health Action Plans (HAPs). Our ambition is to increase the proportion of completed HAPs beyond the current expected position of 81% for 2025/26. Improving AHC and HAP coverage will support earlier identification of health needs, reduce avoidable illness, and improve communication and outcomes for individuals. This aligns with national NHS requirements to reduce premature mortality and improve physical health outcomes for people with a learning disability.

For all-age neurodiversity (autism and ADHD), although there are currently no formal national planning requirements, we have completed a comprehensive pathway review in response to significant national and local challenges in capacity and access. This review, co-produced with service users, carers and professionals, will inform a new pathway from 2026/27, ensuring needs led pre and post-diagnostic support and improved access. We will also incorporate recommendations from the national ADHD Taskforce and any future national reviews into neurodiversity services.

We will continue to work with commissioned providers to improve access to autism and ADHD assessments for both children and adults, recognising that demand significantly exceeds available resource. Access, equity and sustainability will be key considerations in future commissioning and pathway redesign.

We remain committed to ensuring that autistic people and people with a learning disability receive high-quality, person-centred mental health inpatient care when required. National evidence shows these individuals are more likely to experience mental health challenges, and therefore inpatient services must provide appropriate reasonable adjustments, personalised care planning and trauma-informed approaches. Their involvement in service design and quality improvement will help create more accessible, recovery-focused and efficient inpatient pathways. We will also continue to deliver improvements in LeDeR (Learning from Lives and Deaths) processes to ensure learning is embedded and inequalities are addressed.

We will be aiming to meet the national standard for learning disability and autism as outlined in the Medium Term Planning Framework – delivering change together 2026/27–2028/29:

Success measure	2026/27 target	2028/29 target
Reduce reliance on mental health inpatient care for people with a learning disability and autistic people	10% reduction each year	10% reduction each year

Mental health

Our ambition for mental health services is to improve access, reduce unwarranted variation and ensure people receive timely, high-quality care in the most appropriate setting.

We will reduce the number of inappropriate adult acute mental health out-of-area placements (OAPs). A key barrier is the absence of a local Psychiatric Intensive Care Unit (PICU). To address this, capital has been allocated to develop a 12-bed PICU at Redwoods in Shrewsbury by 2028/29. This will support local access, reduce length of stay, and improve continuity and quality of care, working in partnership with Staffordshire and Stoke-on-Trent ICB to ensure regional flexibility.

Through the Inpatient Quality Transformation Programme (IQTP), we will work with Midlands Partnership University NHS Foundation Trust (MPFT) to reduce average length of stay. This will require strong collaboration with local authorities and the VCSE sector to improve discharge pathways and reduce the proportion of people who remain in hospital despite being medically fit for discharge. Reducing length of stay will also reduce reliance on OAPs and improve access to local beds.

We will work with acute providers to reduce the number of adults and children waiting excessive periods in A&E (12-hour UEC breaches), improving patient experience and supporting UEC care flow. This aligns with national NHS performance requirements for mental health crisis response and reducing avoidable delays.

We will continue to expand Talking Therapies to ensure timely access and improved performance against national metrics, including reliable recovery, reliable improvement and treatment completion rates.

We will expand Individual Placement Support (IPS) services in line with national ambitions to increase access to employment support for people with serious mental illness.

We will maintain access rates for specialist perinatal and maternal mental health services, building on our strong performance in recent years and ensuring continued compliance with national targets.

We will deliver improvements in CYP mental health access, in line with our remedial action plan, with full recovery expected by July 2026. This will reduce waiting times and improve access, supported by the rollout of the new CAMHS model.

We will continue to monitor and improve local mental health services not subject to national planning requirements, including:

- Community mental health services for adults
- Physical health checks for adults with serious mental illness
- Assertive outreach services
- Crisis pathways, including the Crisis Text service
- Liaison psychiatry in acute hospitals
- Adult mental health rehabilitation services
- Dementia and memory assessment services

Performance and quality will be monitored through provider contracts, with any concerns addressed through established contractual mechanisms to ensure access, safety and outcomes continue to improve.

We will be aiming to meet the national standard for mental health as outlined in the Medium Term Planning Framework – delivering change together 2026/27–2028/29:

Success measure	2026/27 target	2028/29 target
Expand coverage of mental health support teams (MHSTs) in schools and colleges (including teams in training)	77%	94%
Meet the existing commitments to expand NHS Talking Therapies – reliable recovery	51%	53%
Meet the existing commitments to expand NHS Talking Therapies – reliable improvement	69%	71%

Success measure	2026/27 target	2028/29 target
Eliminating inappropriate out-of-area placements	Reduction each year	Reduce or maintain at zero

Special educational needs and disabilities (SEND) 0–25 years

As identified in sections regarding learning disability and autism and mental health, access to services which support CYP with SEND needs to be improved. At present, lengthy waiting times for access to speech and language therapy (SLT) and neurodevelopmental diagnostic assessments often result in escalation of need. Additionally, there continues to be a national postcode lottery for access to diagnostic services for other conditions such as foetal alcohol spectrum disorder. However, while considering the importance of diagnosis, it is equally important to ensure that needs-led services are commissioned across the partnership to deliver the support required without relying on a diagnosis.

Accessible information can enable families and partners to support CYP with SEND whilst waiting for appointments. Efforts have been made to improve the information provision however more needs to be done to ensure that there is sustainability for digital platforms (such as the Healthier Together website) alongside a robust communication plan.

At present, children's health services including SLT, occupational therapy, physiotherapy, child development centre and neurodevelopmental support in CAMHS offer telephone support. However, more needs to be done to ensure high quality advice and support can be provided via calls and online in a timely way. This does not negate the need for face-to-face services but provides graduated support while waiting and can reduce the requirement for full referrals. CAMHS neurodevelopmental pathway drop-in sessions supported by local Parent Carer Forums have proved an effective way to deliver care in accessible environments. Further roll-out of this approach is necessary across services to ensure timely support, preventing escalation of need.

Action needs to be taken to address processes regarding equipment, notably but not solely for those with physical disabilities and occupational therapy needs. A partnership approach is required to develop increasingly robust processes which ensure that equipment is recommended and procured in a timely way.

Productivity and efficiency

The national 10 Year Plan places productivity and efficiency at the heart of NHS reform, recognising that the health service cannot remain sustainable without major improvements in how care is organised, delivered and supported through modern technology.

Overall ambition

We will maximise the value of our resources by eliminating duplication, streamlining pathways, expanding the use of digital tools and reducing unwarranted variation – ensuring that every pound spent delivers better outcomes for local people. Improving productivity and efficiency is fundamental to building a sustainable health and care system. By simplifying how people move through services, cutting delays and using technology more effectively, we can release capacity, improve patient experience and enable staff to focus on delivering high-quality care. This will help us respond to rising demand, support our workforce and accelerate the shift towards prevention and community-based care.

Our ambition is to create a system where processes are efficient, digital solutions save time for both staff and patients, and services operate consistently and effectively across all settings.

Productivity and efficiency are not standalone workstreams – they underpin every part of this plan and are essential to delivering better outcomes across neighbourhoods, Places and the wider system.

To achieve this in Shropshire, Telford and Wrekin, we will:

- **Deliver our system-wide efficiency programme** – aligning actions across urgent and emergency care, planned care, primary care, medicines optimisation, individual commissioning, integration and community neighbourhood transformation to maximise impact.
- **Strengthen value-based commissioning** – ensuring financial decisions prioritise prevention, neighbourhood models and reduced reliance on hospital-based care.
- **Use our Strategic Decision-Making Framework** – to ensure evidence-based commissioning decisions are undertaken including using a health economic value-based assessment.¹
- **Reduce unwarranted variation** – by standardising pathways and sharing best practice so that people receive consistent, high-quality care regardless of where they live.
- **Eliminate duplication and improve flow** – through digital triage, Advice and Guidance, community triage, pathway redesign, UEC modelling and actions aligned to Discharge to Assess.
- **Maximise digital enablers for efficiency** – including Docman Connect, expansion of the NHS App, digital Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) and Electronic Palliative Care Coordination Systems (EPaCCS) records, remote monitoring, virtual wards and continued development of integrated electronic patient records.
- **Improve medicines efficiency** – through increased biosimilar uptake, deployment of AnalyseRx®, robust medicines horizon scanning and implementation of the Single National Formulary.
- **Reduce avoidable hospital admissions** – by strengthening neighbourhood-based multidisciplinary teams, expanding risk stratification, early intervention and targeting prevention where it will have the greatest effect.

These actions will help us manage rising demand, support our workforce, reduce waste and reinvest resources where they will make the biggest difference for our citizens.

Individual commissioning

In Shropshire, Telford and Wrekin, individual commissioning is a key driver of excess costs, this is supported by the nationally-produced ICB productivity packs which benchmark spend per 50,000 head of population. Due to the demographic and rurality of our area, some of this excess cost is warranted and some of it is unwarranted.

The key areas of unwarranted variation to be addressed through the Five Year Strategic Commissioning plan are to develop and implement an improved quality offer for patients at end of life and to complex children not eligible for continuing healthcare. We will also take a different approach to market management in conjunction with local authority partners to reduce the overall cost of care to deliver better value for money for individual commissioning.

¹ [What is value-based healthcare? | HFMA](#)

Urgent and emergency care (UEC)

Aligning financial arrangements across UEC contracts will enable more strategic planning and a clearer understanding of future service requirements. Providers will continue to undertake robust demand and capacity forecasting across all urgent pathways, ensuring accurate modelling that can be regularly reviewed and refined.

The UEC Improvement Programme is delivered through a series of linked workstreams designed to strengthen demand management, access and flow. These improvements will enhance patient experience, increase ambulance capacity and support delivery of key UEC performance measures, including four-hour and 12-hour standards, while ensuring that we maximise investment into community services and reduce the reliance on our acute-based services.

Elective care

Improving productivity and efficiency across planned care in Shropshire, Telford and Wrekin is essential to reducing waiting times, making best use of available capacity and ensuring patients receive timely, high-quality treatment. As demand continues to rise, we will redesign pathways to remove duplication, eliminate unnecessary steps and embed digital tools and modern clinical models to support more effective working.

To support new models of care, we will explore opportunities to commission lead provider models where these can improve coordination across speciality pathways, enhance patient experience and create the conditions for innovation, economies of scale and greater efficiency such as the planned MSK Provider Collaborative led by RJAH. From 2026, we will embed clear productivity and efficiency standards into provider contracts, including improved theatre utilisation, reduced follow-up appointments, increased use of patient-initiated follow-up (PIFU) and a greater proportion of procedures delivered as day cases or in outpatient settings.

We will also look to align the commissioning of the Independent Sector with our Acute providers to ensure capacity is managed in line with our ambitions and set clear Indicative Activity Plans (IAPs) and Activity Management Plans (AMPs) to ensure that we have equitable access for our population when utilising elective services. These changes will help us treat more patients, deliver performance against NHS England metrics, reduce delays and deliver better value for the NHS.

Primary care

Primary care across Shropshire, Telford and Wrekin will be strengthened through digital innovation, modernised estates, and continued workforce development, including new roles and skill mixes. This will enable primary care to meet rising demand, support people with long-term conditions and deliver sustainable, high-quality services at neighbourhood level. As practices increasingly work together through collaboratives and neighbourhood teams, Locally Commissioned Services (LCS) will need to evolve to support delivery of universal services at scale where appropriate.

Medicines optimisation

We will take a system-wide lead on medicines finance, including developing the ICB's medicines-related cost improvement plan, setting efficiency targets within commissioned services, and establishing robust financial controls as neighbourhood health services mature. Our overarching aim is to support long-term financial stability across NHS services in Shropshire, Telford and Wrekin.

National Specialist Pharmacy Services publishes an annual medicines outlook that enables us to horizon scan for emerging cost pressures and opportunities to deliver efficiencies. The ICB spends around £136 million of total drug spend of which approximately £96 million is driven by primary care prescribing. Commissioning arrangements with general practice are already in place, and the service specification will be updated to reflect new cost-saving opportunities.

The ICB works closely with pharmacy teams across the acute, mental health and community trusts to share intelligence on high-cost medicines used in secondary care and to maximise opportunities for efficiencies across the system.

As neighbourhood health services develop, new financial controls will be required, supported by close collaboration between finance teams and the medicines optimisation function.

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Section 4 – Financial ambitions over the five years

Finance is more than balancing budgets; it is a critical foundation of strategic commissioning and population health improvement. By aligning resources to the greatest areas of need and value, finance ensures 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 (STW) and Staffordshire and Stoke-on-Trent (SSOT) over the next five years. It brings together the STW Finance Strategy (approved June 2025), the STW Joint Forward Plan (2025–2030), and SSOT's Joint Forward Plan Finance Strategy (2023–28) into a single, coherent framework.

The plan is firmly rooted in the Medium Term Planning Framework (2026/27–2028/29) and the government's 10 Year Plan, Fit for the Future. It embeds the three major system shifts, hospital to community, analogue to digital, and sickness to prevention, directly into commissioning, contracting, incentives and capital investment programmes.

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 priorities and deliver maximum value. During the planning stage, financial analysis and data-driven insights help identify cost drivers, inefficiencies, and opportunities to improve value. Budgets are aligned to strategic priorities, supporting the left shift to prevention, community-based care, and digital innovation. At the procurement stage, finance shapes contracts and payment mechanisms that incentivise outcomes, 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 plan set out in Section 3 will require significant changes in how resources are allocated, with greater investment moving towards neighbourhood models, proactive care and evidence-based prescribing. 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. This ensures that medicines optimisation contributes directly to delivering the wider system priorities and achieving financial sustainability across the ICB.

Joint financial vision

Our shared financial 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 some financial flexibility to fund key commissioning priorities

- Use value-based strategic decision making to guide resource allocation, supporting delivery of the 10 Year Plan's left-shift priorities and reducing spend in acute and resource-intensive settings.

Context – challenges, opportunities and shared values

Both systems start this Five Year Strategic Commissioning Plan with significant financial challenges, but our Three Year Financial Plan sets out a clear route to achieving financial balance. We share common cost pressures and opportunities to spend more effectively, which shape our focus, particularly in:

- urgent and emergency care
- workforce
- productivity and efficiency
- continuing healthcare.

To address these challenges, we have agreed a System Collaborative Financial Management Agreement, implemented via system-commissioned contracts. This means decisions about resource allocation and risk management are made collectively, underpinned by trust across organisations, places, and the wider system. This approach ensures a clear line of sight from problem identification to action and measurable outcomes.

Strategic vision and key strategic aims

Our overarching ambition is to return both ICBs to a sustainable financial position, create headroom for strategic investment, and embed value-based decision making to support the 'left shift' and reduce reliance on acute and high-cost services.

We will achieve this by:

- Making data-driven decisions to ensure transparency and accountability.
- Prioritising and aligning capital and revenue resources to deliver the greatest health value.
- Embedding financial stewardship across the system to support transformation and long-term sustainability.

Key strategic aims

1. **Achieve financial sustainability** – Establish a balanced financial position through targeted cost reductions, productivity and efficiency improvements, delivery of transformation programmes and realignment of resources.
2. **Maximise value from investment** – Ensure that investment in prevention, community services and digital care grows in line with allocation uplifts. Direct funding towards interventions using a health economics approach to the delivery of value² to improve outcomes, enhance system efficiency and support preventative and community-based care.
3. **Enable transformation through strategic investment** – Use capital and revenue investment to support service transformation, digital innovation and workforce development, improving quality, efficiency and integration.

² Value is assessed using best practice definitions of the assessment of economic value as set out by the Healthcare Financial Management Association - [What is value-based healthcare? | HFMA](#)

4. **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.
5. **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

Oversight and assurance are provided through the ICB Finance Committee, reporting to the ICB Board. This includes:

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 the Mental Health Investment Standard and Dental ring-fence).
- Implementing efficiency and transformation plans to achieve a medium-term break-even position.

Assurance is supported by monthly finance, efficiency and transformation reports, alongside quarterly thematic deep dives (for example – Medium-Term Finance Plan 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 with in-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 Shropshire, Telford and Wrekin and Staffordshire and Stoke-on-Trent. 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
 - Use of diagnostic hubs
 - 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 of neighbourhood focus, prevention, and digital innovation, alongside our quality and performance standards.

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 and will draw on best practice health economic value evaluation methodology.³

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.

³ [What is value-based healthcare? | HFMA](#)

Capital investment approach

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

- Diagnostics, including opportunities for new community diagnostic centres in Shropshire, Telford and Wrekin and Staffordshire and Stoke-on-Trent
- 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 clear approval points at key stages, clinical safety approval, compliance with Digital Technology Assessment Criteria (DTAC), and regular quarterly reports on benefits. 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.

Revenue investment approach

All investments will be scored through the Strategic Decision-Making Framework to provide a relative prioritisation of investment with affordability using a health economic value-based assessment methodology.⁴

Key performance indicators (KPIs)

Achieve financial sustainability

- Annual break-even position
- Reduction in underlying deficit
- Compliance with 'Grip and Control' requirements.

Maximise health value

- Return on investment

⁴ [What is value-based healthcare? | HFMA](#)

- Reduction in cost per outcome
- Compliance with the Commissioning for Value framework.

Enable transformation

- Capital prioritisation and utilisation
- Adoption of outcomes-based contracting.

Embed financial stewardship

- Financial governance assurance rating
- Internal audit substantial assurance.

Strengthen collaboration

- Medium-Term Financial Plan triangulation
- Delivery of system-wide efficiency programmes.

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.

Section 5 – People and workforce

This sets out how we will develop, support, and sustain the workforce needed to deliver high-quality health and care services across Shropshire, Telford and Wrekin and Staffordshire and Stoke-on-Trent. It explains the challenges our systems are currently facing, including financial pressures and increasing demand, as well as the opportunities created through national workforce reforms and closer partnership working. 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 across the system.

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. To deliver this, 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 up to date workforce data covering experience and wellbeing, stability, supply, and future pipeline throughout the commissioning cycle is essential to ensuring safe, equitable, and sustainable services. A consistent focus on workforce enables responsible, data-driven commissioning aligned to statutory duties and health inequality objectives, shaping decisions at every stage of the cycle.

Given the scale of change signalled within our commissioning intentions, the future health and care landscape will require an agile, flexible workforce under the ethos of 'right staff, right skills, right place' (NQB 2016). To support our five key system shifts and deliver population-centred care models, 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.

The ICB must also ensure urgent care workforce models balance generalist and specialist roles, and that sufficient capability is commissioned to support wellbeing and self-management. Through these levers, the ICB enables a sustainable workforce that improves access, reduces inequalities, and relieves pressure on acute services across the systems.

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.

System convening

This involves strengthening partnerships and collaboration across all our strategic partners, including NHS, primary care, local authority, social care, and voluntary and education 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.
- Across Shropshire, Telford and Wrekin, significant progress is already being made to establish INTs, bringing care into the community and achieving the 'left shift' – reducing demand on our acute hospitals and leading on prevention strategies. This will be rolled out across all PCN footprints and is embedded within the workforce plans of acute and community providers.
- The Shropshire, Telford and Wrekin Pharmacy Workforce Strategy identifies key initiatives for bolstering community pharmacy, embedding the Pharmacy First approach and supporting the 'left shift'. It has been co-produced by members of the Shropshire, Telford and Wrekin Pharmacy Faculty and is now being developed into a programme plan designed to achieve transformation across the pharmacy workforce, delivered in collaboration with partners across both Shropshire, Telford and Wrekin and the region.
- The Shropshire, Telford and Wrekin Shared Services programme promotes a real shift in system working across the STW/SSOT cluster. The focus is on helping our workforce work more effectively and make better use of our shared resources, so we can offer improved opportunities for staff and deliver better outcomes for our population. The HR workstream prioritises temporary staffing including establishment of a collaborative bank, recruitment and occupational health.
- 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 are needed to enable outcomes-based commissioning of new care and service models, and contract management.
- The ICB will continue to work with providers to ensure that their workforce plans continue to align to our priorities. The SaTH/SCHT group model facilitates much closer alignment between acute and community settings alongside the MSK Provider Collaborative led by RJAH.
- Workforce plans are being developed based on workforce modelling to determine shift in demand and supply that will inform our response to recruitment and retention including upskilling, 'grow your own' pathways, and 'skills passports' to facilitate cross-sector working and expansion of apprenticeship schemes.

Socio-economic and anchor model

- Commissioning for reductions in health inequalities through workforce – 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 via system partnerships.
- 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 the NHS England Strategic Commissioning Development Programme. This will strengthen our payor function, support delivery of the new operating model, and enable effective implementation of neighbourhood health and integrated health organisations.
- Engagement with the national strategic commissioning development programme to focus on improving commissioning capability at pace.

Looking after our ICB workforce

Prioritising staff health, engagement, and inclusion is essential to reducing burnout, improving retention, and fostering a positive culture within the ICB and across the system. By creating an environment where staff feel supported, heard, and valued, we will strengthen resilience, improve outcomes for patients, and enable sustainable transformation. This is of particular importance during reform and transition, as our workforce navigates the challenges associated with clustering and merger.

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

- Creating opportunities for staff to shape decisions through forums and feedback mechanisms (for example – Staff Survey and pulse checks).
- Recognising and celebrating achievements to build morale and motivation.
- Ensuring transparent communication about organisational priorities and changes.

Inclusion and belonging

- Further embedding equality, diversity, and inclusion in all workforce policies and practices.
- Offering training and development to strengthen and support inclusive leadership.
- Fostering a culture where every individual feels valued and respected.

Retention and development

- Investing in career pathways and continuous professional development.
- Supporting succession planning and talent management.
- Addressing workload pressures through workforce planning and resource allocation.

Section 6 – Enablers

Digital, data and technology

Digital technology and effective use of data are fundamental to delivering high-quality, joined-up care across Shropshire and Telford and Wrekin. This is not only about having the right systems in place – it is about creating a culture where staff have the skills, confidence and tools to use information well, make informed decisions and continuously improve services.

Our ambition is as follows:

- 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 social care.
- Implement national data platforms in line with agreed timelines, ensuring full interoperability across all local providers.
- Strengthen data sharing agreements and governance frameworks to safeguard privacy and support the safe, appropriate use of linked datasets.
- Build analytical capability and competence within the ICB, including health economists, analysts and data scientists, to interpret complex data and facilitate actionable insights for the system.
- Develop outcome dashboards and predictive analytics tools to support commissioning decisions and enable real-time monitoring of progress.
- Improve forecasting and modelling techniques using near real-time data to identify pressure points across hospitals, community teams, social care, pharmacies and urgent community response services.
- Use population health management tools to strengthen system-wide intelligence and shared understanding.
- Deliver the data infrastructure required, agreeing a fit-for-purpose data architecture and mobilising a plan to implement it across the system.
- Co-design digital solutions with clinicians and service users, ensuring they are intuitive, accessible and deliver meaningful benefits.
- 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.
- Explore and, where appropriate, develop AI-enabled solutions to support Advice and Guidance and patient-initiated follow-up (PIFU).
- Explore how we support virtual wards providing increased monitoring and digitising diagnostics to maximise capacity and improve productivity.
- 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 across all care settings.
- Adopt a 'digital by default' approach to support targeted, preventative interventions that improve outcomes and reduce demand.
- Support major acute providers, to secure approval for NHS business case investment in modern digital infrastructure and ensure all providers progress towards an integrated Electronic Patient Record (EPR) service.
- Support the implementation of Child Protection Information Sharing Service phase 2.
- Develop with partners a system wide SEND data dashboard to consider demand and support future planning of services to meet need.

Estates and infrastructure including the Green Plan

Modern, flexible estates are fundamental to delivering integrated care across Shropshire, Telford and Wrekin and to supporting the shift from hospital-based services towards neighbourhood and community-led models. Our Estates Strategy sets out a vision for a well-planned, networked estate that supports multidisciplinary working, digital-first pathways, and sustainable service delivery across all parts of the system.

This includes the development of neighbourhood hubs that bring together primary care, community services and voluntary sector partners; Community Diagnostic Centres that improve access to tests and reduce waiting times; and modernised acute facilities that support elective recovery and strengthen urgent and emergency care. Alongside this, our system-wide Green Plan ensures that all estate developments embed sustainability, energy efficiency and low-carbon design.

Collectively, these changes will accelerate the 'left shift' from hospital to community, making care more accessible, proactive and closer to home, while helping us meet our net zero commitments.

- Align estates planning with commissioning intentions and the commissioning cycle – ensuring that investment decisions directly support our strategic priorities.
- Prioritise schemes that expand community and primary care capacity, enhance diagnostic provision, support elective recovery and strengthen urgent care resilience.
- Ensure all estates upgrades are fully aligned with digital infrastructure programmes, including the Shared Care Record, interoperable Electronic Patient Records and wider digital first pathways.
- Embed sustainability principles in every project – guided by our Green Plan – to reduce carbon emissions and support long-term environmental resilience.
- Work collaboratively with partners across the NHS, local authorities and the VCSE sector to deliver co-located services and neighbourhood models that reduce duplication, improve access and make best use of shared assets.

Equality, diversity and health inequalities duties (ED&I / PSED / Core20PLUS5)

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.

We design our services so they work for everyone, especially those who may face barriers or have poorer outcomes, and we work with a wide range of providers, including voluntary and community-led organisations, to make this happen. 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

Safeguarding is a core statutory duty and fundamental to delivering safe, high-quality care, and we will ensure strong arrangements are in place to protect both adults and children in line with the Care Act and Children Act. All commissioned services will be required to meet safeguarding standards and maintain appropriate training, 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 and person-centred care.

The implementation of the Families First Partnership programme guidance will support early identification of need and intervention for families which all commissioned services will contribute towards.

The learning from safeguarding reviews – including Child Safeguarding Practice Reviews, Rapid Reviews, Domestic Homicide Reviews and Safeguarding Adult Reviews – will continue to be embedded across the system for sustained change, with assurance provided to each safeguarding partnership.

Emergency preparedness, response and resilience (EPRR)

We are 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.

Section 7 – Risks and mitigations

Risk Number	Risk and description	Risk score (consequences x likelihood)	Mitigations	Target risk score (consequences v likelihood)	Committee/ICB oversight
Finance					
1	Delivery of the Revenue Financial Plan Failure to achieve planned financial balance due to rising demand, performance pressures, and cost challenges, including efficiency delivery.	Likely 4 x Major 4 = High 16	- Refresh the Medium Term Financial Plan on a regular basis and the Long Term Financial Plan on an annual basis. - Implement actions to support the delivery of the overarching Financial Strategy. - Continue robust financial controls including pay vacancy control panel and non-pay discretionary spend controls, monthly monitoring including recurrent underlying. - Accelerate delivery of efficiency and productivity programmes (minimum 2% annually for each). - Maintain a risk reserve to offset unforeseen pressures where possible. - Conduct scenario planning for inflation, cost pressures, performance and activity variations. - Use collaborative procurement and contract renegotiation to secure best value. - Prioritise revenue and capital investment/disinvestment to ensure value for money and support the 'left shift'. - Progress the agreed System Strategic Transformation Programme delivery, utilising the system-wide Financial Improvement Programme financial governance to track efficiency and productivity savings including Programme Management Office (PMO) support as required. - Embed efficiency schemes into provider contracts with clear accountability. - Use productivity information, best practice, benchmarking and digital tools to identify further opportunities. - Apply dynamic activity modelling and demand management strategies. - Invest in community and prevention programmes to reduce acute pressure including neighbourhoods, community and primary care.	Possible 3 x Major 3 = Moderate 9	System Finance Committee in Common

2	Delivery of the Capital Financial Plan Delays or overspend on capital projects impacting depreciation and financial sustainability.	Likely 4 x Major 4 = High 16	- Continue to utilise a Capital Prioritisation Oversight Group with strong governance and assurance processes to ensure effective planning, oversight and management of capital. - Prioritise system strategic capital to support delivery of the commissioning plan priorities and phased delivery to align with available funding envelopes and support performance and quality standards alongside digital transformation, constitutional standards, estates safety and 'left shift'. - Regularly review capital prioritisation against strategic objectives using the agreed capital prioritisation scorecards.	Possible 3 x Major 3 = Moderate 9	System Finance Committee in Common
3	Changes in national policy Revenue and capital allocations or financial framework/business rules affecting planned trajectories and the NHS payment scheme.	Likely 4 x Major 4 = high 16	- Maintain close engagement with NHS England and the Department of Health and Social Care for early visibility of changes. - Build flexibility into financial plans to adapt to policy shifts. - Develop contingency scenarios for funding reductions and NHS payment scheme changes. - Work collaboratively with providers on the impact of national policy – for example referral to treatment times, breaking down block contracts, and marginal rates for urgent and emergency care activity.	Possible 3 x Major 3 = Moderate 9	System Finance Committee in Common
Workforce and people					
4	50% reduction in ICB running costs Potential capacity challenges in being able to deliver the full Five Year Strategic Commissioning ambition due to human resource and limited capacity following the voluntary redundancy process and management of change.	Possible 3 x Major 4 = 12	- Prioritise commissioning activity to focus limited capacity on the highest impact programmes. - Strengthen shared functions and pooled expertise across the system to reduce duplication. - Use standardised commissioning, business case and programme tools to streamline workload. - Improve forward planning and sequencing of work to avoid overstretching reduced teams. - Enhance digital tools and automation to reduce manual corporate workload and free-up staff for strategic tasks.	Possible 3 x Major 3 = Moderate 9	Transition Committee in Common
5	Back-office cost reduction in our NHS providers Potential capacity challenges in freeing up of resource to support the planning and delivery of the 'left shift' and service changes due to reduction in corporate capacity to cover pathway redesign and development of business cases.	Possible 3 x Major 4 = 12	- Prioritise transformation and 'left shift' programmes so limited corporate capacity is focused on the highest impact areas. - Strengthen shared corporate, analytical and Project Management Office functions across providers to reduce duplication and pool expertise. - Use standardised pathway redesign tools, templates and business case frameworks to streamline work and reduce workload. - Improve programme planning to sequence work realistically and avoid overstretching reduced corporate	Possible 3 x Major 3 = Moderate 9	Strategic Commissioning Committee in Common

			teams. Enhance digital tools and automation to reduce manual corporate workload and free-up staff for transformation activity.		
6	Workforce shortages across sectors limit service delivery and transformation Rising demand, sickness absence, burnout and industrial action may reduce workforce supply across acute, community, primary care, mental health, learning disabilities and autism and social care.	Possible 3 x Major 4 = 12	- Strengthen recruitment across all sectors including expanded training pipelines, apprenticeship schemes and 'grow your own' pathways. - Improve retention through flexible working, wellbeing support and reduced administrative burden. - Expand multidisciplinary teams to reduce pressure on scarce roles. - Enhance sickness management and early intervention to reduce absence. - Implement Health and Wellbeing Action Plans. - Maintain system-wide contingency plans for industrial action. - Use population health approaches and prevention to reduce avoidable demand. - Strengthen cross sector workforce planning and shared roles across health and social care. - Invest in digital tools and interoperability to improve productivity and free-up clinical time.	Possible 3 x Major 3 = Moderate 9	People, Culture and Inclusion Committee in Common
7	Insufficient GP numbers to meet population need There is a risk that general practice will not have sufficient GP numbers to meet the needs of the local population. Contributing factors include an ageing GP workforce, recruitment challenges in rural and deprived areas, high workload pressures, limited training capacity, increasing demand from an ageing population, and reliance on locum cover. Insufficient GP capacity may lead to reduced access, longer waits, increased pressure on urgent and emergency care, and poorer patient outcomes.	Likely 4 x Major 4 = High 16	- Expand GP recruitment and retention schemes. - Increase training and fellowship opportunities. - Strengthen multidisciplinary teams to reduce GP workload. - Targeted support for rural and high-need practices. - Workforce modelling aligned to population health needs.	Possible 3 x Major 3 = Moderate 9	Strategic Commissioning Committee in Common

8	Cultural transformation and organisational development do not embed Organisational development (OD), leadership development and cultural change may not progress at pace across the ICB and wider system.	Possible 3 x Major 4 = 12	• Prioritise OD and cultural change within systemwide programmes so it remains a core enabler, not an add on. • Strengthen leadership development offers and ensure consistent access across all organisations and levels. • Use a clear cultural framework and shared behaviours to align teams and reduce variation. • Build OD capacity through shared expertise, communities of practice and targeted support to areas with the greatest need. • Improve communication and engagement so staff understand the purpose and benefits of cultural change. • Monitor progress through regular feedback, staff experience data and leadership indicators to adjust support quickly.	Possible 3 x Major 3 = Moderate 9	People, Culture and Inclusion Committee in Common
Delivery of 'left shift' – hospital to community, analogue to digital and sickness to prevention					
9	Failure to deliver neighbourhood health / 'left shift' due to system constraints The transition from hospital-centric care to neighbourhood-based, integrated community services may not be delivered effectively. Risks include insufficient community capacity, variation in primary care network (PCN) maturity, workforce shortages, digital and estate constraints, and lack of public understanding. Failure to deliver the 'left shift' would result in continued pressure on acute services, poorer patient experience, and inability to meet long-term demand.	Possible 3 x Major 4 = 12	• Phased implementation by neighbourhood readiness. • Strengthen community workforce and multidisciplinary teams. • Invest in neighbourhood hubs, diagnostics and digital tools. • Public engagement and codesign. • Standardised operating model for neighbourhood teams.	Possible 3 x Major 3 = Moderate 9	Strategic Commissioning Committee in Common

10	Failure to reduce health inequalities Failure to address these issues may widen gaps in outcomes, reduce life expectancy in priority groups, and increase pressure on acute and community services. There is a risk that the ICS will not achieve meaningful reductions in health inequalities due to: • Significant rurality and transport barriers limiting access to services. • Pockets of high deprivation with poorer health outcomes. • Variation in PCN and neighbourhood maturity. • Digital exclusion affecting older, deprived and rural populations. • Workforce shortages in primary, community and social care. • Inconsistent data quality and limited analytical capacity. Lower engagement from underserved communities.	Possible 3 x Major 4 = 12	• Improve access in rural communities through mobile services, outreach clinics, and strengthened transport partnerships. • Prioritise areas of high deprivation using needs-based resource allocation and targeted health improvement interventions. • Support PCN and neighbourhood maturity, including leadership development, capability building, and shared learning. • Reduce digital exclusion via digital literacy programmes and ongoing non-digital access routes (phone, walk-in, community outreach). • Strengthen workforce capacity through multi-year workforce planning, multidisciplinary roles, and retention initiatives. • Improve data quality and analytical capability with standardised data processes, enhanced analytics capacity, and improved data sharing. • Increase engagement with underserved groups through culturally competent approaches, trusted community partners, and continuous feedback mechanisms	Possible 3 x Major 3 = Moderate 9	Strategic Commissioning Committee in Common
11	Low uptake of screening and immunisation programmes There is a risk that screening and immunisation uptake remains below national targets. This due to factors such as: • Rurality • Transport barriers • Digital exclusion • Vaccine hesitancy • Limited outreach capacity • Variation in PCN engagement • Lower uptake among deprived or underserved communities.	Possible 3 x Major 4 = 12	• Expand targeted outreach and mobile clinics. • Strengthen PCN and community pharmacy involvement. • Work with VCSE partners to reach underserved groups. • Improve data quality and population health analytics. • Tailored communications to address hesitancy.	Possible 3 x Major 3 = Moderate 9	Health and Care Senates in Common

	Persistently low uptake may lead to late diagnosis, preventable illness, widening health inequalities, and increased pressure on primary, community and acute services.				
12	Challenges in delivering the sickness-to-prevention system ambition There is a risk that the ICS will not achieve the shift from reactive, illness-based care to a proactive, prevention-focused model. This may occur due to: • Limited investment in prevention workforce shortages in public health and community services • Variation in neighbourhood maturity digital and data constraints • Insufficient population health capability • Low public engagement • Competing operational pressures in acute and primary care. Failure to deliver this shift would lead to continued high demand for urgent and emergency care, widening health inequalities, poorer long-term outcomes, and reduced system sustainability.	Possible 3 x Major 4 = 12	• Increase investment in prevention and early intervention. • Strengthen neighbourhood teams and community hubs. • Expand population health analytics capability. • Work with VCSE partners to reach underserved groups. • Embed prevention objectives across all programmes and contracts. • Targeted communications and behaviour change campaigns.	Possible 3 x Major 3 = Moderate 9	Health and Care Senates in Common

13	Digital transformation not adopted at scale Key enablers: NHS App, remote monitoring, Electronic Patient Records, Docman Connect, Digital ReSPECT and triage tools, may not embed consistently.	Possible 3 x Major 4 = 12	- Provide clear systemwide standards and expectations for adoption of key digital tools across all providers and primary care networks (PCNs). - Strengthen training, onboarding and digital literacy support for staff to build confidence and consistent use. - Use targeted implementation support and clinical champions to drive uptake in areas with slower adoption. - Improve interoperability and integration so digital tools fit smoothly into clinical workflows. - Monitor adoption levels through dashboards and use data to focus support where gaps persist. - Engage patients and the public to increase awareness and use of tools such as the NHS App and remote monitoring.	Possible 3 x Major 3 = Moderate 9	Strategic Commissioning Committee in Common
14	Insufficient digital capability and capacity across system partners Variation in digital maturity, infrastructure, and skills across providers and PCNs limits the ability to deliver 'left shift' models. This may result in inconsistent care, reduced efficiency, and inability to scale digital-enabled pathways.	Possible 4 x Major 3 = 12	- Set clear systemwide digital standards and minimum capability requirements for all providers and PCNs. - Target support and investment toward organisations with lower digital maturity to level up capability. - Strengthen digital skills training and onboarding for staff to improve confidence and adoption. - Improve interoperability and infrastructure so digital tools integrate smoothly into workflows. - Use data and dashboards to monitor adoption and focus support where gaps persist. - Engage patients and communities to increase use of digital-enabled pathways where appropriate.	Possible 3 x Major 3 = Moderate 9	Strategic Commissioning Committee in Common
15	Data quality and population health management (PHM) limitations Poor data quality or inconsistent coding may undermine population health management, risk stratification and proactive care.	Likely 4 x Major 4 = High 16	- Strengthen data quality standards and provide targeted support to practices and providers with coding gaps. - Identify and implement training on accurate coding adopting national standards/best practice, improving data entry and use of PHM tools. - Improve interoperability between systems and streamline volume of data flows to reduce duplication and inconsistencies. - Use regular data quality audits and dashboards to identify issues early and focus improvement efforts. - Implement a Data Strategy incorporating data quality standards. - Further develop a shared PHM framework so all partners use consistent methods for risk stratification and proactive care.	Possible 4 x Major 3 = 12	Strategic Commissioning Committee in Common

16	Development and Implementation of the National Data Platform There is a potential but yet unknown possibility that there may be issues with accessing local data during the transition process which may impact upon the ability to undertake effective PHM analysis.	Likely 4 x Major 4 = High 16	- Document what will be needed locally. - Explore at-scale solutions across the West Midlands. - Identify resource and assessing necessary training required to facilitate transition.	Possible 3 x Major 3 = Moderate 9	Strategic Commissioning Committee in Common
17	Planned care digital transformation does not reduce demand Digital pathways: Advice and Guidance, digital referrals and patient portals, may not be consistently used, limiting reductions in unnecessary referrals and follow ups.	Possible 4 x Major 3 = 12	- Set clear expectations for consistent use of Advice and Guidance, digital referrals and patient portals across all providers and PCNs. - Strengthen training and clinical engagement to build confidence in digital pathways. - Use data to monitor uptake and target support to specialties or practices with low utilisation. - Improve integration of digital tools into clinical workflows to make them the easiest, default option. - Provide patient support and communication to increase use.	Possible 3 x Major 2 = Low 6	Strategic Commissioning Committee in Common
18	Limited uptake of remote monitoring and virtual care Patients or clinicians may not adopt remote monitoring tools at scale, reducing impact on long-term condition management and admission avoidance.	Possible 4 x Major 3 = 12	- Strengthen training and clinical engagement so staff feel confident using remote monitoring tools. - Provide clear patient support, simple onboarding and accessible guidance to increase uptake. - Target implementation support to practices, teams or specialties with low adoption. - Improve integration of remote monitoring into existing workflows to make it easy and routine. - Use data to track utilisation and focus improvement efforts where uptake is lowest.	Possible 3 x Major 2 = Low 6	Strategic Commissioning Committee in Common
19	Digital exclusion widens inequalities Underserved groups may struggle to access digital tools, leading to inequitable access to care and poorer outcomes.	Possible 3 x Major 4 = 12	- Provide non-digital alternatives to ensure services remain accessible for all groups. - Expand digital inclusion support such as training, community outreach and assisted digital options. - Work with VCSE partners to reach underserved communities and tailor support to local needs. - Improve availability of devices, connectivity and safe digital access points in community settings. - Monitor uptake by deprivation, age, ethnicity and rurality to target support where exclusion is greatest.	Possible 3 x Major 3 = Moderate 9	Strategic Commissioning Committee in Common
Delivery of improved access and performance					

20	Non-delivery of the urgent and emergency care access targets Sustained high demand, flow constraints, workforce shortages, delays in discharge and inconsistent use of community and virtual care alternatives. Failure to meet targets could lead to overcrowding, longer waits, poorer patient experience, and increased clinical risk.	Likely 4 x Major 4 = High 16	- Strengthen front-door streaming, same-day emergency care and alternative community pathways to reduce avoidable attendances. - Improve flow through enhanced discharge processes, community capacity and closer social care coordination. - Target workforce support to high-pressure UEC areas and optimise multidisciplinary team models. - Use real-time data and escalation frameworks to manage surges and maintain performance. - Expand virtual wards and remote monitoring to reduce admissions and support early discharge.	Possible 3 x Major 3 = Moderate 9	Quality and Performance Committees in Common
21	Referral to treatment (RTT) – spinal waits Spinal pathways continue to experience long RTT waits due to high demand, limited specialist capacity, complex diagnostics, and constrained theatre availability. Delays in triage, imaging and surgical decision-making may further extend waits, leading to poorer patient outcomes, increased pain and disability, and potential breaches of national RTT standards.	Likely 4 x Major 4 = High 16	- Strengthen spinal triage and optimise use of musculoskeletal (MSK) and advanced practice clinicians to manage demand earlier. - Increase capacity through additional clinics, targeted insourcing/outourcing and improved theatre scheduling. - Streamline diagnostics and reduce delays in MRI and specialist review. - Use demand and capacity modelling to prioritise high-risk patients and improve flow through the pathway. - Implement standardised referral criteria and advice and guidance to reduce inappropriate referrals.	Possible 3 x Major 3 = Moderate 9	Quality and Performance Committees in Common
22	Psychiatric Intensive Care Unit (PICU) – capital There is a risk that insufficient capital funding prevents the development of a local PICU. Without a local facility, patients requiring intensive psychiatric care may continue face long travel distances, delayed access to specialist beds, and increased reliance on out-of-area placements leading to poorer clinical outcomes, higher costs, reduced family involvement, and operational pressures across acute mental health pathways.	Likely 4 x Major 4 = High 16	- Strengthen the capital case using clear clinical, financial and operational evidence, including demand modelling and out-of-area cost analysis. - Explore alternative funding options such as systemwide capital prioritisation or joint ventures. - Enhance interim pathways through strengthened relationships with regional PICUs and improved transfer protocols. - Build local capability by upskilling staff, improving crisis response models and using enhanced observation or step-up care where safe. - Maintain engagement with NHS England and regional networks to align with future capital opportunities and strategic planning.	Possible 2 x Major 3 = Low 6	Strategic Commissioning Committee in Common

23	Children and young people (CYP) mental health access targets Improvement Plan not achieved due to rising demand, workforce shortages, long waits for assessment, and limited capacity across child and adolescent mental health services (CAMHS) and community services. Inconsistent early intervention, variable digital adoption and pressures in wider children's services may further delay access, leading to unmet need, poorer outcomes and increased crisis presentations.	Possible 3 x Major 3 = Moderate 9	- Implement new model and expand early intervention and community-based support to reduce pressure on specialist CAMHS. - Strengthen workforce capacity through targeted recruitment, retention and skill-mix models. - Improve triage, flow and demand management to prioritise high-risk CYP and reduce bottlenecks. - Use digital tools and remote support to increase reach and reduce waiting times where appropriate. - Enhance partnership working with schools, social care and VCSE organisations to support earlier identification and access. - Monitor access performance closely and target improvement support to areas with persistent delays.	Possible 2 x Major 3 = Low 6	Quality and Performance Committees in Common
Patient and system engagement					
24	Planning timescales Prevented up front meaningful engagement with health and wellbeing boards, patients and the public and wider stakeholders and ongoing work required.	Possible 3 x Major 3 = Moderate 9	- Strengthen forward planning and build longer lead in times for future cycles to enable meaningful early engagement. - Use targeted, rapid engagement methods, such as focused workshops, virtual sessions and surveys to gather input within tight timescales. - Maintain ongoing dialogue with health and wellbeing boards, VCSE partners, patients and the public outside formal planning windows. - Develop a standing engagement framework so stakeholders can contribute continuously rather than only during planning rounds. - Provide clear, timely communication on priorities and timelines to ensure stakeholders can prepare and participate effectively.	Possible 2 x Major 3 = Low 6	Strategic Commissioning Committee in Common
25	Ongoing patient engagement To not sustain engagement with patients, carers and the public throughout the development and delivery of the 10 Year Plan may reduce participation, leading to commissioning decisions that do not fully reflect lived experience, local needs or health inequalities. This could weaken legitimacy, reduce impact and limit the plan's ability to deliver meaningful change.	Possible 3 x Major 3 = Moderate 9	- Establish a standing engagement framework with regular, predictable opportunities for patient and public involvement. - Strengthen partnerships with VCSE organisations, Healthwatch and community groups to reach diverse voices. - Use a mix of engagement methods such as digital, in-person and targeted outreach to maintain accessibility and reduce fatigue. - Provide clear, ongoing communication on how feedback has shaped commissioning decisions to build trust and continued participation. - Embed patient and public representatives in programme boards and working groups to ensure continuous input.	Possible 2 x Major 3 = Low 6	Strategic Commissioning Committee in Common

			Monitor engagement levels and demographics to identify gaps and target additional outreach where needed.		
26	Substantive service change/decommissioning There is a risk that the management of substantive service changes required for the 10 Year Plan is not delivered effectively due to limited capacity, complex interdependencies, regulatory requirements, and variable readiness across system partners. Poor coordination, unclear governance or insufficient programme oversight may lead to delays, inconsistent implementation, stakeholder challenge, and reduced ability to realise the intended benefits of service transformation.	Likely 4 x Major 4 = High 16	- Strengthen programme governance with clear roles, decision-making structures and escalation routes for all service change activity. - Develop a systemwide service change framework aligned to statutory guidance to ensure consistent and compliant processes. - Use robust programme and project management support, including shared PMO capacity, to coordinate timelines and interdependencies. - Maintain early and ongoing engagement with local authorities, providers, Healthwatch and regulators to reduce risk of challenge. - Apply structured impact assessments (quality, equality, finance, workforce) to inform decision-making and ensure safe implementation. - Monitor progress through regular reporting and use data to identify emerging risks and adjust plans quickly.	Possible 3 x Major 3 = Moderate 9	Strategic Commissioning Committee in Common

Glossary to be added following Board approval of the plan

DRAFT

19th March 2026 – Final Draft

Five Year Strategic Commissioning Plan

2026/27 to 2030/31



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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.

Simon Whitehouse

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

Ian Green OBE

ICB Cluster Chair
NHS Staffordshire and Stoke-on-Trent
NHS Shropshire, Telford and Wrekin

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 (UHNH), 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.



Our way of working

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.

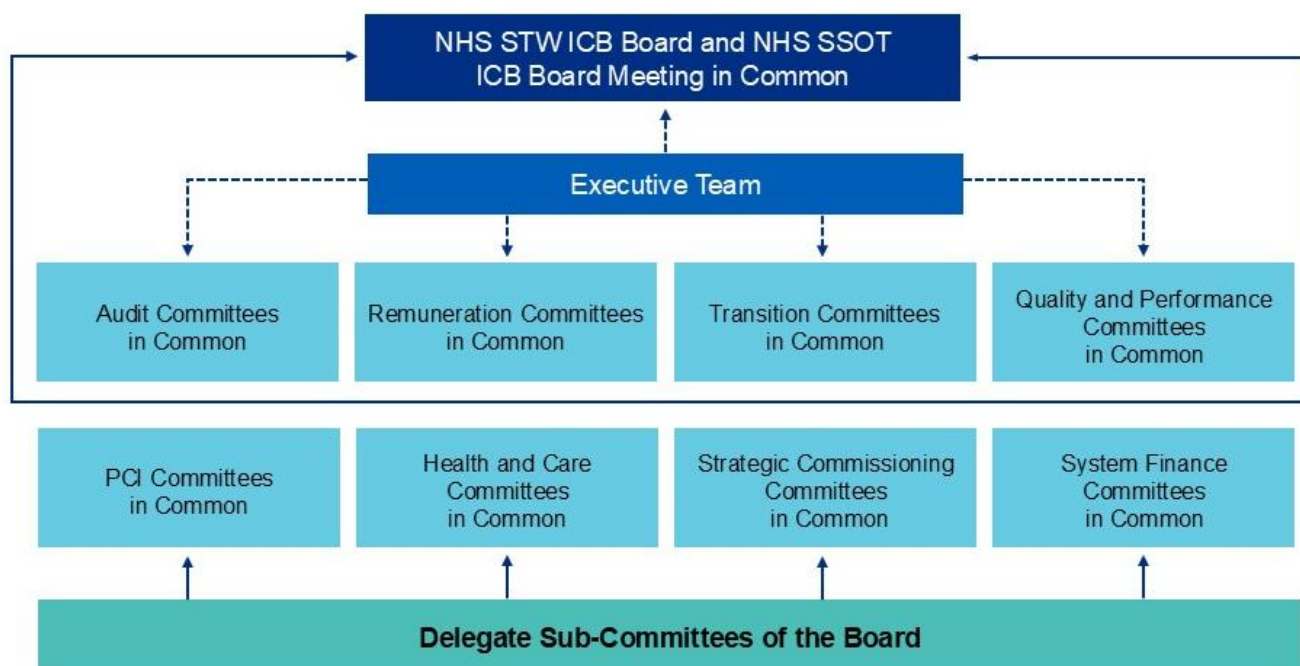
This provides one clear framework that guides the decisions we make across all aspects of planning and commissioning health and care services. It also helps ensure we meet our legal responsibilities, being transparent, involving the public and showing strong joint leadership across the system. Most importantly, 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 that they promote high clinical value and optimising resource allocation. Through the Health and Care Senate, multidisciplinary 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

The ICB must continue to strengthen its own skills and capabilities. We will make full use of national development programmes to support this. This includes:

Building expertise in strategic commissioning

Strengthening analytical and financial skills

Working more effectively across agencies

Improving leadership, culture and organisational development

Develop our intelligent healthcare payer skills

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.

Commissioning Plan for 2026/27 to 2030/31

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 cavities 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

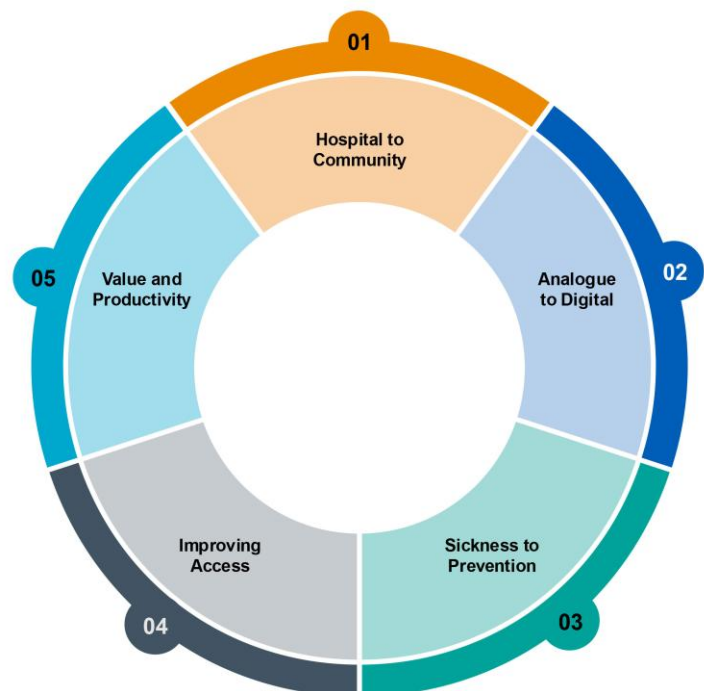
Our operating model provides the architecture, leadership, governance and commissioning cycle required to set these in motion – enabling effective planning, procurement and evaluation across neighbourhood, place and system levels. The following sections of the plan set out the key actions against our 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.



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.

[illegible]

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 neighbourhoods 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 spring 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 3-year review and realign the inpatient services strategic plan.
- Embed end-to-end pathway coherence (from admission to discharge to community).
- Ensure alignment between population need, bed numbers and pathways – reducing the average length of stay in adult and older adult acute mental health beds 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 Ubbertley 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 Child Health Record, 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 child immunisation 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 extends to staff and significant 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.
- Support local authority-commissioned stop smoking providers to offer support on discharge.
- 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.

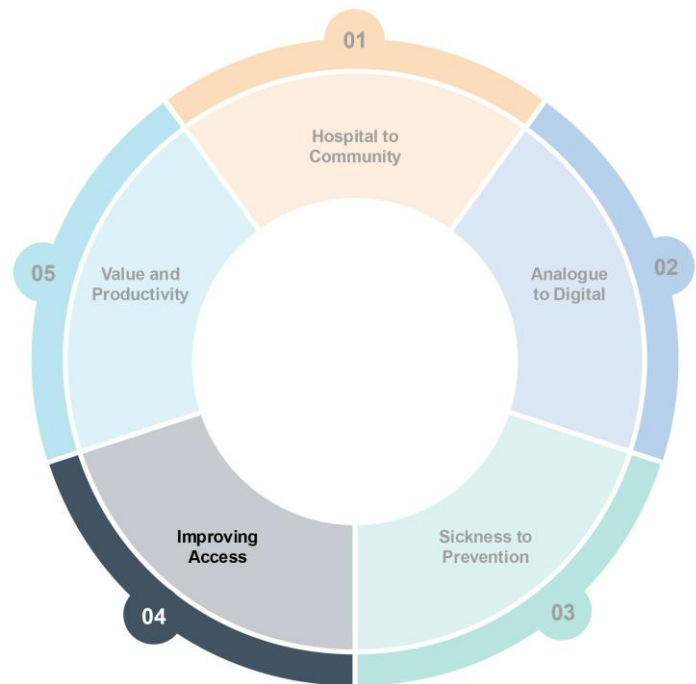
The design of CEW clinics will be based on three core aims:

- 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 (ED presentations, s136, ambulance conveyances), 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 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:

- Identifying opportunities using population health management and a robust evidence base.
- Prioritising our resources through evidence-based insights.
- 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 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 value, 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** to pump prime commissioning intentions
- Use value-based strategic decision making to guide resource allocation

Context – challenges, opportunities and shared values

Both systems enter this planning period with significant and longstanding financial deficits. The Medium Term Financial Plan for Staffordshire and Stoke-on-Trent 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
- Workforce 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 MTFP 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 stage-gate approvals, clinical safety sign-off, Digital Technology Assessment Criteria (DTAC) 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 and utilising the right 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.

● 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.



● 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 multi-disciplinary analytical and improvement teams
- Development of a cross-system ICS Intelligence function.

● 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 (SSHERP).

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.



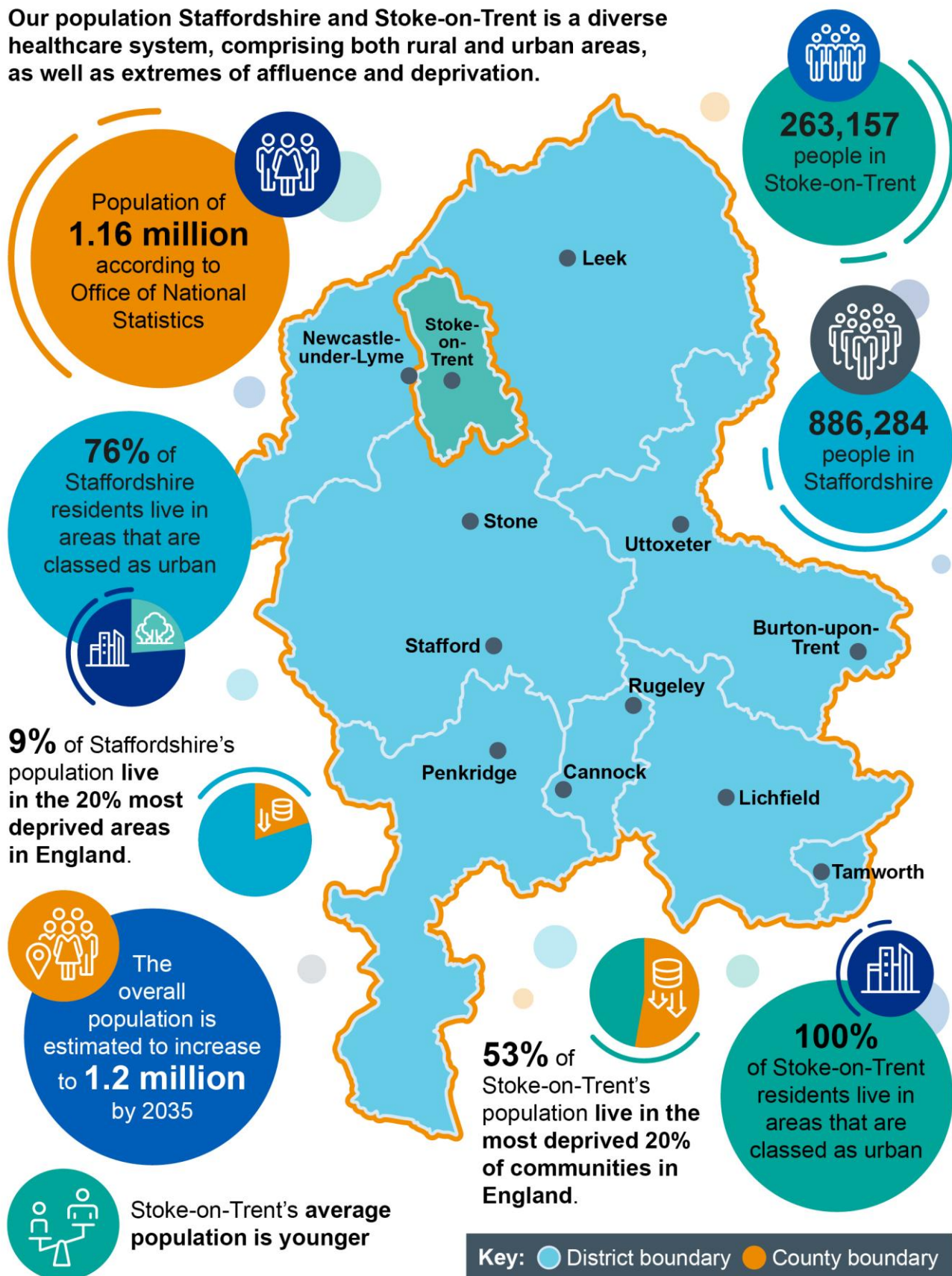
Appendices

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.



Our population Staffordshire and Stoke-on-Trent is a diverse healthcare system, comprising both rural and urban areas, as well as extremes of affluence and deprivation.



Enclosure No: 09

Report to:	ICB Board							
Date:	26 March 2026							
Title:	ICB Performance Reports							
Presenting Officer:	Claire Skidmore, NHSSTW and NHSSSOT							
Author(s):	Angela Parkes, NHSSTW and Vicki Inch, NHSSSOT							
Document Type:		Action Required (select):						
Report	☒	Business Plan	☐	Information (I)	☐	Discussion (D)	☐	
Strategy	☐	Policy	☐	Assurance (S)	☒	Approval (A)	☐	
Other	☐	<i>(please describe)</i>		Ratification (R)	☐	<i>(check as necessary)</i>		
Is the decision within SOFD powers & limits					Yes	☐	No	☐
Any potential / actual Conflict of Interest?					Yes	☐	No	☒
<i>If Y, the mitigation recommendations:</i>		<i>E.g. Staff have Financial + Non-Financial Professional Interests which can be managed by recording those in minutes and allowing presence in discussions with recusals from formal decisions</i>						
Any financial impacts: ICB or ICS?					Yes	☐	No	☒
<i>If Y, are those signed off by and date:</i>		<i>E.g. Chief Finance Office, dd-mmm-yyyy</i>						
Any impacts on ICB Undertakings?					Yes	☐	No	☒
<i>If Y, are those signed off by and date:</i>		<i>E.g. Chief Finance Office, dd-mmm-yyyy</i>						
Appendices:	Appendix A: NHSSTW Integrated Performance Report Appendix B: NHSSSOT							

(1) Purpose of the Paper:

The Performance Report is brought to the Board to provide the latest position regarding finance, quality, performance and workforce across the two ICBs. It provides assurance on the delivery of our key measurable outcomes and informs the Board of the current risks and issues related to that delivery.

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

First Review today

(3) Implications:

Legal / Regulatory	No legal, regulatory or equality implications identified as a direct result of this report
CQC / Patient Safety	Quality Leads have worked with Planning and Performance Leads to ensure Quality is reflected throughout the report.
Financial (CFO-assured)	Delivery of the financial plan and efficiency plan targets supports financial recovery and sustainability.
Sustainability	n/a
Workforce / Training	Workforce is reflected at relevant points in the report.
Equality & Diversity	n/a
Due Regard: Inequalities	The report seeks to provide assurance against key measurable outcomes and to highlight areas of concern and actions being taken to address these, to support improving outcomes in population health.
Due Regard: wider effect	n/a

(4) Statutory Dependencies & Impact Assessments:

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

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

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

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

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

The Performance Report is brought to the Board to provide the latest position regarding finance, quality, performance and workforce across the two ICBs. It provides assurance on the delivery of our key measurable outcomes and informs the Board of the current risks and issues related to that delivery.

There are two appendices one containing the full Shropshire, Telford and Wrekin Integrated Performance Report and the second containing the Staffordshire and Stoke on Trent Performance Report.

Shropshire, Telford and Wrekin

Areas showing improvement include:

- Primary care: Improved GP access
- UEC: Reduction in 8-hour ambulance delays from 58 to 14
- Elective care: RTT performance above plan. Cancer standards better than plan. 13 week waits for diagnostics.
- Mental health: Access to perinatal and maternal mental health. Eating disorder routine appointments at 100%. CYP MH access showing sustained improvement.
- Maternity: Maternity bookings before 10 weeks. Mothers smoking at time of delivery.

Areas showing concern include:

- UEC: 4-hour A&E. 12-hour A&E. Ambulance handovers.
- Elective care: RTT long waits with 47 over 65 weeks. Diagnostics 6 weeks waits.
- Mental health: Inappropriate out of area placements. Urgent eating disorder referrals.
- LDA: Adult inpatients in a MH bed now 9 above plan. Waiting lists for ASD and ADHD assessments high.
- IPC over trajectory for C-diff, Klebsiella, Pseudomonas, MRSA.

Headline financial position:

Revenue:

- STW ICS is reporting a £2.8m actual YTD System deficit v's £0.8m deficit plan, giving a £2m adverse variance at M11, improved from £3.6m in M10.
- 2025/26 expected forecast outturn is a surplus to the planned breakeven of £2.3m (after £83.8m deficit support funding).

Workforce:

- Overall provider workforce expenditure YTD is adverse to plan by £16.6m - bank overspend YTD at £11.9m.
- Current full year run rate is £20.4m adverse to plan showing slight deterioration on M10 of £0.3m.
- Overall WTE is above plan by 102 WTE (1%) with bank exceeding plan by 87 WTE (13%) but partially mitigated by agency which is 32 WTE (34%) below plan.

- NHS Infrastructure Support costs favourable to plan by £5.7m/6.5% YTD.

Capital:

- STW ICS at Month 11 is reporting a £30.5m underspend against plan namely due to the profile of capital spend compared to plan.
- All providers and the ICB have confirmed expected FOT in line with the capital plan, this includes additional capital received and spent in year above the original plan value offset by HTP cash reprofiling.

Staffordshire and Stoke on Trent

Areas showing improvement include:

- Diagnostics: 6 weeks performance showing improvement but below plan
- Cancer: FIT cancer standard above plan
- UEC: 4-hour standard improved but below plan. Ambulance handover improved but below plan. Urgent community response above plan.
- Primary care: GP access improved but below plan. Pharmacy First above plan.
- Mental health: Perinatal mental health above plan. CYP MH access above plan.
- Community transformation measures all meeting plan.
- Improving population measures all meeting plan

Areas showing concern include:

- Elective care: RTT performance deteriorated and below plan.
- Cancer standards deteriorated and below plan with the exception of FIT.
- UEC: Virtual ward occupancy deteriorated and below plan.
- Primary care: Urgent dental activity deteriorated and below plan
- Mental health: Inappropriate out of area placements above plan (35 against plan of 4).
- LDA: Reduce inpatient MH care for learning disability and for autistic people.

Headline financial position:

Revenue

- At month 11, the system is reporting a £4.9m deficit, representing a £1.8m favourable variance against the planned £6.6 deficit (£3.2m favourable at month 10). Year-to-date, this includes deficits of £5.1m for the ICB, £2m at UHNM and offset by a surplus of £1m at MPFT and £1.2m at NSCHT. While the overall position remains broadly on track, the key driver of variances continues to be lower than planned efficiency delivery, offset by several non-recurrent mitigations.
- The reported system efficiency delivery YTD is £28.5m behind our submitted plan of £275.4m, this comprises of ICB (£6.5m), MPFT (£0.6m), NSCHT (£0.2m) and UHNM (£21.1m). As a system this equates to 90% delivery YTD.
- As a system we are forecasting to meet our year-end financial plan of break even, after £95m deficit support funding (DSF).

Workforce

- The system workforce numbers across providers and ICB (substantive + bank + agency) were 25,273WTE in February 2026. This is a decrease on month 10 of 92.6 WTE. Much of this decrease can be attributed to a decrease in bank and agency staff for MPFT (29.6 WTE) and UHNM (82.6 WTE), offset by 22.9 WTE substantive posts at UHNM. Month 11 workforce numbers were 836 WTE above plan which was seen in substantive (758 WTE) and bank (90 WTE), offset by agency which is under plan by (12 WTE).

Capital

- The system submitted a compliant forecast at month 11, any deviations from this will potentially impact 2026/27 should there be material underspends in the remaining months. The capital pressures of IFRS16 and the deferral of the UHNM land sale have been mitigated through a combination of internal actions, additional regional support and system-wide working.

(7) Recommendations to Board:

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

Appendix A: NHSSTW Performance Report

1. Integrated Performance Report March 2026

Contents

1. Integrated Performance Report March 2026	1
1.1 Assurance Matrix Summary	2
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1.1 Assurance Matrix Summary

Interpreting SPC charts

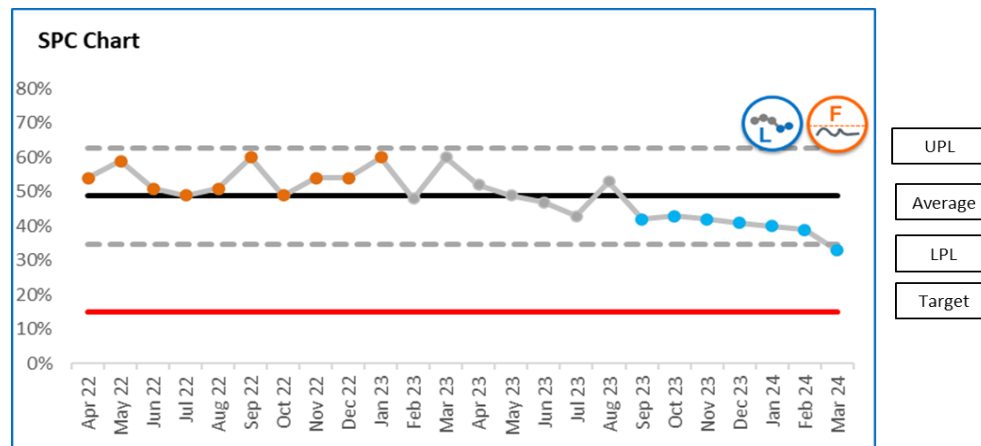
A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly).

The following colour convention identifies important patterns evident within the SPC charts in this report.

Orange – there is a concerning pattern of data which needs to be investigated, and improvement actions implemented.

Blue – there is a pattern of improvement which should be learnt from

Grey – the pattern of variation is to be expected. The key question to be asked is whether the level of variation is acceptable.



The dotted lines on SPC charts (upper and lower process limits) describe the range of variation that can be expected.

Process limits are very helpful in understanding whether a target or standard (the red line) can be achieved always, never (as in this example) or sometimes.

SPC charts therefore describe not only the type of variation in data but also provide an indication of the likelihood of achieving target.

Summary icons have been developed to provide an at-a-glance view. These are described on the following page.

1.2 Interpreting summary icons

These icons provide a summary view of the important messages from SPC charts.

Variation / performance icons			
Icon	Technical description	What does this mean?	What should we do?
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is currently not changing significantly . It shows the level of natural variation you can expect from the process or system itself.	Consider if the level/range of variation is acceptable. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of a CONCERNING nature.	Something's going on! Something, a one-off or a continued trend or shift of numbers in the wrong direction	Investigate to find out what is happening or has happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an IMPROVING nature.	Something good is happening! Something, a one-off or a continued trend or shift of numbers in the right direction. Well done!	Find out what is happening or has happened. Celebrate the improvement or success. Is there learning that can be shared to other areas?
Assurance icons			
Icon	Technical description	What does this mean?	What should we do?
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies within those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is the target will be achieved or missed at random.	Consider whether this is acceptable and, if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	If a target lies outside of those limits in the wrong direction then you know the target cannot be achieved.	You need to change something in the system or process if you want to meet the target. The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	If a target lies outside of those limits in the right direction then you know the target can consistently be achieved.	Celebrate the achievement. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

1.3 Overview Matrix

SPC Matrix		Assurance				Movement in Month
		Consistently Achieving the Target	Inconsistently Achieving the Target	Consistently Failing the Target	No National Target	
Improving Variation		Patients accessing perinatal mental health - STW	- Diagnosis to First Treatment < 31 days - STW - CYP Eating Disorders (Routine) seen within 4 weeks - STW	- Time to first appointment < 18 weeks - STW - All Diagnostics - < 6ww against target - STW - All Diagnostics - < 13ww against target - STW 28 Day Faster Diagnosis Standard - STW - Referral to treatment < 62 days % - STW - Talking Therapies First seen < 18 weeks - STW - CYP - persons U18 supported with at least 1 contact - STW % Annual Health checks per LD register aged 14 or over - STW	- ARRS - WTE - STW - Direct Patient Care in Post (FTE) - STW - Dental activity as a proportion of contracted activity - STW - Pharmacy First consultations - STW - Number of people accessing IPS (rolling 12 months) - STW - Proportion of PW split by discharge P1 - SaTH - FFT: AE % Responded - SaTH - FFT: AE % Positive - SaTH - Maternity Booking before ten weeks - SaTH	Metric Performance deteriorated from improving to normal variation or from normal to concerning variation
				- Incomplete RTT pathways of 65+ weeks - STW - Incomplete RTT pathways of 52+ weeks - STW - Incomplete RTT pathways of 52+ weeks where patient age is <=18 - STW - LDA children currently inpatient in MH setting - STW - Community Waits of 52 or more weeks for CYP services - SCHAT - Community Waits of 52 or more weeks for adult services - SCHAT	- CYP - ASD Total waits (5-17) - STW - CYP - ADHD Total waits (5-17) - STW - Adult - ADHD Total waits - STW - Proportion of PW split by discharge P2 - SaTH - Mothers Smoking at Time of Delivery - SaTH - Community Waits for CYP services, total - SCHAT	
Normal Variation		% of GP appointments attended within 2 weeks (ACC-08) - STW	% Urgent Community Response patients seen within 2hrs - STW - FIT - % of suspected Lower GI cancers with FIT - STW - Talking Therapies reliable recovery after 2+ contacts - STW - Talking Therapies patients reliably improved after 2+ contacts - STW - LD adults currently inpatient in MH setting - STW - No. of cases - C-difficile - STW - No. of cases - E-coli - STW - No. of cases - Pseudomonas aeruginosa - STW - Number of cases - Klebsiella - STW - No. of cases - MRSA - STW - Cat 2 Response Mean time - WMAS - Average handover time - WMAS	- A&E 4 hour performance achievement (Type 1&3) - STW - OAP - Active inappropriate out of area adult placements - STW - Proportion of Adult SMI having Physical Health Checks - STW - A&E 4 hour performance achievement (Type 1&3) - SaTH - A&E 4 hour performance achievement (Type 1) - SaTH % of Ambulance Handovers within - 45 mins - WMAS	- Total Primary care appointments - STW - Total Face to Face appointments - STW % of GP appointments attended same or next day - STW - GPs in Post (FTE) - STW - Units of dental activity delivered in the period - STW - Referrals U18 from A&E to liaison psychiatry <1hr - STW - No. of cases - MSSA - STW - Total A&E attendances against plan - SaTH - FFT: Maternity Antenatal Care % Positive - SaTH - FFT: Maternity Postnatal Community % Positive - SaTH - Mothers per 1000 with post-partum haemorrhage >=1500ml - SaTH - FFT: Inpatient % Responded - RJAH - FFT: Inpatient % Positive - RJAH - FFT: Community % Positive - SCHAT - FFT: MH % Responded - MPFT - FFT: MH % Positive - MPFT	Metric Performance improved from concerning to normal variation or from normal to improving variation

SPC Matrix		Assurance Matrix - Concerning Variation				Movement in Month
		Consistently Achieving the Target	Inconsistently Achieving the Target	Consistently Failing the Target	No National Target	
						
Concerning Variation			♦ LDA: Autistic adults currently inpatient in MH setting - STW		♦ Adult - ASD Total waits - STW ♦ Proportion of PW split by discharge P3 - SaTH ♦ Community Waits for adult services, total - SCHAT	Metric Performance remained static
					♦ FFT: Inpatient % Responded - SaTH ♦ FFT: Inpatient % Positive - SaTH ♦ FFT: Maternity Birth % Responded - SaTH ♦ FFT: Maternity Birth % Positive - SaTH ♦ FFT: Maternity Postnatal Ward % Positive - SaTH ♦ FFT: Community % Responded - SCHAT	
Insufficient data						New metric for this report

Monthly Movement in Metrics:

Metrics where performance deteriorated from improving to normal variation or from normal to concerning variation – no metrics this month

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

- ♦ FFT: AE % Positive – SaTH
- ♦ CYP - ADHD Total waits (5-17) - STW
- ♦ Proportion of PW split by discharge P2 – SaTH
- ♦ Community Waits of 52 or more weeks for CYP services – SCHAT
- ♦ Proportion of Adult SMI having Physical Health Checks - STW

New metrics this report – no new metrics this month

1.4 Primary Care

Primary Care

Metric Table

Metric Name	Workstream	Metric Type	Latest Date	Target	Value	Var.	Ass.	Target Met	Plan Met	Mean
Total Primary care appointments	Primary Care	STW	Jan 26		271,411					255,184
Total Face to Face appointments	Primary Care	STW	Jan 26		167,934					170,792
% of GP appointments attended within 2 weeks (ACC-08)	Primary Care	STW	Jan 26	85%	90.2%					88.4%
% of GP appointments attended same or next day	Primary Care	STW	Jan 26		56.0%					52.4%
ARRS - WTE	Primary Care	STW	Feb 26		330					269
GPs in Post (FTE)	Primary Care	STW	Jan 26		238					237
Direct Patient Care in Post (FTE)	Primary Care	STW	Jan 26		166					160
Units of dental activity delivered in the period	Primary Care	STW	Nov 25		60,208					54,193
Dental activity as a proportion of contracted activity	Primary Care	STW	Nov 25		96%					82.2%
Pharmacy First consultations (CP,BP,OC)	Primary Care	STW	Jan 26		4,645					3,809

Escalation charts

No concerning variation reported, so no charts required this month.

Primary Care Escalation Points

Focus Headlines:

- **Appointments in GP practices:** Total number of appointments increased by 7.7% and face to face increased by 5.1%. Appointments in 14 days continued to increase achieving the 85% target. Same day or next day appointments increased by 0.6%.
- **Workforce:** Number of FTE GPs increased by 2.2., ARSS (Additional Roles Reimbursement Scheme) increased by 24 on top of last month's increase of 21.
- **Dental activity:** Latest data is November as data is not yet available for December. Preliminary data indicates that activity will increase compared to last month.
- **CQC:** The ICB continues to offer support to the General Practice that is under review following the Care Quality Commission (CQC) visit. A meeting has been arranged in March.

Narrative:

- **Practice Level Support (PLS) Programme update:** Of four practices, only two remain actively engaged. Two have withdrawn due to the programme being resource-intensive, which may limit sustained improvement.
- **Pharmacy First:** Slight reduction in Pharmacy First activity of 322 compared to last month. This is expected seasonal demand variation.
- **Dental:** Registration increased by 3,144 in January showing the largest monthly rise for over 3 years. The current "Golden Hello Scheme" for dentists have recruited 2.8 of the expected 4 wte.

Key Actions:

- Further promotion planned from Local Authorities for Pharmacy First service. ICB working with SSOT ICB regarding improving referrals from Urgent and Emergency Care (UEC) sites

Key Risks and mitigations:

- General practice identified with concerns following feedback from CQC visit. Mitigating actions outlined above

1.5 Urgent and Emergency Care

Urgent and Emergency Care (UEC)										
Metric Table										
Metric Name	Workstream	Metric Type	Latest Date	Target	Value	Var.	Ass.	Target Met	Plan Met	Mean
Cat 2 Response Mean time	UEC	WMAS	Feb 26	00:30	00:30			✓	✗	00:39
Average handover time	UEC	WMAS	Feb 26	00:45	01:13			✗	✗	01:13
% of Ambulance Handovers within ~ 45 mins	UEC	WMAS	Feb 26	100%	58.7%			✗	✗	58.0%
A&E 4 hour performance achievement (Type 1&3)	UEC	SaTH	Feb 26	76%	51.9%			✗	✗	51.9%
A&E 4 hour performance achievement (Type 1&3)	UEC	STW	Feb 26	76%	60.8%			✗	✗	61.2%
A&E 4 hour performance achievement (Type 1)	UEC	SaTH	Feb 26	76%	43.9%			✗	✗	43.4%
Total A&E attendances against plan	UEC	SaTH	Feb 26		12,275				✗	12,999
Proportion of PW split by discharge P1	UEC	SaTH	Feb 26		54.4%				✗	42.9%
Proportion of PW split by discharge P2	UEC	SaTH	Feb 26		27.5%				✗	31.3%
Proportion of PW split by discharge P3	UEC	SaTH	Feb 26		18.1%				✗	13.9%
% Urgent Community Response patients seen within 2hrs	Community	SCHT	Jan 26	70%	77.6%			✓		82.4%
Escalation charts										
Proportion of PW split by discharge P3: UEC, SaTH										
Focus Headlines:										
Ambulance: Category 2 response time improved to 30 minutes and is ranked 21st out of 42 reporting systems. Ambulance handover time did not achieve the national target or the local plan. STW ranked 118 of the 120 reporting trusts. A&E: 4-hour performance significantly off track against national target. 12 hour waits remain off track with SaTH ranked 112th out of 116 trusts.										
Narrative:										
Ambulances: The system continues to operate under sustained winter demand affecting ambulance response times and ambulance handover Alternatives: Extension of Urgent Community Response to midnight beginning to provide additional same day alternatives to conveyance, supporting admissions avoidance during peak evening periods. A&E: Sustained pressure from high acuity attendances and downstream discharge constraints. Virtual ward utilisation remains below trajectory limiting its impact on admission avoidance and contributing to sustained pressure on inpatient capacity. Discharge delays: Delays are largely driven by complexity in domiciliary care provision, reablement capacity and housing-related barriers. This cohort is having a disproportionate impact on bed availability and ED recovery										
Key Actions:										
Flow: Increased promotion of Integrated Out of Hospital Services via GP engagement. Ongoing optimisation of clinical portal with Health Hero. STW After Action Review Deep Dive UEC multi-provider exercise planned for end of March. Maximum handover threshold process launched to improve ambulance handover times. Senior decision makers embedded within ED and assessment areas to accelerate review and streaming. In hospital capacity: Modular wards to support gastro and surgery wards at RSH (56 beds). Planning for the creation of Acute Trauma Assessment Area. UEC Recovery at PRH (40 beds/assessment spaces). Haematology assessment bay pilot with aim to optimise workforce capacity and improve patient flow. A&E: National Spring Reset in Marh focused on improving A&E waiting times, maximising 4 hour performance without detriment to 12 hour performance. Discharge delays: A targeted improvement approach is in place focusing on reducing delays beyond 48 hours, including strengthened daily review of delayed patients, improved discharge planning within the first 24–48 hours of admission, and system escalation of complex cases requiring packages of care, transport or placement. “Preparing for Tomorrow” model embedded on targeted wards to improve early discharge planning, criteria clarity and expected discharge date discipline. Strengthened system engagement with community providers to increase pace of home-first discharge.										

Urgent and Emergency Care (UEC) ctd.

Key Risks and mitigations:

- Prolonged ambulance handover delays create compounding operational risk — impacting patient safety, increasing time to definitive care, and reducing available ambulance resource across the system. Mitigating actions include deployment of Offload to Assess pathways, escalation framework for prolonged waits and executive monitoring through system operational calls.
- Delay to PRH bed reconfiguration and SDEC capacity may limit performance
- Sustained delays beyond 48 hours risk maintaining bed occupancy above safe operating levels, directly impacting ED performance, ambulance handovers and overall system resilience. Overnight boarding in Discharge Lounge at RSH impacts on the ability to pull patients prior to 08.45. Mitigating actions include a dedicated workstream to reduce >48 hour NCTR delays through improved coordination of packages of care, transport and placement brokerage. Additional discharge transport capacity commissioned to remove non-clinical delays. Ongoing monitoring of pathway mix to rebalance discharge flow toward home-first trajectories. Boarding overnight has been escalated in SaTH and is part of the improvement work for the discharge improvement group – part of the hospital full policy.

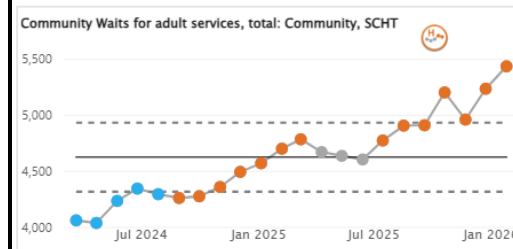
1.6 Planned Care

Planned Care

Metric Table

Metric Name	Workstream	Metric Type	Latest Date	Target	Value	Var.	Ass.	Target Met	Plan Met	Mean
Incomplete RTT pathways of 65+ weeks	Planned Care	STW	Jan 26	0	47					526
Incomplete RTT pathways of 52+ weeks	Planned Care	STW	Jan 26	0	596					3,257
Incomplete RTT pathways of 52+ weeks where patient age is <=18	Planned Care	STW	Feb 26	0	27					286
Time to first appointment <18 weeks, ages 18 and under	Planned Care	STW	Feb 26	67%	71.3%					61.3%
All Diagnostics - < 6ww against target	Diagnostics	STW	Jan 26	95%	80.8%					73.3%
All Diagnostics - < 13ww against target	Diagnostics	STW	Jan 26	100%	98.3%					92.7%
28 Day Faster Diagnosis Standard	Cancer	STW	Jan 26	80%	80.7%					71.6%
FIT - % of suspected Lower GI cancers with FIT	Cancer	STW	Feb 26	80%	87.9%					83.2%
Referral to treatment < 62 days %	Cancer	STW	Jan 26	85%	65.2%					57.9%
Diagnosis to First Treatment < 31 days	Cancer	STW	Jan 26	96%	94.1%					87.7%
Community Waits of 52 or more weeks for CYP services	Community	SCHT	Jan 26	0	0					72.0
Community Waits of 52 or more weeks for adult services	Community	SCHT	Jan 26	0	3					34.7
Community Waits for CYP services, total	Community	SCHT	Jan 26		2,819					3,046
Community Waits for adult services, total	Community	SCHT	Jan 26		5,433					4,623

Escalation charts



Focus Headlines:

- **RTT:** 47 patients waiting over 65 weeks all at RJA. 596 patients waiting over 52 weeks forecasts indicating reductions in February. Incomplete pathways seen within 18 weeks meeting target at 64.2%. First appointment within 18 weeks meeting target at 74.2%
- **CYP:** 52 week waits reduced to 27 against a local plan of 54. Continuous improvement in the CYP RTT waitlist reducing 7,074 (Jan 25) to 4,430 (Feb 26)..
- **Cancer:** All cancer standards above plan.
- **Community waits:** No CYP waiting over 52 weeks; adult patients decreased to 3
- **DM01 diagnostics:** Decrease to 80.8% for patients seen within 6 weeks. 13-week waits have decreased to 264. Echo and Urodynamics are a concern.

Narrative:

- All RTT continues to show improving variation. Tiering calls with NHSE continue for both providers for RTT and diagnostics
- Cancer performance has improved significantly following strengthened senior leadership and delivery of phase one cancer improvement programmes. Phase two is now progressing. Workforce constraints in Oncology, Maxillofacial and Urology pathways are a key risk to sustaining improvements.
- External referral timeliness remains a risk to cancer performance.
- Wheelchair service have a small number of children waiting over 40 weeks who are neurodivergent with complex needs.
- Diagnostics recovery plans in place for both RJA and SaTH, which are being monitored via the ICB and tiering calls.

Key Risks and mitigations:

- **Risks:** 1) Backlogs in specialties will continue to cause long waits. 2) Capacity constraints. 3) Impact not at level expected. 4) Clinical and operational workforce constraints 5) Pathways requiring multiple diagnostics have greater chance of delays. 6) CYP with already complex difficulties may develop more exacerbating needs whilst waiting for assessment or treatment which may then impact upon their treatment outcomes including wider impacts e.g. access to education. Clinical risk assessment to ensure impact of harm minimised. 7) Reliance on outsourced reporting for diagnostics presents a sustainability and cost risk. 8) Reliance on mobile MRI capacity creates a continuity risk
- **Mitigations:** Actions outlined above

Planned Care ctd.

Key Actions:

- SaTH specific RTT actions: Using breach forecasting tool to improve specialty capacity planning and reduce waiting times. Implement “route to zero” methodology to eliminate long waiting patients. Continue Planned Care Improvement Programme for outpatient and inpatient productivity. Working with For Eyes consultancy on clinic template optimisation and implementation of digital tools. Implement Dr Doctor communication system across specialties booked via Patient Access
- RJAH specific RTT actions: Target NHSE Q4 sprint investment to reducing long waits. Introduce additional Metabolic Medicine infusion clinics supporting 100 patients per week. Use independent sector support for DEXA scans for 360 patients. Restart agile insourcing for Rheumatology to address 301 unbooked first appointments. Deploy external resource for telephone validation and booking for 1,330 patients in the 52+ week cohort.
- SCHAT specific RTT actions: Maintain Joint Patient Tracking Lists (PTLs). Implement job planning and standardised clinic templates. Deliver targeted interventions for ENT, Respiratory and Gynaecology waiting lists. Continue collaboration with SaTH to increase ENT capacity.
- SaTH specific cancer actions: Recruitment of a Cancer Clinical Lead. Continue implementation of the Cancer Improvement Plan to improve time to treatment and 62-day performance. Address workforce constraints through partnership working with neighbouring trust and insourcing for key pathways.
- RJAH specific cancer actions: Service Manager to review and address cancer breach reasons. Engage with Shropshire Cancer Programme Lead to address late external referrals. Work with ICB to improve communication from GPs so patients are aware they are on a cancer pathway.
- There is a cohort of children who may require restrictive buggies who are unable to access the current wheelchair provider. These families have been asked to contact the ICB if they have needs relating to wheelchairs/buggies. This will enable unmet needs to be identified and an approach to be determined.
- SaTH specific actions for diagnostics: Continue outsourced reporting to provide additional capacity and support MRI and CT turnaround times. Use enhanced payments and waiting list initiatives to increase in house reporting sessions across modalities. Daily coordination between Radiology and Gynaecology booking teams to maximise utilisation of PMB ultrasound capacity. Additional ultrasound slots to support urology cancer pathway. Progress the sustainable endoscopy programme, including implementation of the approved 3-year business case, use of independent sector support, recruitment and training of substantive endoscopy workforce.
- RJAH specific actions for diagnostics: Develop and submit a radiography workforce plan to address upcoming staffing gaps. Work with Specialist Unit Associate Chief Nurse to secure a patient transfer area for spinal injury patients requiring MRI. Provide staff training for complex patient transfers to improve MRI access for spinal injury patients,

1.7 Mental Health - Adults

Mental Health - Adults											
Metric Table											
Metric Name	Workstream	Metric Type	Latest Date	Target	Value	Var.	Ass.	Target Met	Plan Met	Mean	
Talking Therapies reliable recovery after 2+ contacts	Mental Health	STW	Jan 26	48%	50%					48.1%	
Talking Therapies patients reliably improved after 2+ contacts	Mental Health	STW	Jan 26	67%	73%					72.1%	
Talking Therapies First seen <18 weeks	Mental Health	STW	Jan 26	95%	90%					82.4%	
OAP – Active inappropriate out of area adult placements	Mental Health	STW	Nov 25	0	5					5	
Patients accessing perinatal mental health	Mental Health	STW	Jan 26	501	975					814	
Proportion of Adult SMI having Physical Health Checks	Mental Health	STW	Feb 26	60%	55.1%					53.9%	
Number of people accessing IPS (rolling 12 months)	Mental Health	STW	Jan 26		580					476	
Escalation charts No concerning variation reported, so no charts required this month.											
Focus Headlines: Talking therapies: 18-week first seen performance below target at 90% SMI health checks: Performance remains below target at 55.1% but still expected to achieve the year-end target of 60% Narrative: Talking therapies: Affected by patient preferences for specific appointment times SMI health checks: Practices with low performance identified for follow up Inappropriate out of area placements: Published data rounded to nearest 5 affecting accuracy of reporting. Local reporting will be used to mitigate this. Key Actions: Talking therapies: Patients being offered more appointment choices SMI health checks: Meeting arranged in March to review workforce issues in MPFT Long stays: Inpatient Quality Transformation Programme (IQTP) will explore alternative local specialty services for Emotionally Unstable Personality Disorder patients with long stays Out of area placements: Patients reviewed daily to support repatriation to Redwoods. MPFT reviewing rehabilitation and discharge pathways. Hospital at Home programme framework will support community reintegration and reduce admissions (March 2026) Key Risks and mitigating actions: Out-of-Area Placements: Limited local bed capacity can cause clinical harm, longer stays away from family, reduced therapeutic support, and higher supervision needs, with oversight more difficult due to distance. Regular reviews of OOA patients undertaken. OOA protocol monitoring and authorising OOA placements. Housing and Rehabilitation Gaps: Lack of appropriate pathways delays discharges, extending hospital stays unnecessarily. Elms Unit serving as the rehabilitation pathways from Redwoods											

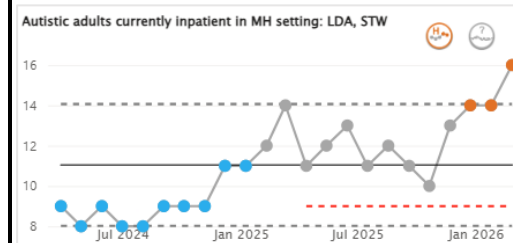
1.8 Learning Disability and Autism – LDA

Learning disability and Autism (LDA)

Metric Table

Metric Name	Workstream	Metric Type	Latest Date	Target	Value	Var.	Ass.	Target Met	Plan Met	Mean
% Annual Health checks per LD register aged 14 or over	LDA	STW	Jan 26	75%	55.1%					22.4%
Autistic adults currently inpatient in MH setting	LDA	STW	Feb 26	9	16					11.0
LD adults currently inpatient in MH setting	LDA	STW	Feb 26	7	9					9.39
LDA children currently inpatient in MH setting	LDA	STW	Feb 26	1	1					2.83

Escalation charts



Focus Headlines:

- There are 25 Adults occupying a MH bed of which 16 are Autistic and 9 with diagnosed LD, against Q4 plan of 14.
- Annual health checks continue ahead of plan and on track to meet 75% target by year end.
- Autistic inpatients in mental health settings is beginning to show concerning variation

Narrative:

- **Adult Inpatients:** Three admissions and two discharges in month, now 9 above plan. Issue with admissions of Autistic adults whose mental health issues were not known to service and not on the DSR (Dynamic Support Register). Some discharges are planned but estimated discharge dates need to be reviewed.
- **CYP Inpatients:** The remaining child has an amber-rated discharge plan

Actions:

- Oswestry bungalows project for up to four individuals progressing and NHSE approval achieved
- Adults with complex needs: Procurement undertaken due to be in place April 2026
- Review of Intensive Support Team (IST) to be undertaken as caseload is above capacity. To be monitored as part of Contract Review Meetings (CRM)
- Redwoods to work with TCP to review any adjustments required in discharge planning and co-ordination including post discharge support.

Key Risks and mitigations:

- People are staying in hospital in more restrictive placement longer than necessary which can impact on their quality of life. Mitigating actions include: treatment and discharge plans monitored for longer stay patients; proactive strategies to prevent avoidable admissions; all inpatients regularly review through TCP; a Barriers to Discharge checklist developed to identify obstacles early supporting proactive planning and escalation

1.9 ASD and ADHD

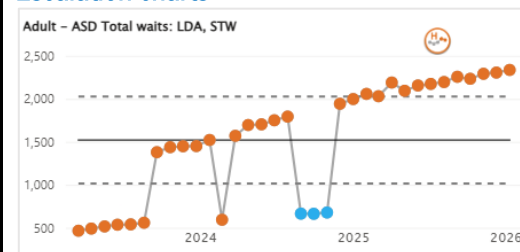
ASD and ADHD

All data in this section based on unvalidated local data

Metric Table

Metric Name	Workstream	Metric Type	Latest Date	Target	Value	Var.	Ass.	Target Met	Plan Met	Mean
CYP – ASD Total waits (5-17)	LDA	STW	Jan 26	1						711
CYP – ADHD Total waits (5-17)	LDA	STW	Jan 26	272						475
Adult – ASD Total waits	LDA	STW	Jan 26	2,336						1,520
Adult – ADHD Total waits	LDA	STW	Jan 26	2,549						2,779

Escalation charts



All Age ASD and ADHD Escalation Points

NB – This data is subject to validation, so must not be relied upon until fully validated.

Focus Headlines:

- Waiting lists remain high for adults and children waiting for ASD and ADHD assessments
- Adults ASD waiting list continues to show concerning variation as numbers continue to rise.
- It has been identified that some ADHD accredited providers waiting lists are not included in the reported figures. Work is in hand to identify how these waiting lists can be captured effectively.

Narrative:

- Adult ADHD:** High demand continues to exceed commissioned capacity leading to long waits consistent with national trends. The average wait is 38 weeks.
- Adult ASD:** High demand continues to exceed commissioned capacity with numbers waiting increasing to 2,336
- Children's ND:** Increased to 3,948 waiting. Young patients are initially triaged under ND before being added to other lists. ND waits continue to rise, and these will incorporate waits for ADHD and autism.

Key Actions:

- ASD/ADHD Task and Finish group reviewing action plan and issues escalated to Exec level group for oversight and governance
- Recruitment of Care Navigators to support children and families waiting for assessment
- Adult ASD improvement plan and trajectory requested from MPFT
- Quality improvement project refining processes to increase capacity
- Waiting list validation process being undertaken

Key Risks and mitigations:

- Longer waiting times for assessment and treatment that could potentially lead to Physical and Psychological Harm. Mitigating actions include access to 24/7 Mental Health Access Team for support reducing harm from long waits; Neurodevelopmental Waiting List Group reviewing opportunities to reduce waiting times and ensure system wide support; utilise Right to Choose for providers offering shorter waits; pilot specialist autism and ADHD service is proposed to support people with mental health needs in the community; and enhanced pre-diagnosis support,

1.10 Children and young people (CYP)

Children and Young People (CYP)										
Metric Table										
Metric Name	Workstream	Metric Type	Latest Date	Target	Value	Var.	Ass.	Target Met	Plan Met	Mean
Referrals aged u18 from A&E to liaison psychiatry < 1 hour	Mental Health	STW	Jan 26		65%					43.1%
CYP Eating Disorders (Routine) seen within 4 weeks	Mental Health	STW	Jan 26	95%	100%					84.4%
CYP – persons U18 supported with at least 1 contact	Mental Health	STW	Jan 26	8,341	7,135					6,143

Escalation charts

No concerning variation reported, so no charts required this month.

 Children and Young People Escalation Points **Focus Headlines:** - Eating Disorders (routine) standard achieved with 100% seen within 4 weeks - CYP access has improved again in-month but remains below plan; remedial action plan is in place. **Narrative:** - Eating disorder:** Routine performance is now meeting target, with sustained improvement. However, urgent referrals are underperforming. - CYP Access:** On target to meet planned recovery trajectory by summer 2026. **Key Actions:** - Eating disorder:** Deep dive into Urgent Eating Disorder provider data involving NHS Digital regional lead. - CYP access:** A formal remedial action plan is in place with fortnightly task & finish group meetings reviewing progress against key actions around recruitment, productivity, and improving data quality. Extension of contracts for Kppth and SYA. Main provider undertaking a quality improvement project to refine pathways and improve productivity **Key Risks and mitigations:** - CYP risk harm or crisis while waiting for assessment or treatment. Provider data reliability (and MHSDS resubmission) is uncertain, limiting ability to predict CYP access performance. Mitigations include the 24/7 Mental Health Text Support Service remains in place, alongside the 24/7 Mental Health Access Team, with triage in place to prioritise higher-risk cases and reduce harm; Quality Improvement project outlined above. The “Proactive support whilst waiting” programme monitors CYP on waiting lists to identify changes in circumstances and mitigate risk. |

1.11 Quality

Quality

Metric Tables

Metric Name	Workstream	Metric Type	Latest Date	Target	Value	Var.	Ass.	Target Met	Plan Met	Mean
FFT: Maternity Birth % Positive	Quality	SaTH	Dec 25	0%						85.6%
Mothers per 1000 with post-partum haemorrhage >=1500ml	Quality	SaTH	Dec 25	24						26.9
Mothers Smoking at Time of Delivery	Quality	SaTH	Dec 25	4.3%						7.74%
Maternity Booking before ten weeks	Quality	SaTH	Nov 25	68.2%						49.4%

Metric Name	Workstream	Metric Type	Latest Date	Target	Value	Var.	Ass.	Target Met	Plan Met	Mean
FFT: Inpatient % Responded	Quality	RJAH	Jan 26	100%						100%
FFT: Inpatient % Responded	Quality	SaTH	Jan 26	1.93%						13.7%
FFT: Inpatient % Positive	Quality	RJAH	Jan 26	97.7%						98.5%
FFT: Inpatient % Positive	Quality	SaTH	Jan 26	92.7%						97.5%
FFT: Community % Responded	Quality	SCHT	Jan 26	0.731%						1.32%
FFT: Community % Positive	Quality	SCHT	Jan 26	96.3%						97.2%
FFT: Maternity Antenatal Care % Positive	Quality	SaTH	Jan 26	80%						80.6%
FFT: Maternity Birth % Responded	Quality	SaTH	Jan 26	0.322%						3.60%
FFT: Maternity Birth % Positive	Quality	SaTH	Dec 25	0%						85.6%
FFT: Maternity Postnatal Ward % Positive	Quality	SaTH	Dec 25	0%						49.2%
FFT: Maternity Postnatal Community % Positive	Quality	SaTH	Jan 26	0%						70.2%
FFT: AE % Responded	Quality	SaTH	Jan 26	7.42%						3.28%
FFT: AE % Positive	Quality	SaTH	Jan 26	72.2%						65.1%
FFT: MH % Responded	Quality	MPFT	Jan 26	0.756%						1.21%
FFT: MH % Positive	Quality	MPFT	Jan 26	81.5%						88.8%

Metric Name	Workstream	Metric Type	Latest Date	Target	Value	Var.	Ass.	Target Met	Plan Met	Mean
Number of cases – C-difficile	Quality	STW	Jan 26	12	16					14.1
Number of cases – E-coli	Quality	STW	Jan 26	36	34					39.7
Number of cases – Pseudomonas aeruginosa	Quality	STW	Jan 26	2	4					3.38
Number of cases – Klebsiella	Quality	STW	Jan 26	7	9					9.74
Number of cases – MRSA	Quality	STW	Jan 26	0	2					0.676
Number of cases – MSSA	Quality	STW	Jan 26	9						11.6

Focus Headlines:

- **Maternity:** Mothers smoking at time of delivery (SATOD) – Data continues to show sustained improvement this month at 4.3%. Maternity Booking before 10 weeks showing continued sustained improvement.
- **Maternity FFT:** Response rates remain extremely low currently at 0%. This indicates existing mechanisms for collecting feedback are not generating meaningful engagement. Further targeted action required to improve accessibility, awareness and real-time completion of the survey.
- **MPFT FFT:** Remains within normal variation and consistent in response rates
- **SCHT** – Overall positive response static; response rates remain low.
- **IPC:** C-diff above trajectory in January at 16 cases. E-coli is below monthly trajectory. Klebsiella above monthly trajectory at 9 cases. Pseudomonas above monthly trajectory at 4 cases.
- **IPC:** MRSA above trajectory in January at 3 cases. PIR themes / trends from the 3 January cases identified that correct cleaning of site did not follow policy including incorrect swabbing of sites, delay in prescribing therefore delaying decolonisation treatment. Awaiting action plans

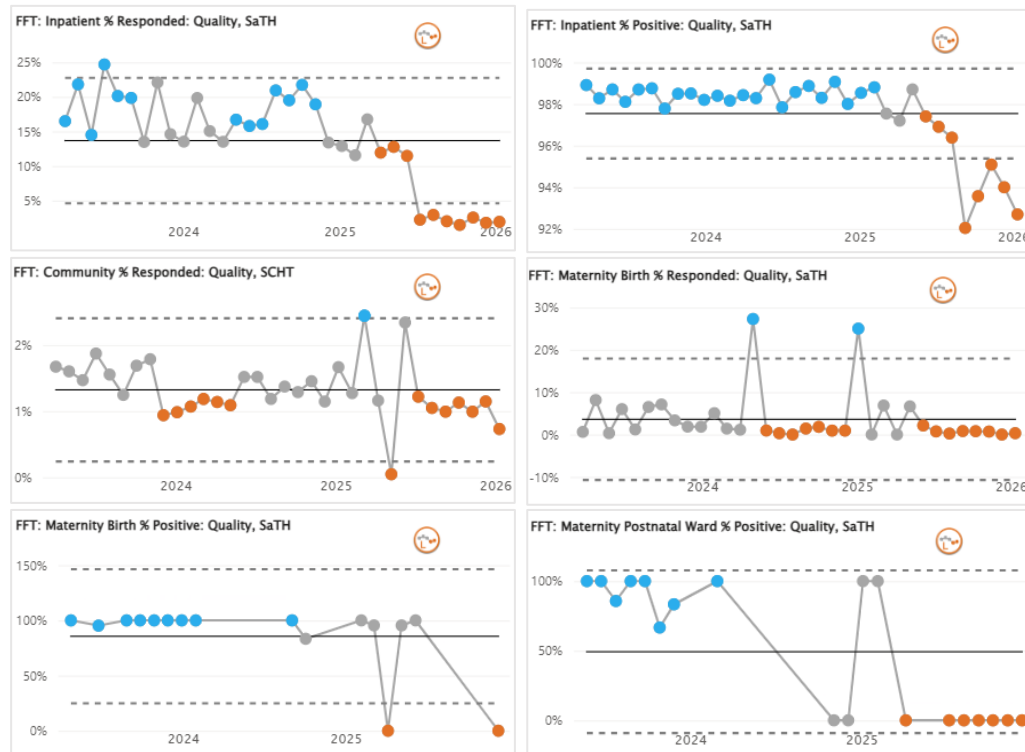
Key Actions:

- **SaTH FFT**– Patient feedback is being reviewed for thematic learning. Patient Experience Team undertaking additional audits as response rate is low for ED.
- **Maternity FFT:** QR codes on inpatient bedsides for ease of response. Discharge Planning specialist leading targeted work to improve response rates. This includes proactive engagement with mothers on the ward rather than waiting to point of discharge to encourage feedback.
- **SCHT FFT:** FFT text messaging and supporting teams continues to boost response rates
- **MPFT FFT:** Continue to collect telephone feedback for those unable to use digital methods. Inpatients encouraged to complete on ward.
- **CDI:** Business case for Fidaxomicin going through governance. Fidaxomicin used first line for vancomycin failures and recurrence/relapse in current recommendations.

Key Risks and mitigating actions:

- **FFT Risks:** 1) Risk of not receiving timely data for FFT from NHS England means that we cannot act upon recommendations of patients. 2) The move to digital FFT responses is causing a decrease in response by patient

Escalation charts



in several organisations. 3) FFT responses are not representative of experience due to low response rates

- **Mitigations for FFT: MPFT** – Patient experience team supporting divisions with SMS/digital FFT rollout. **SaTH** – Deputy Director of Nursing and Patient Experience Lead promoting QR code and feedback methods in ED. **ED Audits** – 20 extra weekend audits per site; themes to be reviewed in new monthly assurance paper. **SCHT** – Teams encouraged to promote responses/escalation via divisional meetings; FFT text messaging service in development.
- **IPC Risks:** 1) Harm to patients and potential for extended hospital stay. 2) Unable to complete deep cleans as no decant ward / area available. Mitigations are the key actions identified above

1.12 Workforce

Workforce	
Focus Headlines: • Overall provider workforce expenditure YTD is adverse to plan by £16.6m - bank overspend YTD at £11.9m. • Current full year run rate is £20.4m adverse to plan showing slight deterioration on M10 of £0.3m • Overall WTE is above plan by 102 WTE (1%) with bank exceeding plan by 87 WTE (13%) but partially mitigated by agency which is 32 WTE (34%) below plan. • NHS Infrastructure Support costs favourable to plan by £5.7m/6.5% YTD. The mismatch in reporting between WTE and pay spend is a national issue due to different definitions within PFRs and PWRs and is being addressed through a regional workforce establishment working group.	Key Actions: • SaTH successfully fulfilled the criteria to exit special measure including demonstration of increased grip and control over temporary staffing usage • SCHAT recruitment plans in delivery for prison vacancy, monitoring impact of UCR expansion of agency usage (inc. Band 2/3 agency) and continued rollout of NHSP • Reconcile contracted and actual worked wte to understand underlying causes of misalignment between workforce spend and WTE alongside the NHSE Regional Pay Spend Disaggregation Template – commencing April 2026 Key Risks: • SaTH medical efficiency schemes fail to deliver planned savings and increase reliance on bank – mitigations in place overseen by the Financial Recovery Team. • Continued reliance on temporary staffing adversely impacts quality, performance and financial plans – mitigated but premium bank rates still in use across fragile services

Shropshire, Telford and Wrekin: Workforce Highlight Report: M11

STW M11 Workforce Expenditure (£000) * NB: Numbers below are provider only and exclude capital pay costs

	Plan YTD £000	Actual YTD £000	Var YTD £000	FY Plan £000	FY Forecast £000	FY Run Rate £000	FY Plan vs Forecast £000	FY Plan vs Run Rate £000
Substantive								
Non Medical Clinical	317,211	338,239	21,028	345,163	363,660	368,988	18,497	23,825
Non Medical Non Clinical	83,863	77,626	-6,237	91,366	84,996	84,683	-6,370	-6,683
Medical Dental	152,458	144,381	-8,077	166,150	154,276	157,507	-11,873	-8,643
Total Substantive	553,532	560,246	6,714	602,679	602,933	611,177	254	8,499
Bank								
Non Medical Clinical	24,033	29,409	5,376	25,948	30,134	32,083	4,186	6,135
Non Medical Non Clinical	3,532	4,203	671	3,774	4,327	4,585	553	811
Medical Dental	18,289	24,181	5,892	19,834	24,479	26,379	4,645	6,545
Total Bank	45,854	57,793	11,939	49,556	58,940	63,047	9,384	13,491
Agency								
Non Medical Clinical	5,918	4,588	-1,330	6,283	5,152	5,005	-1,131	-1,278
Non Medical Non Clinical	642	523	-119	700	700	571	0	-129
Medical Dental	6,187	5,833	-354	6,531	6,906	6,363	375	-168
Total Agency	12,747	10,944	-1,803	13,514	12,758	11,939	-756	-1,575
GRAND TOTAL	612,133	628,983	16,850	665,749	674,631	686,163	8,882	20,415

Overall Headcount (WTE)

WTE	M11 Plan	M11 Actual	M11 Variance
Substantive	10,591	10,639	+ 48
Bank	678	765	+ 87
Agency	95	63	- 32
Total	11,364	11,467	+ 102

NHS Infrastructure Support (WTE & £000)

	WTE M11 Plan	WTE M11 Actual	WTE M11 Var	£000 M11 YTD Plan	£000 M11 YTD Actual	£000 M11 YTD Var
Subs	2,434	2,607	+173	83,863	77,626	(6,237)
Bank	69	111	+ 42	3,532	4,203	671
Agency	6	5	- 1	642	523	(119)
Total	2,509	2,723	+214	88,037	82,352	(5,685)

KPI	Plan	Performance *exc MPFT
Delivery of 2025/26 Workforce Plan: WTE	WTE 11,364	WTE 11,467 (102 WTE or 0.9% adverse variance)
Delivery of 2025/26 Workforce Plan: Expenditure across all staff types (exc capitalised pay costs)	£612.13 m	£628.98m (£16.85m or 2.8% adverse variance)
Turnover	9.8%	TBC
Sickness	5.2%	TBC
% Agency Framework Compliance	100%	100%
Agency as % Total Pay	2.0%	1.7%
Consultant Job Plans	95% (national target)	STW 370/382 = 97% SCHAT 6/6 SATH 265/269 RJA 99/107

Key Messages:

- Overall provider workforce expenditure YTD is adverse to plan by £16.6m - bank overspend YTD at £11.9m.
- Current full year run rate is £20.4m adverse to plan showing slight deterioration on M10 of £0.3m
- Overall WTE is above plan by 102 WTE (1%) with bank exceeding plan by 87 WTE (13%) but partially mitigated by agency which is 32 WTE (34%) below plan.
- NHS Infrastructure Support costs favourable to plan by £ 5.7m/6.5% YTD. The mismatch in reporting between WTE and pay spend is a national issue due to different definitions within PFRs and PWRs and is being addressed through a regional workforce establishment working group.

Key Actions:

- SaTH successfully fulfilled the criteria to exit special measure including demonstration of increased grip and control over temporary staffing usage
- SCHAT recruitment plans in delivery for prison vacancy, monitoring impact of UCR expansion of agency usage (inc. Band 2/3 agency) and continued rollout of NHSP
- Reconcile contracted and actual worked wte to understand underlying causes of misalignment between workforce spend and WTE alongside the NHSE Regional Pay Spend Disaggregation Template – commencing April 2026

1.13 System Financial Position

Finance (Month 11)	
Focus Headlines: Narrative - Revenue: The ICS is reporting a £2.8m actual YTD System deficit, £2m adverse to plan YTD at M11, post deficit support funding. The 2025/26 expected forecast outturn is a £2.3m favourable variance to plan (SCHT £0.3m and ICB £2m), after £83.8m deficit support funding. These forecasts include delivery of efficiency of £103.2m against a target of £95.5m, an over delivery of £7.7m. ICB – Has a year-to-date favourable variance of £1.75m this is namely due to the delivery of additional efficiency and prior year benefits. SaTH – Are reporting a year-to-date adverse variance of £4m, namely driven by additional costs of UEC capacity and non-delivery of wte reductions. RJAH – Are reporting delivery on plan year-to-date. SCHT – Have a year-to-date favourable variance of £0.3m. Narrative - Capital: Year to date system operational capital spend is £30.5m behind plan at month 11, namely due to the difference in spend profile of HTP compared to plan, all capital schemes are expected to be delivered in line with plan by year end.	Key Actions: Revenue: Note that the ICS is reporting a £2.8m actual YTD System deficit v's £0.8m deficit plan, giving a £2m adverse variance at M11, improved from £3.6m in M10. Note that the 2025/26 expected forecast outturn is a £2.3m surplus after £83.8m deficit support funding. Capital: Note that the ICS at Month 11 is reporting a £30.5m underspend against plan namely due to the profile of capital spend compared to plan. Note that all providers and the ICB have confirmed expected FOT in line with the capital plan, this includes additional capital received and spent in year above the original plan value offset by HTP cash reprofiling. Key Risks and mitigating actions: Revenue: At month 11 SATH have reported potential unmitigated risk of £2m, the System has sought to mitigate this difference to plan thus delivering the System plan overall. Capital: Ongoing capital programme management is in place to ensure capital spend is in line with plan.

System Financial Position Month 11

Financial Performance	YTD			FULL YEAR		
	Plan	Actual	Variance	Plan	Forecast	Variance
Organisation	Surplus/ (Deficit)	Surplus/ (Deficit)	to Plan	Surplus/ (Deficit)	Surplus/ (Deficit)	to Plan
	£000	£000	£000	£000	£000	£000
Commissioners						
NHS Shropshire, Telford and Wrekin	(1,569)	182	1,751	(2,000)	38	2,038
Total Commissioners	(1,569)	182	1,751	(2,000)	38	2,038
Providers						
The Shrewsbury and Telford Hospital NHS Trust	0	(4,098)	(4,098)	0	0	0
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS FT	(1,070)	(1,052)	18	0	0	0
Shropshire Community Healthcare NHS Trust	1,798	2,093	295	2,000	2,300	300
Total Providers	728	(3,057)	(3,785)	2,000	2,300	300
TOTAL SYSTEM Performance Financial Position Surplus/(Deficit)	(841)	(2,875)	(2,034)	0	2,338	2,338
Non-Recurrent Deficit Funding	(79,265)	(79,265)	0	(83,795)	(83,795)	0
NHSE Approved Position	(80,106)	(82,140)	(2,034)	(83,795)	(81,457)	2,338

System Key Data:

System FOT improved from breakeven at M9 to £2.3m favourable variance at M10, ICB breakeven and £2m favourable variance and SCHAT £0.3m favourable variance. FOT for RJA/SATH is breakeven.

System - In month 11 the system is reporting a £2,875k YTD deficit, £2,034k adverse variance to plan and improvement from £4,341k deficit in month 10 which was a £3,581k adverse variance to plan.

Organisation Specific Key Data:

- ICB** - Month 11 YTD surplus of £182k which is £1,751k favourable to plan. This is after the recognition of £35.4m non recurrent deficit funding. Efficiency delivery is ahead of the phased plan year to date (£6.4m favourable) due to individual commissioning but is in line with the overall annual efficiency plan. 25/26 costs include the impact of ICB government reform.
- SaTH** - Month 11 YTD £4,098k deficit, supported by £43.8m of non-recurrent deficit funding. £37.1m efficiency delivery year to date which is £0.3m favourable against plan. Pressures on pay of £20.8m year to date, partly offset by income backed posts overspend on bank is due to additional support for escalation activity and the effect of holding vacancies, however, is partially offset against reduced agency and substantive pay. SATH have mitigated non-delivery of wte reductions and bank overspend although additional funding for Industrial Action costs was provided in Month 9. The adverse variance is offset by income, namely in respect of WMCA income, and early recognition of some efficiency schemes.
- RJA** - Month 11 YTD £1,052k deficit, £18k favourable to plan. £9,715k efficiency delivery year to date, £1,118k favourable to plan. Shortfalls in clinical and commercial income are being offset by expenditure decreases from marginal cost reductions, recruitment slippage and continued delivery of Investigation and Interventions action.
- SCHT** - Month 11 YTD surplus of £2,093k, £295k favourable to plan due mainly to cost pressures in Prison mental health and Rehab and Recovery Unit out of hours being offset by non-recurrent pay savings and efficiency performance. Pay underspend £584k driven by delays in filling substantive vacancies. Bank staff overspend offset by substantive vacancies and agency underspend. Efficiency is £227k favourable to plan.

System Risk Summary Month 11

	25/26 Gross Risk £'000	Mitigation £'000	Un-Mitigated Risk/ (Opportunity) £'000
System Risk			
NHS Shropshire, Telford & Wrekin ICB	3,200	(3,200)	0
Robert Jones & Agnes Hunt Hospital	2,608	(2,608)	0
Shrewsbury & Telford Hospitals	17,300	(15,300)	2,000
Shropshire Community Hospital Trust	300	(300)	0
Grand Total	23,408	(21,408)	2,000

System Key Data:

System - In month 11 the system is reporting a net risk of £2m, this is an improvement from £3.6m reported in month 10, mitigations have been identified to address this risk by year end.

Organisation Specific Key Data:

ICB - Total Risk £3.2m; fully mitigated

- Efficiency risk £0.5m – Independent Sector activity – mitigated by activity plan enforcement/contract management.
- Cost risk £2.7m – Individual Commissioning activity and inflation, Prescribing costs, Better Care Fund and Acute and Mental Health NCAs – mitigated by internal processes for reducing Individual Commissioning cost, Commissioning policies under development and control processes in place to monitor spend in line with agreed criteria.

RJAH - Total Risk £2.6m; fully mitigated

- Income risk £2.5m - LVA, Insourcing, non delivery of elective activity plan, Contract activity and Powys contract – mitigated by activity monitoring, workforce controls and ongoing contract negotiation.
- Efficiency risk £0.1m – medium risk schemes – mitigated by additional contingency schemes being reviewed monthly.

SATH - Total Risk £17.3m; £15.3m mitigated, mitigations have been identified to offset the remaining risk by year end

- Income risk £2.4m - Activity and Clinical income - £1.4m unmitigated Powys Non-Elective activity growth.
- Efficiency risk £2.8m - medium risk schemes - increased efficiency scheme delivery to meet the original plan target plus UEC investment - fully mitigated by additional contingency and pipeline mitigation schemes, being reviewed monthly.
- Cost risk £12.1m - Workforce, inflation, escalation and pay award additional costs – £11.5m mitigated through delayed investments, additional temporary staffing controls for bank/agency, reduced insourcing and elective activity cost reductions (reduced RTT activity in second 6 months), further non pay controls, balance sheet flexibilities and workforce management and FIP/FRG oversight and management. £0.6m unmitigated arising due to industrial action activity.

SCHT - Total Risk £0.3m; fully mitigated

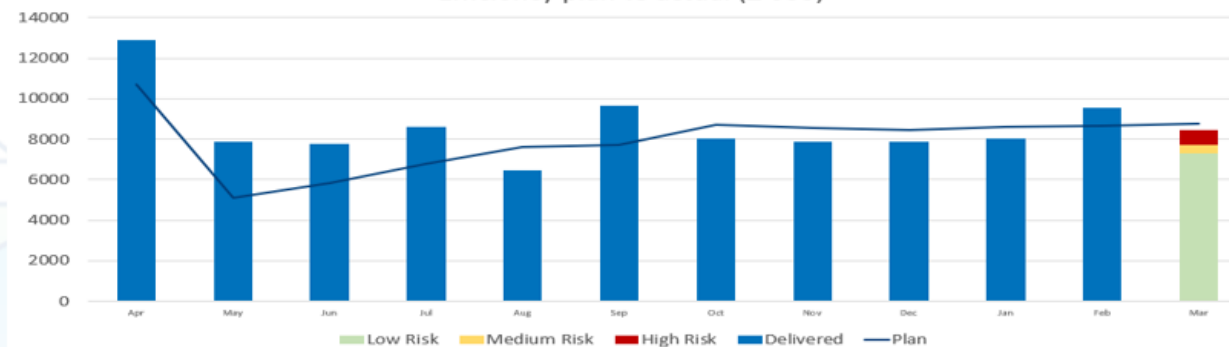
- Cost risk £0.3m – Estates and escalation risk – mitigated by contract monitoring and FRG oversight.

Efficiency Summary Month 11

25/26 Month 11 YTD Planned Savings £86.7m	25/26 Month 11 YTD Actual Savings £94.7m	25/26 Savings Month 11 YTD Variance £8m	25/26 Savings Plan £95.5m	25/26 Savings Forecast £103.2m	25/26 Savings Variance £7.7m

Partner Organisation	Annual Plan £'000	YTD Plan £'000	YTD Delivery £'000	YTD Variance to Plan £'000
ICB	39,180	36,442	42,802	6,360
SaTH	41,400	36,848	37,123	275
RJAH	9,594	8,597	9,726	1,129
SCHT	5,359	4,869	5,096	227
Total	95,533	86,756	94,747	7,991

Efficiency plan vs actual (£'000)



Key Updates

- At Month 11 NHS Shropshire Telford and Wrekin has delivered **£94.7m** of efficiency savings against a plan of **£86.7m** which is **£8m** favourable to plan.
- We are anticipating to meet the most likely forecast position of **£103.2m** which is **£7.7m** favourable to plan.
- This includes the delivery of High-Risk schemes including planned headcount reductions (£550k).
- The remaining Medium Risk relates to reducing the cost of workforce and UEC Pathways at SaTH and specialist unit efficiency at RJAH.
- Focus is now drawn to the development and delivery of 26/27 efficiency including the benefits from transformational plans which will deliver over the next 3 years.



Capital Summary

CAPITAL PROGRAMME	YTD			FULL YEAR		
	Plan	Actual	Variance to Plan	Plan	Forecast	Variance to Plan
Organisation	£000	£000	£000	£000	£000	£000
Total Charge against Capital Allocation (including impact of IFRS16)						
NHS Shropshire, Telford and Wrekin	757	532	(225)	6,191	1,191	(5,000)
The Shrewsbury and Telford Hospital NHS Trust	20,168	20,443	275	22,530	28,321	5,791
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS FT	5,879	5,406	(473)	6,336	6,334	(2)
Shropshire Community Healthcare NHS Trust	3,889	3,506	(383)	4,253	4,453	200
TOTAL SYSTEM	30,693	29,887	(806)	39,310	40,299	989
Total CDEL						
NHS Shropshire, Telford and Wrekin	1,607	602	(1,005)	7,083	1,331	(5,752)
The Shrewsbury and Telford Hospital NHS Trust	131,135	102,282	(28,853)	145,915	149,702	3,787
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS FT	7,879	7,866	(13)	9,243	10,375	1,132
Shropshire Community Healthcare NHS Trust	4,566	3,935	(631)	4,975	4,975	0
TOTAL SYSTEM	145,187	114,685	(30,502)	167,216	166,383	(833)

- SATH operational capital YTD is £0.3m ahead of plan. The operational forecast also includes £4.8m additional allocation awarded for UEC capital with capital allocated to the ICB for this spend. Total SATH capital is £28.9m underspent year to date due to RAAC, Estates Safety and a different cash profile for HTP. Total CDEL FOT is £5.8m higher than plan due to additional CDEL for Estates Safety schemes including LIMS/EV charging points. To note HTP cash profiling of £9m has also been approved by NHSE. The HTP project is ahead of plan but under the original cash profile.
- RJAH operational capital is £0.5m behind plan due to the phasing of digital and estates capital schemes which are expected to be caught up by the end of the financial year. FOT is £1.1m above plan due to additional PDC funding received namely for estates safety.
- SCHT operational capital is £0.4m behind plan due to delays in finalising an internal estates capital project which will be recovered by year end. The forecast also includes £0.2m additional allocation awarded for UEC capital.

YTD System spend against CDEL is behind plan by £806k primarily due to a phasing of major capital scheme for digital and estates reconfiguration in the internal SCHT and RJAH capital programmes - spend for both schemes are expected to fall in line with planned FOT.

The total system capital spend - CDEL plus national capital schemes including the Hospital Transformation Programme (HTP) - is £30,502k behind plan due to delays in SaTH schemes (RAAC/Estates Safety). Recovery is anticipated in month 12.

System FOT has decreased by £0.8m largely due to additional CDEL received for RJAH estates safety (£1.1m) and SATH - EV charging points, cyber security, SaTH estates safety and additional revenue to capital support (£8m in total) being offset by the removal of the HTP allocation change request (c.£9m) – approved by NHSE.

SCHT - the Capital Freedoms and Flexibility regime allows capital spend against prior year surplus. This has resulted in £3.6m being deferred to the 26/27 capital plan (IT Hardware and Software, and Whitchurch Ward Refurbishment).

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

ICB spend was delayed due to quotes awaited from practices but spend is expected to catch up by year end. The forecast has reduced by £752k due to changes in the Primary Care Modernisation and Utilisation Fund schemes which are now deferred until 26/27 as agreed with NHS England. The forecast is compared to a £7m plan with £5m system capital receipt for UEC Incentive Capital received by the ICB but with expenditure recorded against SaTH/SCHT.



Finance

Month 11 Financial Summary

This report details the aggregate financial position as at month 11 with high level metrics

Year to date position

At month 11, the system is reporting a £4.9m deficit, representing a £1.8m favourable variance against the planned £6.6 deficit (£3.2m favourable at month 10). Year-to-date, this includes deficits of £5.1m for the ICB, £2 at UHNM and offset by a surplus of £1m at MPFT and £1.2m at NSCHT. While the overall position remains broadly on track, the key driver of variances continues to be lower than planned efficiency delivery, offset by a number of non-recurrent mitigations. Following the adverse variance reported at month 1, recovery trajectories were developed where appropriate. At month 11, the system is now £22.7m behind these recovery trajectories (£19.2m behind at Month 10).

Efficiency delivery

The reported system efficiency delivery YTD is £28.5m behind our submitted plan of £275.4m, this comprises of ICB (£6.5m), MPFT (£0.6m), NSCHT (£0.2m) and UHNM (£21.1m). As a system this equates to 90% delivery YTD.

Forecast and net risk

As a system we are forecasting to meet our year end financial plan of break even, including £95m deficit support funding (DSF) and at month 11 we have reflected revised forecasts as set out below.

Net risk is £1.1m at month 11. This net risk is primarily made up of efficiency risk and additional cost risk. MPFT holds (£0.8m) net risk, NSCHT holds £0m net risk, UHNM holds (£0.1m) net risk and the ICB holds (£0.2m) net risk.

Workforce

The system workforce numbers across providers and ICB (substantive + bank + agency) were 25,273WTE in February 2026. This is a decrease on month 10 of 92.6 WTE. Much of this decrease can be attributed to a decrease in bank and agency staff for MPFT (29.6 WTE) and UHNM (82.6 WTE), offset by 22.9 WTE substantive posts at UHNM. Month 11 workforce numbers were 836 WTE above plan which was seen in substantive (758 WTE) and bank (90 WTE), offset by agency which is under plan by (12 WTE).

Capital

The system submitted a compliant forecast at month 11, any deviations from this will potentially impact 2026/27 should there be material underspends in the remaining months. The capital pressures of IFRS16 and the deferral of the UHNM land sale have been mitigated through a combination of internal actions, additional regional support and system-wide working.

Month 11 Position

- The System is reporting a YTD **favourable position to plan of £1.8m** against a planned deficit of £6.6m. The main drivers for the aggregate YTD position are efficiency slippage (£28.0m) offset with greater than planned use of flexibilities and underspends on vacancies and investment slippage. The efficiency programme phasing in response to the month 1 adverse variance, where appropriate organisations have developed recovery trajectories. At month 11 the system has fallen behind this recovery trajectory by £22.7m (£19.1m month 10).

System	Month 11		
	Plan	£m YTD	Variance
Income	5,049.8	5,062.9	13.2
Pay	(1,291.4)	(1,309.5)	(18.1)
Non Pay	(704.0)	(699.3)	4.7
Non Operating Items (exc gains on disposal)	(33.4)	(31.4)	2.0
ICB Expenditure	(3,027.6)	(3,027.6)	(0.0)
Total	(6.6)	(4.9)	1.8
			0.0%

	Month 10		
	Plan	£m YTD	Variance
	4,593.1	4,599.9	6.8
	(1,175.5)	(1,188.9)	(13.4)
	(640.5)	(637.0)	3.5
	(30.2)	(28.4)	1.8
	(2,758.4)	(2,754.0)	4.4
	(11.6)	(8.4)	3.2
			0.1%

MPFT	Month 11		
	Plan	£m YTD	Variance
Income	659.3	668.9	9.7
Pay	(476.9)	(479.3)	(2.4)
Non-Pay	(183.9)	(191.4)	(7.4)
Non Operating Items (exc gains on disposal)	2.6	2.8	0.2
TOTAL Provider Surplus/(Deficit)	1.0	1.0	0.0
			0.0%

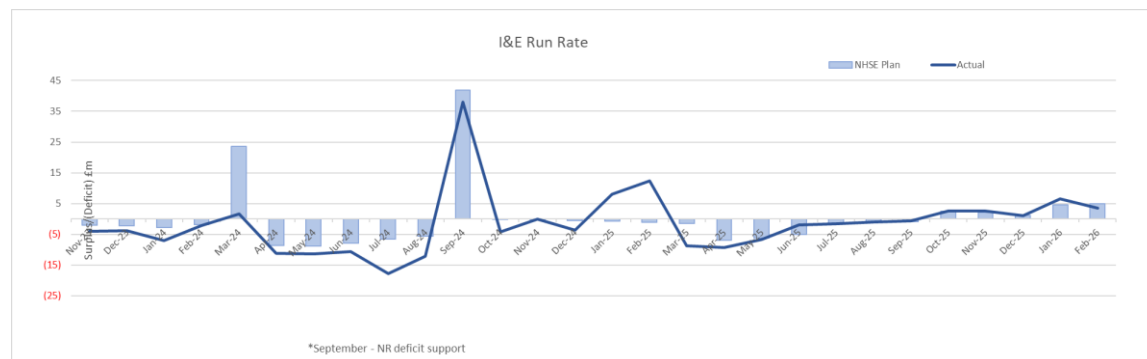
	Month 10		
	Plan	£m YTD	Variance
	599.5	608.4	8.8
	(433.2)	(435.4)	(2.2)
	(166.9)	(173.6)	(6.7)
	2.5	2.5	0.1
	1.9	2.0	0.0
			0.0%

ICB	Month 11		
	Plan	£m YTD	Variance
Allocation	3,022.5	3,022.5	0.0
Expenditure	(3,027.6)	(3,027.6)	(0.0)
TOTAL ICB Surplus/(Deficit)	(5.1)	(5.1)	(0.0)
			0.0%

	Month 10		
	Plan	£m YTD	Variance
	2,749.5	2,749.5	0.0
	(2,758.4)	(2,754.0)	4.4
	(8.9)	(4.5)	4.4
			0.2%

NSCHT	Month 11		
	Plan	£m YTD	Variance
Income	164.9	164.3	(0.7)
Pay	(100.3)	(99.8)	0.5
Non-Pay	(63.9)	(62.2)	1.7
Non Operating Items (exc gains on disposal)	(0.8)	(1.1)	(0.3)
TOTAL Provider Surplus/(Deficit)	(0.1)	1.2	1.3
			-0.8%

	Month 10		
	Plan	£m YTD	Variance
	149.9	149.2	(0.7)
	(91.3)	(90.6)	0.7
	(58.1)	(56.7)	1.4
	(0.7)	(1.0)	(0.3)
	(0.1)	0.9	1.1
			-0.7%



UHNH	Month 11		
	Plan	£m YTD	Variance
Income	1,203.1	1,207.2	4.2
Pay	(714.1)	(730.4)	(16.2)
Non-Pay	(456.2)	(445.8)	10.4
Non Operating Items (exc gains on disposal)	(35.2)	(33.1)	2.1
TOTAL Provider Surplus/(Deficit)	(2.4)	(2.0)	0.5
			0.0%

	Month 10		
	Plan	£m YTD	Variance
	1,094.1	1,092.8	(1.3)
	(651.1)	(662.9)	(11.9)
	(415.5)	(406.7)	8.8
	(32.0)	(30.0)	2.0
	(4.4)	(6.8)	(2.4)
			-0.2%

Key Performance Metrics

- The tables below summarise the run variances. The key point for the Committee to note is that the net risk at month 11 is £1.1m with a run rate extrapolated variance of (£0.3m) – please note that NHS England returns could not be changed this month which has caused North Staffordshire Combined to show a net risk of 0.3m in error in national reporting. The correct position is set out below.

Position	Run Rate		
	Income Extrapolated	Expenditure Extrapolated	Run rate difference to forecast
Staffordshire and Stoke On Trent ICB			
Midlands Partnership University NHS Foundation Trust	729.7	(728.6)	1.1
North Staffordshire Combined Healthcare NHS Trust	179.2	(177.9)	1.3
University Hospitals of North Midlands NHS Trust	1,317.0	(1,319.1)	(2.2)
Total	2,225.9	(2,225.7)	0.3

Efficiency	Efficiency		
	YTD Actual	YTD Variance	YTD Variance %
Staffordshire and Stoke On Trent ICB	146.5	(6.5)	(4%)
Midlands Partnership University NHS Foundation Trust	49.0	(0.6)	(1%)
North Staffordshire Combined Healthcare NHS Trust	6.5	(0.2)	(3%)
University Hospitals of North Midlands NHS Trust	44.9	(21.1)	(32%)
System	246.9	(28.5)	(12%)

Workforce	Agency		
	YTD agency spend £m	FOT agency spend £m	YTD agency spend as % of FOT
Staffordshire and Stoke On Trent ICB			
Midlands Partnership University NHS Foundation Trust	5.5	6.0	91%
North Staffordshire Combined Healthcare NHS Trust	1.5	1.5	95%
University Hospitals of North Midlands NHS Trust	12.1	14.0	87%
System	19.1	21.5	89%

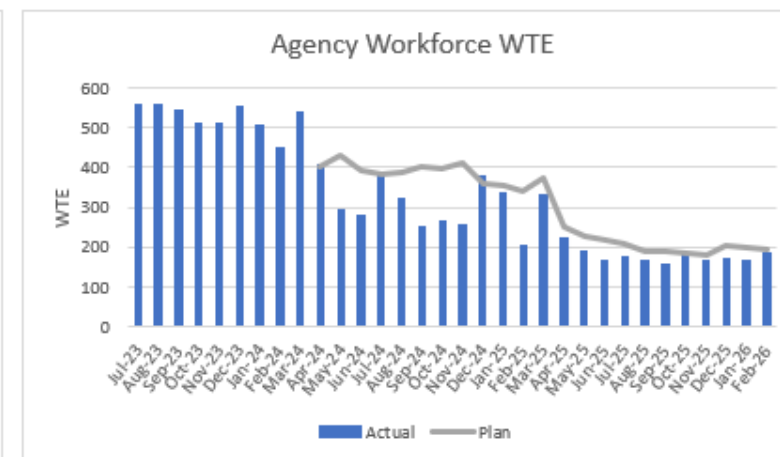
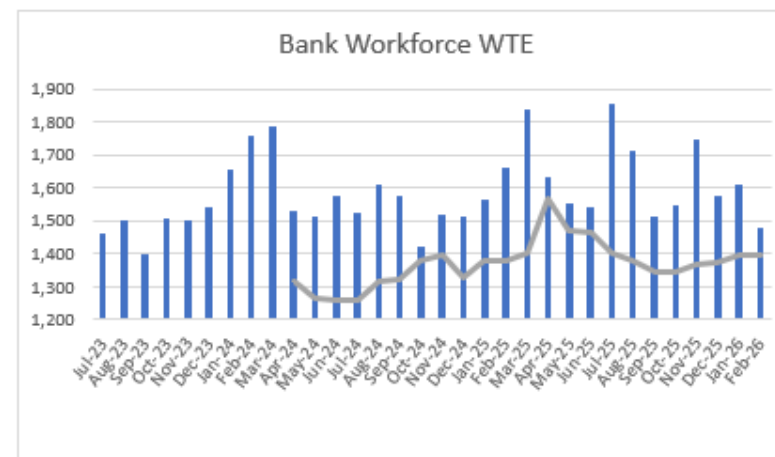
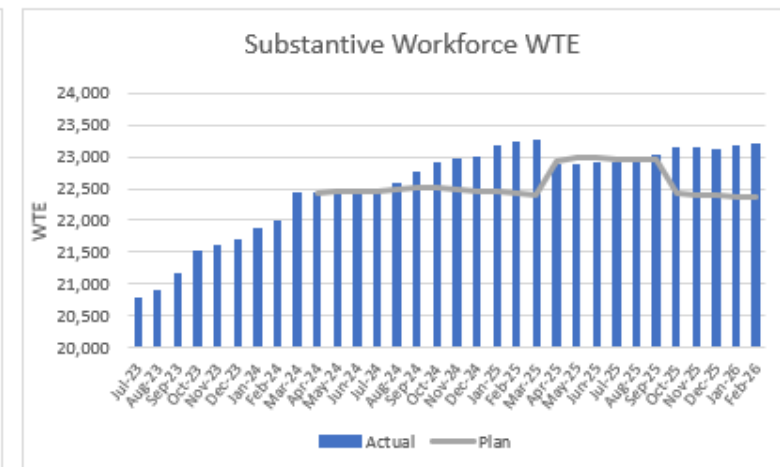
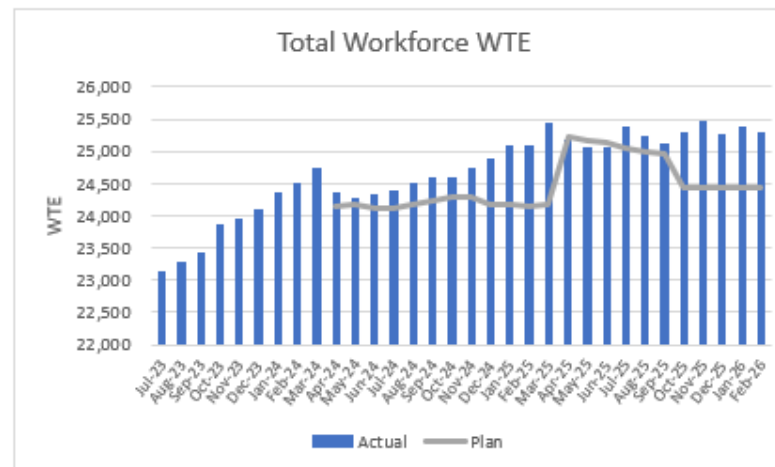
System Net Risk		
Planning Submission	Month 10	Month 11
(11.7)	(0.0)	0.2
(0.7)	(0.0)	0.8
(30.0)	(0.2)	0.0
(54.9)	(7.0)	0.1
(97.3)	(7.3)	1.1

Efficiency FOT		
Efficiency FOT	Forecast Variance	YTD as % of FOT
169.9	(0.0)	86%
54.5	0.5	90%
7.4	0.0	88%
51.6	(23.4)	60%
283.3	(22.9)	81%

Bank		
YTD Bank spend £m	FOT Bank spend £m	YTD Bank spend as % of FOT
21.8	23.6	92%
5.9	6.3	93%
62.0	67.6	92%
89.7	97.6	92%

Workforce

- The system workforce numbers across providers and ICB (substantive + bank + agency) were 25,273WTE in February 2026. This is a decrease on month 10 of 92.6 WTE. This is due to a decrease in bank and agency spend and MPFT and UHNM, offset by 22.9 WTE substantive posts at UHNM
- Month 11 workforce numbers were 836 WTE above plan which was seen in substantive (758 WTE) and bank (90 WTE), offset by agency which is under plan by (12 WTE).
- As a system we were within our agency ceiling by 19.3% (£4.6m),
- Agency spend was 1.5% of total staff spend therefore (1.7%) under the 3.2% ceiling/target.



Capital

- For Month 11 expenditure actuals were £5.4m behind plan
- The majority of the under spend against plan relates to schemes where the plans are not approved or being deferred to 2026/27
- The system submitted a compliant forecast at month 11, any deviations from this will potentially impact 2026/27 should there be material underspends in the remaining months.
- The capital pressures of IFRS16 and the deferral of the UHNM land sale have been mitigated through a combination of internal actions, additional regional support and system-wide working.

Category	YTD £000		
	Plan	Spend	Variance
Capital allocation	37,334	36,266	(1,068)
Return to Constitutional Standards	27,838	25,918	(1,920)
2025/26 Estates Safety	6,454	5,365	(1,089)
2025/26 Mental Health: Reducing Out of Area Placements	5,272	3,900	(1,372)
Total	76,898	71,449	(5,449)

By Organisation	YTD £000		
	Plan	Spend	Variance
MPFT	24,711	20,315	(4,396)
NSCHT	3,502	2,989	(513)
UHNM	48,685	48,145	(540)
System total	76,898	71,449	(5,449)

At month 11 key variances are:

- MPFT** – The main pressure on the forecast has been IFRS16 (£5.5m) due to timing of remeasurements review. The region have confirmed this will be supported with an increase to the system CDEL limit. It should also be noted that one of the 2025/26 Mental Health: Reducing Out of Area Placements schemes (Ellesmere in Patient Rehab £3.95m) was rejected post submission therefore the overall planned spend will be reduced to remain within allocation and potentially funded through the freedoms and flexibility confirmed funding.
- UHNM** – YTD is on track. The main forecast movement in year relates to the disposal of land at former RI and COPD site has deferred into 2026/27, which has been mitigated, including a further allocation for revenue funding. Total forecast expenditure is on plan with the Trust deferring funding on UTC and UEC schemes into 2026/27.
- NSCH** – Small YTD underspend on Chrysalis (replacement of Dormitory Wards) and £159k behind on leases. Both of these are timing issues and plan will be delivered. The project Chrysalis has been funded by mental health funding which has helped the system operating capital position.
- The ICB are forecasting a £318k underspend on GPIT and Utilisation and Modernisation Funding. This sits outside the monthly reporting process as ICB capital is reported within NHSE accounts.

System Performance Report 2025 / 2026

Month 10 (January 2026)

Prepared for the System Performance Group by
the Integrated Care Board (ICB) Intelligence Team,
with drivers of underperformance and actions set out and signed
off in the relevant Portfolios.



Planned Care

Programme	Measure Name	Currency	ICB / Provider	Reporting period	Current Month & direction from previous month		Target	Variance	Plan / baseline	Variance	Trend from April 2024 to current month
Electives	Elective - ordinary spells	Number	ICB	Jan-26	1,855	▼	n/a	-	2,078	-223	
	Elective - day case spells	Number	ICB	Jan-26	15,533	▲	n/a	-	16,444	-911	
	First outpatient attendances - Consultant-led	Number	ICB	Jan-26	42,107	▲	n/a	-	42,107	0	
	Follow-up outpatient attendances - Consultant-led	Number	ICB	Jan-26	70,208	▲	n/a	-	65,706	4,502	
Referral to Treatment (RTT)	Time to first attendance, waiting less than 18 weeks	%	ICB	Jan-26	68.4%	▼	71.8% March 2026	-3.4%	70.3%	-1.9%	
	Total waiting list (Referral to Treatment - Incomplete Pathways)	Number	ICB	Jan-26	138,727	▲	147,032 March 2026	-8,305	148,225	-9,498	
	% Patients waiting less than 18 weeks (Referral to Treatment - Incomplete Pathways)	%	ICB	Jan-26	62.8%	▼	63.4% March 2026	-0.6%	62.1%	0.7%	
	% Patients waiting more than 52 weeks (Referral to Treatment - Incomplete Pathways)	%	ICB	Jan-26	1.7%	▲	0.8% March 2026	1%	1.2%	0.5%	
	Number patients waiting more than 65 weeks (Referral to Treatment - Incomplete Pathways)	Number	ICB	Jan-26	90	▲		90	0	90	
Diagnostics Tests	Diagnostic test activity	Number	ICB	Jan-26	49,254	▲	n/a	-	57,210	-7,956	
	Diagnostic Test Waiting List less than 6 weeks	%	ICB	Jan-26	76.1%	▲	n/a	-	90.5%	-14.4%	
Cancer	People treated beginning first or subsequent treatment of cancer within 31 days	%	ICB	Jan-26	91.8%	▼	94.0% March 2026	-2.2%	93.7%	-1.9%	
	Total patients seen within 62 days (on cancer 62 day pathway)	%	ICB	Jan-26	60.9%	▼	75.2% March 2026	-14.3%	74.5%	-13.6%	
	Cancer 28 day waits (faster diagnosis standard)	%	ICB	Jan-26	72.8%	▼	80.0% March 2026	-7.2%	79.1%	-6.2%	
	Lower gastrointestinal (GI) referrals with an Faecal Immunochemical Test (FIT) result (Year to Date Cumulative)	%	ICB	Jan-26	81.0%	▲	n/a	-	78.0%	3.0%	
Procedures Completed (Local Metric)	Increase the proportion of procedures completed in outpatients or as a day case (UHNM)	%	UHNM	Jan-26	89.3%	▲	n/a	-	87.9%	1.4%	
Community	Community care contacts	Number	ICB	Dec-25	169,240	▼	n/a	-	135,518	33,722	
	52+ weeks in community services	Number	ICB	Jan-26	5	⇒	n/a	-	0	5	
	Combined elective/non-elective length of stay (LOS) - community beds	Bed days	ICB	Jan-26	19.0	⇒	n/a	-	19.3	-0.3	

Key to arrows showing direction from previous month	
▲	Improved with a higher value than the previous month,
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▲	Deteriorated with a higher value than the previous month
▼	Deteriorated with a lower value than the previous month
⇒	Equal to the previous month
n/a	not available

Key to variation Colour	
Red	Negative impact / unwanted variation
Green	Positive impact / desired variation
Yellow	No change / equal
Black	Not applicable / not available

Planned Care National Planning Metrics off Plan and Actions, 1 of 4

Programme Area	Metric	Drivers for underperformance	Top 3 Planned actions provided by portfolio
Elective Activity	Elective Activity – Day Cases and Ordinary Spells In January 2026, the level of activity was below plan for Day Cases (911 under plan) and Ordinary Spells (223 under plan).	- Reduced level of activity with Independent Sector in line with agreed Activity Management Plans, therefore expected. - Across all of 2025/2026 Elective activity remains above plan.	Actions remain the same as last month: NHS providers have 'Sprint' funding to increase elective capacity in Spring 2026 to recover waiting list position. - Continue to monitor Independent Sector providers against Activity Management Plans.
	Follow-up outpatient attendances - Consultant-led In January 2026, there were 70,208 Outpatient Follow-Up attendances, against a plan of 65,706 (a variance of 4,502 attendances). Year to date, there were 715,139 Outpatient Follow-Up attendances, against a plan of 660,490 (a variance of 54,649 attendances).	- Drivers remain consistent with those reported in the previous months. - Although there has been a reduction in Follow-Up attendances compared to 2024/2025, providers, particularly NHS providers, have not yet reduced activity to the planned levels.	Actions remain the same as last month: - Indicative Activity Plans (IAPs) have been agreed with the two main Independent Sector Providers of acute care for the ICB. These specify the 'new to follow up' rates for outpatients by specialty. These IAPs are effective from 1st July 2025 to 31st March 2026 and require providers to not breach agreed levels of activity. Providers are being actively managed through the Contract Management process. The Activity Managements Plan (AMP) process commenced in October 2025 due to activity being over-trajectory at Month 5; the AMPs are now in place. - Work looking at productivity metrics has identified areas where levels of follow-up attendances are above peer organisations. This work is informing the planning round for 2026/2027.

Planned Care National Planning Metrics off Plan and Actions, 2 of 4

Programme Area	Metric	Drivers for underperformance	Top 3 Planned actions provided by portfolio
Referral to Treatment (RTT)	Number patients waiting more than 65 weeks (Referral to Treatment - Incomplete Pathways) Across all providers there were 90 patients waiting over 65 weeks to start treatment, at the end of January 2026. This is an increase from 80 at the end of December 2025.	At University Hospitals North Midlands (UHNM) there are long waits in Gynaecology due to lack of Endometriosis capacity. Theatre, ward, and staffing capacity also driving long waits in Orthopaedics and Ear Nose and Throat (ENT).	1. Reviewing theatre reallocation, including swapping consultant clinic sessions for operating time 2. Accelerating diagnostic reporting and test scheduling (notably sialograms and imaging for spine and ENT) 3. Looking at using Elective Recovery Funding to increase Endometriosis capacity.
	% Patients waiting more than 52 weeks (Referral to Treatment - Incomplete Pathways) At the end of January 2026, there were 2,409 ICB patients waiting over 52 weeks at all providers. This is above the planned trajectory of 1,887, but a reduction from the number waiting at the end of April 2025 (3,392). As a percentage of the total waiting list, 1.7% of patients were waiting over 52 weeks, against a target of 1.2% (0.4% over plan).	Drivers for 52 week breaches continue and reflect those for 65-week breaches (above).	

Planned Care National Planning Metrics off Plan and Actions, 3 of 4

Programme Area	Metric	Drivers for underperformance	Top 3 Planned actions provided by portfolio
Cancer	Percentage of people waiting no more than 28 days from urgent referral to receiving a communication of diagnosis for cancer or a ruling out of cancer Performance in January 2026 for ICB (all providers) was 72.8% against a target of 79.1%.	Drivers remain consistent with those reported previously: - Increased skin referrals over the summer period resulting in backlog for Skin Cancer. - Increased surgical capacity required, including weekend lists (Colorectal, Gynaecology & Skin Cancers).	Actions planed last month remain: 1. Additional third-party capacity sought and operational for skin cancer referrals to UHNM. 2. Additional internal weekend lists activated at UHNM 3. Daily monitoring of activity at UHNM.
	Total patients seen within 62 days (cancer 62-day pathway) Performance in January 2026 for ICB (all providers) was 60.9% against a target of 74.5%.		
	People treated beginning first or subsequent treatment of cancer within 31-days Performance in January 2026 for ICB (all providers) was 91.8% against a target of 93.7%.		

Planned Care National Planning Metrics off Plan and Actions, 4 of 4

Programme Area	Metric	Drivers for underperformance	Top 3 Planned actions provided by portfolio
Diagnostic Tests	Diagnostic test activity Total Tests Completed: 49,254 in January 2026. Variance from Plan: 7,956 fewer tests (14% below plan of 57,210). YTD position: 80,137 fewer tests (-14%) than plan.	Driver as previously identified: UHNM, the 2025/2026 CT activity plan was set 34% higher than the actual delivery in 2024/2025 to meet rising demand. However, activity has not increased in line with the assumed planned uplift and remains consistent with 2024/2025 levels.	Action as reported last month: Computed Tomography (CT) activity levels in line with 2024/2025. No action required.
	Diagnostic test waiting list less than 6 weeks Percentage of patients waiting less than 6 Weeks for a diagnostic test at the end of January 2026 was 76.1% (below the plan of 90.5%). This is a continued improvement from 63.6% at the end of April 2025. Total patients waiting more than 6 weeks for a diagnostic test has reduced from 13,680 (April 2025) to 7,252 (January 2026).	Main drivers are as previously identified: - The main driver for non-compliance continues to be the Non-Obstetric Ultrasound (NOUS) backlog at UHNM. Although the backlog continues to reduce. - There has been a significant increase in Dual-energy X-ray absorptiometry (DEXA) scans with waits over 6 weeks at Midlands Partnership Trust (MPFT), from 7 at the end of November 2025 to 140 at the end of January 2026.	Actions previously planned continue driving improvements : - Backlog at UHNM for NOUS being reduced by increased capacity. Includes using capacity at Cannock Community Diagnostic Centre and increased 'in house' capacity at UHNM. - Increase in DEXA backlogs linked to capacity issues. Backlog expected to be cleared within a couple of months, with a reported reduction from December 2025 to January 2026.
Community	Community Services Waiting List At the end of January 2026 there were 5 ICB patients on the Community Services Waiting List, that had been waiting over 52 weeks. All 5 patients were under Children and Young People services (all in Community Paediatrics Service)	As identified in previous report main drivers are; - Growth in Attention-Deficit/Hyperactivity Disorder (AHDH) referrals. - Patients not being brought in for appointments. - Staff capacity affected by vacancies and sickness.	Action as reported last month: Although capacity issues largely resolved, there are patients still waiting over 52 weeks due to parents cancelling or not bringing child in for appointment. To resolve MPFT are applying a 'Not brought in' policy.

Urgent and Emergency Care

Programme	Measure Name	Currency	ICB / Provider	Reporting period	Current Month & direction from previous month		Target		Variance	Plan / baseline	Variance	Trend from April 2024 to current month
Urgent and Emergency Care (UEC)	A&E Type 1-3 - less than 4 hours	%	UHNM	Feb-26	64.7%	▲	78.0%	March 2026	-13.3%	75.5%	-10.7%	
	A&E Types 1 & 2 - more than 12 hours	%	UHNM	Feb-26	17.2%	▼	16.65%	2025/26	0.5%	19.9%	-2.8%	
	Ambulance handover time (average)	Minutes	UHNM	Feb-26	01:15:31	▼	00:43:00	March 2026	00:32:31	00:55:00	00:20:31	
	Total Non-Electives spells	Number	UHNM	Jan-26	6,198	▼	n/a		-	7,332	-1,134	
	Non-elective average of Length of Stay	Bed days	UHNM	Jan-26	7.09	▼	n/a		-	7.60	-0.51	
	General and Acute bed occupancy	%	UHNM	Feb-26	97.1%	▲	n/a		-	95.5%	1.6%	
	Average delay - bed days lost through discharge delays	Days	UHNM	Jan-26	3.1	▼	n/a		-	3.4	-0.3	
	Virtual Ward Occupancy	%	ICB	Feb-26	71.4%	▼	n/a		-	85.0%	-13.6%	
	Urgent Community Response (UCR) referrals	Number	ICB	Jan-26	965	▼	n/a		-	953	12	
Urgent and Emergency Care (UEC) (Local Metrics)	Childrens A&E Type 1 - 4hr performance	%	UHNM	Feb-26	79.6%	▲	78.0%	March 2026	1.6%	-	-	
	Urgent community response (UCR) - patients seen within 2 hours	%	ICB	Jan-26	75.5%	▼	70.0%		5.5%	70.0%	5.5%	
	Ambulance Hours lost due to Handover delays > 15min (UHNM)	Minutes	ICB	Feb-26	5,142	▼	n/a		-	8,228	-3,086	
	Ambulance Compliance - % Handovers within 45 minutes	%	UHNM	Feb-26	63.7%	▲	100%	March 2026	-36.3%	-	-	
	Readmissions	Number	ICB	Jan-26	282	▼	n/a		-	637	-355	

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Urgent and Emergency Care Metrics off Plan and Actions, 1 of 2

Programme Area	Metric Name	Drivers for underperformance	Top 3 Planned actions provided by portfolio
Urgent and Emergency Care (UEC)	A&E Type 1-3 4hour Performance University Hospitals North Midlands (UHNM) 4-hour Performance at UHNM improved by 1.1% during February 2026 to 64.7%, which was 10.7% below plan for the month.	- Acuity of patients remained high with Resus patients representing 21.3% of Type 1 attendances at UHNM. - Bed Occupancy remained high, constraining flow and restricting available capacity for timely admission.	- Spring Reset in place with a focussed plan on improvement of 4hour performance prior to April 2026. - Review and relaunch of UHNM internal improvement plan. - Getting it Right First Time (GIRFT) working with UHNM to support improvement opportunities.
	General & Acute (G&A) Beds Occupied (UHNM) Bed Occupancy at UHNM for February 2026 increased to 97.1%, up 0.3% on the previous month. This was 1.6% worse than plan.	Increased proportions of 7+, 14+ and 21+ days Length of Stay patients during February 2026 with 46% of occupied beds containing a patient that had been bedded for more than 7 days, and 25% of beds containing a patient that had been bedded for more than 14 days.	- Review and relaunch of UHNM internal improvement plan. - GIRFT working with UHNM to support improvement opportunities. - Capital identified in 2026/2027 for Discharge Lounge redevelopment and plan in progress.

Urgent and Emergency Care Metrics off Plan and Actions, 2 of 2

Programme Area	Metric Name	Drivers for underperformance	Top 3 Planned actions provided by portfolio
Urgent and Emergency Care (UEC)	Average Ambulance Handover Time (average) - University Hospitals North Midlands (UHNM) Average Handover Time at UHNM during February 2026 was reported as 01:15:31, 00:20:31 worse than plan.	- Acuity of patients remained high with Resus patients representing 21.3% of Type 1 attendances at UHNM. - Medical patients represented 13% of ambulance conveyances during February 2026 with respiratory illness and Cardiac issues accounting for a further 10% each. - Bed Occupancy remained high constraining flow and restricting available capacity for timely admission.	- Review and relaunch of UHNM internal improvement plan, - Frailty Same Day Emergency Care (SDEC) at Royal Stoke business case for expansion in development, - Test of change at County Hospital for Integrated Care Coordination (ICC) direct access to Frailty SDEC
	Ambulance Compliance - % Handovers within 45 minutes (UHNM) Handover compliance during February 2026 reported as 63.7%, a 6.8% improvement on the previous month.		
	Virtual Ward (VW) Occupancy - Staffordshire and Stoke-on-Trent ICB (SSoT) The last submission of February 2026 (made 6th March 2026) reported an occupancy rate of 71.4%. This was down 4.3% on the final submission of January 2025 and 12.3% worse than plan. Capacity has remained at 140.	- The service has not been successful in recruiting to the temporary position at Burton, so Matrons have been supporting in having a presence a minimum of twice a week. - Changes to VW provision are being implemented from 1st April 2026. - Surgical Wards continue to be underutilised, impacting system utilisation.	- Positive discussions with the Surgical and Clinical Leads on creating consistency in utilisation particularly around the Upper GI pathways. - Business Case being developed by UHNM to support increase capacity across Acute Care at Home in preparation for Winter for 2026/2027. - Quality improvement sessions planned with the North Sector Team to ensure all patients are being captured on the systems.

Provider Overview at Trust Site Level – Key Urgent and Emergency Care (UEC)

Metrics for Out of ICB providers, February 2026

Metric	University Hospitals of Derby & Burton (UHDB) Queens Hospital Burton (NHS Derby and Derbyshire Integrated Care Board)	The Royal Wolverhampton (RWT) New Cross Hospital (Black Country Integrated Care Board)
4-hour Performance (%) <i>Type 1-3 [Provider level]</i>	February 2026 reported performance of 72.3%, an increase of 1.6% on January 2026 (70.7%).	February 2026 was 78.6%, an increase of 2.2% on January 2026 (76.4%).
A&E Attendances <i>Type 1 [Site level]</i>	6,022 attendances during February 2026, an 8.1% reduction against the previous month but approximately 4 patients more per day (in real terms) due to the shorter month.	10,507 attendances during February 2026, a 6.4% reduction against the previous month but 13 patients more per day (in real terms) due to the shorter month.
4-hour Performance (%) <i>Type 1 Paediatrics [Site level]</i>	February 2026 reported performance of 86.2%, a deterioration of 2.3% on the previous month (88.5%).	February 2026 reported performance of 85.4%, a deterioration of 1.7% on the previous month (87.1%).
12-hour Performance <i>Type 1 & 2 (%) [Provider level]</i>	15.1% of Type 1 & 2 attendances breached the 12-hour mark for 'Time in Department' in February 2026, down 4.5% on January 2026.	11.2% of Type 1 & 2 attendances breached the 12-hour mark for 'Time in Department' in February 2026, down 2.9% on January 2026.
Bed Occupancy (%) - General & Acute (G&A) [Site level]	G&A Bed Occupancy decreased 3.2% during February 2026 to 95.8% from 99% the previous month.	G&A Bed Occupancy decreased during February 2026 to 96.0% from 97.3% the previous month.
Virtual Wards [Provider level]	UHDB – 41 occupancy out of 40 bed capacity (102%) for last submission in month (6th March 2026).	RWT – 239 occupancy out of reported 98 bed capacity (244%) for last submission in month (6th March 2026).
Average Ambulance Handover Time [Site level]	West Midlands Ambulance Service (WMAS) and East Midlands Ambulance Service (EMAS) combined average handover time for February 2026 was 32 minutes 07 seconds, 24 minutes 01 second better than January 2026.	WMAS average handover time for February 2026 was 56 minutes 18 seconds, down 41 minutes 28 seconds on January 2026.
Ambulance Compliance % Handovers within 45 minutes <i>[Site Level]</i>	WMAS and EMAS combined handover compliance for February 2026 was 87.3%, up 15.6% on January 2026.	WMAS handover compliance for February 2026 was 67.6%, up 11.2% on January 2026.
Time Lost due to handover delays > 15 mins [Site level]	60% decrease in time lost due to handover delays during February 2026, dropping to a combined total of 412 hours between WMAS and EMAS.	Decrease of 52% during February 2026 in time lost, dropping the time lost by WMAS to 2,363 hours from 4,874 hours during January 2026.

Primary Care and Medicines Optimisation

Programme	Measure Name	Currency	ICB / Provider	Reporting period	Current Month & direction from previous month		Target	Variance	Plan / baseline	Variance	Trend from April 2024 to current month
Primary Care	Appointments in General Practice	Number	ICB	Jan-26	579,952	▲	n/a	-	599,558	-19,606	
	Unique patients seen by a NHS dentist - adult	% (quarterly)	ICB	Q3	43.1%	▼	n/a	-	43.2%	-0.1%	
	Unique patients seen by a NHS dentist - children	% (quarterly)	ICB	Q3	65.1%	▲	n/a	-	62.3%	2.8%	
	Units of Dental Activity delivered	% (quarterly)	ICB	Q3	78.8%	▼	n/a	-	82.2%	-3.4%	
	Urgent Dental Activity delivered	Number	ICB	Jan-26	6,184	▼	n/a	-	6,797	-613	
	Pharmacy First consultations	Number	ICB	Jan-26	16,215	▼	n/a	-	13,000	3,215	
Medicines Optimisation (Local Metrics)	Structured medication reviews (SMRs) conducted in general practice. (Year to Date Cumulative)	% (quarterly)	ICB	Q3	63.3%	▲	n/a	-	70.0%	-6.7%	

Key to arrows showing direction from previous month		Key to variation Colour	
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▼	Improved with a lower value than the previous month	Green	Positive impact / desired variation
▲	Deteriorated with a higher value than the previous month	Yellow	No change / equal
▼	Deteriorated with a lower value than the previous month	Black	Not applicable / not available
⇒	Equal to the previous month		
n/a	not available		

Notes on data:

- Unique patients seen by an NHS dentist (adults and children) not updated this month, as quarterly metrics.

Primary Care and Medicines Optimisation Metrics off Plan and Actions, 1 of 3

Programme Area	Metric	Drivers for underperformance	Top 3 Planned actions provided by portfolio
Primary Care	Appointments in General Practice Total appointments: January 2026: 579,952 appointments against the plan of 599,558 (96.7%). Year to date: 5,654,377 against the plan of 5,652,211 (100.04%). Covid-19 vaccination appointments: Year to date: 12,527 against the plan of 83,469 (15.0%). Standard appointments: Year to date: 5,641,850 against the plan of 5,568,742 (101.3%).	Performance continues to be impacted by the unanticipated change in Covid-19 vaccination eligibility in autumn 2025. Year to date, Covid-19 vaccination activity is approximately 71,000 below planned activity. For reference: eligible patients are now adults aged 75 years and over, residents in care homes for older adults and individuals who are immunosuppressed aged 6 months and over. Autumn 2024 also included adults aged 65 to 74 and all those aged 6 months and over in a clinical risk group.	- Primary Care Networks (PCNs) have submitted workforce plans in November 2025 for the remainder of 2026/2027, showing increases in whole time equivalent (WTE) for Additional Roles to utilise available funding, which should result in increased appointments (a high utilisation rate of funding (96%) and an increase of 4 WTE since November 2025 (622.6 WTE as at January 2026). - Access programme ongoing to improve patient experience and access to general practice. No capacity issues identified at this time in addition to the plans in place. - Appointment data is being reviewed on a regular basis at Practice and PCN level to determine variations and understand if there are any coding-related issues. Data discussed with practices as part of contract and quality visits.

Primary Care and Medicines Optimisation Metrics off Plan and Actions, 2 of 3

Programme Area	Metric	Drivers for underperformance	Top 3 Planned actions provided by portfolio
Dental	Units of Dental Activity (UDA) Quarter 3 2025/2026 : 373,306 UDAs were delivered against the plan of 473,516 (78.8%). For reference: January 2026 scheduled activity was 123.8% of contracted.	December activity was affected by a technical issue relating to file transfers between WebEDI and Compass. Q3 2025/2026 performance wasn't reported last month whilst the Portfolio waited for revised December 2025 data. However, in the latest publication, December 2025 hadn't been revised, whilst January 2026 activity is higher than normal, because the missing December 2025 activity has been included in January 2026.	Actions planned previously continue to address performance issues: 1. The ICB continues to deliver on the local dental plan (including redistribution of dental activity from hand backs and terminations, oral health and workforce initiatives). 2. Action with updates: The urgent dental communications campaign continues to be shared in other healthcare settings e.g. GP practices, pharmacies, hospitals, A&E and via the internet. This will run to end of financial year to raise patient awareness of access to Urgent Dental Access. A number of videos have been published in March 2026 featuring Dr Ahmed, Chair of Local Dental Network and local dentist aimed to raise awareness of urgent dental symptoms and how patients can access urgent appointments when required. 3. OWM continue to work with dental practices to ensure activity is reported correctly to support monitoring purposes, baselines and future planning of dental activity. 4. Urgent dental care incentive (UDCI) scheme runs between September 2025 and March 2026. The scheme is to encourage more urgent treatment, offering financial incentives to practices that deliver a higher volume of urgent care. 80 of 111 eligible practices have signed up to the scheme.
	Urgent Dental Activity delivered January 2026: 6,184 units of urgent dental activity were delivered against the plan of 6,797 (91.0%). Year to Date (YTD): 54,962 units of urgent dental activity against the plan of 66,496 (82.7%).	Drivers identified previously remain: - As previously highlighted to the National Team, concerns remain locally that there will be insufficient patient demand to deliver the ICB target. Lack of local urgent dental access is not supported by intelligence from local practices, the local Community Dental Services, Healthwatch etc. - The Office of the West Midlands (OWM) advise that the latest 2 months of activity figures are synthesised using expected delivery activity percentages, due to the 62 day claims window for FP17's (dental claim forms). This makes them subject to change. - Additionally, there is an issue with data quality in terms of how activity is being recorded, which is being addressed by the Office of the West Midlands working with individual practices to improve reporting.	

Primary Care and Medicines Optimisation Metrics off Plan and Actions, 3 of 3

Programme Area	Metric	Drivers for underperformance	Top 3 Planned actions provided by portfolio
Medicines Optimisation	Structured medication reviews (SMRs) conducted – cumulative 63.3% completed this final year to December, below the prediction / plan of 70%, by 6.7%	Drivers as identified previously remain: - The SMRs are part of the quality component of the Medicines optimisation (Meds Op) Service Level Agreement (SLA). Each practice has a maximum number of SMRs eligible for payment, and SMRs completed above this capped level do not attract additional payment. - The end of year target of 100% is expected to be met. However a risk to this will be practices that have not engaged with the SLA at all.	Actions planned previously continue to address performance issues: - The Meds Op team continue to monitor and validate SMR entries on a quarterly basis. They provide support to the Primary Care Network (PCN) pharmacy teams completing the SMRs and highlight any issues such as no interventions made or recording of hospital admissions. - The Meds Op team are also holding and planning training sessions to support PCN teams in confidence and competency, to de-prescribe e.g. medications that increase risk of falls. New action: - Practices have been sent reminders to complete SMRs by the end of March 2026

Mental Health and Learning Disabilities & Autism

Programme	Measure Name	Currency	ICB / Provider	Reporting period	Current Month & direction from previous month		Target		Variance	Plan / baseline	Variance	Trend from April 2024 to current month
Mental Health	Active inappropriate adult acute mental health out of areas placements (OAPs)	Number	ICB	Feb-26	35	▲	n/a		-	4	31	
	Average length of stay for adult acute beds	Bed days	ICB	Jan-26	45	▲	41.1	2025/26	3.9	40.3	4.7	
	Number of people who are discharged having had at least 2 NHS talking therapy appointments	Number	ICB	Feb-26	1,065	▼	n/a		-	1,228	-163	
	Access to NHS talking therapies for anxiety and depression - reliable recovery	%	ICB	Feb-26	48.3%	▲	50.0%	March 2026	-1.7%	50.0%	-1.8%	
	Access to NHS talking therapies for anxiety and depression - reliable improvement	%	ICB	Feb-26	70.6%	▲	68.0%	2025/26	2.6%	68.0%	2.6%	
	Access to Specialist Community Perinatal Mental Health Services	Number, Rolling 12 months	ICB	Jan-26	1,415	▲	1,216	March 2026	199	1,209	206	
	Access to Children and Young People Mental Health Services	Number, Rolling 12 months	ICB	Jan-26	18,100	▲	17,273	March 2026	827	16,842	1,258	
	Access to Individual Placement Support	Number, Rolling 12 months	ICB	Jan-26	870	▲	891	March 2026	-21	977	-107	
Learning Disabilities & Autism (LD&A)	Learning disability registers, Annual health checks delivered by GPs	% (YTD)	ICB	Q3	51.57%	▲	n/a		-	53.50%	-1.9%	
	Reliance on MH inpatient care for adults with a learning disability	Number (quarterly)	ICB	Q3	16	↔	n/a		-	14	2	
	Reliance on MH inpatient care for autistic adults	Number (quarterly)	ICB	Q3	11	▲	n/a		-	7	4	
	Reliance on MH inpatient care for people with a learning disability and/or autism - children	Rate (quarterly)	ICB	Q3	4.4	▼	n/a		-	17.7	-13	
Learning Disabilities & Autism (LD&A) (Local Metrics)	Mean wait to complete autism assessment - Children and Young People (CYP) North	Weeks	ICB	Jan-26	94	▼	26	March 2026	68	26	68	
	Mean wait to complete autism assessment - Children and Young People (CYP) South	Weeks	ICB	Jan-26	116	▲	26	March 2026	90	26	90	
	Learning from Lives and Deaths Review (LeDeR) reviews within 6 months of notification of death.	%	ICB	Feb-26	100.0%	↔	100%	2025/26	0.0%	100%	0.0%	
	Oliver McGowan training - Tier 1 (NHS staff)	%	ICB	Feb-26	30.0%	▲	30%	2025/26	0.0%	30%	0.0%	
	Oliver McGowan training - Tier 2 (NHS staff)	%	ICB	Feb-26	36.6%	▲	30%	2025/26	6.6%	30%	6.6%	

Key to arrows showing direction from previous month

▲ Improved with a higher value than the previous month,

▼ Improved with a lower value than the previous month

▲ Deteriorated with a higher value than the previous month

▼ Deteriorated with a lower value than the previous month

↔ Equal to the previous month

n/a not available

Key to variation Colour

Red Negative impact / unwanted variation

Green Positive impact / desired variation

Yellow No change / equal

Black Not applicable / not available

Notes on data:

- Reliance on MH inpatient (adults and children) and LD Annual Health checks have quarterly plans and have not been updated this month. Next update due in April (Q4).

Mental Health and Learning Disabilities & Autism - Metrics off Plan and Actions, 1 of 4

Programme Area	Metric	Drivers for underperformance	Top 3 Planned actions provided by portfolio
Mental Health (MH)	Active inappropriate adult acute mental health Out of Area Placements (OAPs) 35 OAPs were active at the end of February 2026. Up from 25 last month. 3 OAPs reported by Midlands Partnership University NHS Foundation Trust (MPFT) (down 3 since last month); 32 by North Staffordshire Combined Healthcare Trust (NSCHT) (up 13 since last month).	Drivers identified previously remain in place: NSCHT: - Reduced Bed Availability: system-wide pressure continues due to a significantly reduced number of adult acute beds within NSCHT, linked to the mandatory implementation of Project Chrysalis. This has resulted in the lowest available bed stock since September 2020. - Clinically Ready for Discharge (CRfD) remain an issue across both Local Authorities. MPFT: - Demand for beds, the number of patients who are clinically ready for discharge blocking bed capacity and zero tolerance of mental health patients in Emergency Departments waiting for beds - meaning they need to be moved quickly. Capacity within the market is extremely stretched, including residential and nursing homes with skills around mental health, supported living and supported accommodation.	Current actions remaining in place: - The ICB is in attendance at the weekly discharge calls to provide support and escalate actions. - Continued focused work on reducing the number of patients who are CRfD, working with colleagues across the system. - A root cause analysis has been requested of NSCHT from the Portfolio Board (due March 2026) to understand the increased demand and requirement for the increase in OAPs. New action: - Out of Area Project Implementation Document (PID) with specific actions around Section 12, Cygnet contracting and bed manager resource to be progressed.
	Average Length of Stay (LoS) for adult acute beds January 2026: 45 days. The first month since September to rise above target (40.3). The ICB continues to benchmark well against other ICBs in England and was 3rd lowest in January. For reference: England = 55 days; Midlands = 56 days.	Patients who are Clinically Ready for Discharge (CRfD) are impacting on the average LoS. For NSCHT in particular, the number of patients who are CRfD in acute beds has remained around the 20% figure since September 2025. It has peaked at 25% and been as low as 15% during this time.	- Continue to closely monitor adult acute bed LoS, noting that no immediate actions are required at this stage due to acceptable benchmarking performance. - Actions noted above in OAPs metric.

Mental Health and Learning Disabilities & Autism - Metrics off Plan and Actions, 2 of 4

Programme Area	Metric	Drivers for underperformance	Top 3 Planned actions provided by portfolio
Mental Health (MH)	Talking Therapy (TT) – courses of treatment February 2026: there were 1,065 completed courses of treatment against the plan of 1,228 (87% of plan achieved). Year to Date (YTD): 13,123 courses against the plan of 13,634 (96% of plan achieved). In January 2026 (latest benchmarking month), the system ranked 18/42 amongst ICBs. In terms of percentage of YTD plan delivery, the system achieved 99% in the benchmark month, outperforming both the national and regional averages (England = 96%, Midlands = 90%)	Remaining as per last month: - Completed treatments currently fall 4% below expected target. This has been affected by long-term sickness requiring reallocation on clients that directly reduces the monthly throughput of completed treatments. - Recovery rates have been compromised by higher than ever levels of complexity seen both regionally and nationally. - In a couple of teams, Reliable Recovery has been impacted by the need to reallocate cases from staff being off sick long term – some of these clients have subsequently declined further treatment. - There is a natural variation with reliable recovery rates across teams' month-by-month, but also between treatment modalities and individual therapists.	Remaining as per last month: - As part of the supported workforce plan, trainee and apprentice Psychological Wellbeing Practitioners (PWP) are now able to offer assessment and treatment. This will provide additional treatment capacity that will help to narrow this variance from target. Continued focus remains on teams and clinicians to focus on overall throughput and will be monitored through standard processes, for example, caseload management. - There is consistent on-going focus on strengthening the 'front door' to ensure the service accept suitable clients who are likely to benefit from treatment from TT, but the team are mindful that this may have a knock-on effect to demand on the wider system (secondary care) and/or result in a lack of services to some patients. - The team plan to develop an improvement plan to help understand the reasons for the variance across reliable recovery and proactively develop supported plans to improve this consistently across the whole service. This will be introduced at the teams next Managers Away morning in March 2026.
	Talking Therapy (TT) – reliable recovery Performance was 48.3% in February 2026, and 48.8% year to date. In January 2026 (latest benchmarking month), the system achieved 46% and ranked 25/42 amongst ICBs. This was only slightly below the national and regional averages for the benchmark month, which were 47% for both England and the Midlands.		

Mental Health and Learning Disabilities & Autism - Metrics off Plan and Actions, 3 of 4

Programme Area	Metric	Drivers for underperformance	Top 3 Planned actions provided by portfolio
Mental Health (MH)	Access to Individual Placement Support (IPS) 870 in January 2026, an improved position on the previous month (860) and the 6th consecutive month showing improvement. 107 patients below trajectory; 145 below annual plan*. The rate of access varied between 62 and 84 patients per 100,000 population (6 sub ICBs). England rate = 83. In January 2026 (latest benchmarking data), the system benchmarked at position 27/42 amongst ICBs (in terms of percentage of YTD plan achieved – 89%). England = 102%; Midlands = 98%. * Please note: although NHS England published 'Fair Share' allocations in December 2025, they have confirmed that they require systems to continue to report against original Operational Plan targets.	Remaining as per last month: - Sickness and vacancies within the team continue to affect service delivery and hinder achievement of performance targets. - IPS grow submissions have identified some data quality issues and also some potential performance issues.	Remaining as per last month: - Work continues regarding promotion of the service. There are service stands at depots and self-referral has been introduced, alongside a new website established. - Recruitment underway and mitigating actions are being put into place. - Quarterly steering group meetings moved to monthly for more oversight whilst workforce issues and access are discussed further and mitigations put in place.

Mental Health and Learning Disabilities & Autism - Metrics off Plan and Actions, 4 of 4

Programme Area	Metric	Drivers for underperformance	Top 3 Planned actions provided by portfolio
Learning Disabilities (LD) & Autism	Local Metrics: Autism assessment completion waits (Children and Young People, North & South) The average wait at North Staffordshire Combined Healthcare (NSCHT) was 94 weeks (down from 112 weeks last month). The average wait at Midlands Partnership University Foundation Trust (MPFT) was 116 weeks (up from 107 weeks last month).	- Resource required to deal with increased activity from Right to Choose (RTC) providers. Two key factors are: a. the volume of new providers entering the market via other ICBs (with an uncertainty of the quality of due diligence done). b. the time required on an individual provider case that reaches our ICB via RTC.	In March 2026, Portfolio leads met with other Midlands ICBs and shared practice that is helping to try and manage situation. This work will be on-going in 2026/2027 as ICBs get to grips with the issue and seek to ensure the patients are at the centre of chosen approaches.

Children and Young People, Maternity and Neonates

Programme	Measure Name	Currency	ICB / Provider	Reporting period	Current Month & direction from previous month		Target	Variance	Plan / baseline	Variance	Trend from April 2024 to current month
Children and Young People (CYP)	Asthma emergency admission (≤ 18)	Number	ICB	Jan-26	14	▲	n/a	-	19	-5	
	Epilepsy emergency admission (≤ 18)	Number	ICB	Jan-26	12	▼	n/a	-	15	-3	
	Diabetes emergency admission (≤ 18)	Number	ICB	Jan-26	9	▲	n/a	-	9	0	
Maternity and Neonates	Stillbirth rate	rate per 1,000	UHNM	Feb-26	2.1	⇒	n/a	-	11.3	-9.2	
	Neonate Mortality rate per 1000	rate per 1,000 (quarterly)	UHNM	Dec-25	2.2	▼	n/a	-	2.0	0.2	
	Brain injury rate per 1000	rate per 1,000 (quarterly)	UHNM	Dec-25	2.2	▲	n/a	-	2.0	0.2	
	The % of full - term babies admitted to a neonatal unit	rate per 1,000 (quarterly)	UHNM	Dec-25	5.9%	▲	n/a	-	0	0.0	

Key to arrows showing direction from previous month		Key to variation Colour	
▲	Improved with a higher value than the previous month,	Red	Negative impact / unwanted variation
▼	Improved with a lower value than the previous month	Green	Positive impact / desired variation
▲	Deteriorated with a higher value than the previous month	Yellow	No change / equal
▼	Deteriorated with a lower value than the previous month	Black	Not applicable / not available
⇒	Equal to the previous month		
n/a	not available		

Notes on data:

- Neonatal Maternity data is provided quarterly for Mortality, Brain Injuries and Neonatal admissions. Data is provided for the preceding months, each quarter. An update is not available this month.

Children and Young People, Maternity and Neonates Metrics off Plan and Actions

Programme Area	Metric	Drivers for underperformance	Top 3 Planned actions provided by portfolio
Maternity and Neonatal (UHNM)	Local Metric: Neonatal Mortality rate (per 1,000 births) A rate of 2.2 in December 2025 compared to a rate of 2.0 in December 2024. In real terms there is no change in the count of Neonatal deaths – 1 in each of the stated months.	- No change in the actual number of neonatal deaths between December 2025 (latest data) and the comparator month last year (December 2024). - The fluctuation in the rate is due to the small birth count, therefore the change is not statistically significant.	- None further actions planned as the change in the rate is not due to a change in the number of neonatal deaths. - Neonatal deaths are monitored through the local ICB dashboard, in the main Board meeting and the Quality, Safety and Oversight forum, each month.
	Local Metric: Brain injury (per 1,000 births) A rate of 2.2 in December 2025 compared to a rate of 2.0 in December 2024. In real terms there is no change in the count of cooled neonatal brain injuries – 1 in each of the stated months.	- No change in the actual number of cooled brain injuries between December 2025 (latest data) and the comparator month last year (December 2024). - The fluctuation in the rate is due to the small birth count, therefore the change is not statistically significant.	- None further actions as the change in the rate is not due to a change in the number of cooled brain injuries. - The number of cooled brain injuries are monitored through the local ICB dashboard, in the main Board meeting and the Quality, Safety and Oversight forum, each month.
	Local Metric: The % of full - term babies admitted to a neonatal unit 5.9% in December 2025 (27 babies admitted) compared to 4.2% in December 2024 (21 babies admitted). A total increase of 6 admissions between the current and comparator months.	- The acuity of the baby denotes the need to admit to the neonatal unit. - December 2025 was a very busy period with high acuity. UHNM have reviewed all cases and no themes or trends were identified - This metric reflects long-term improvement efforts and is not intended to drive reactive, month-by-month actions. Its sensitivity to monthly volatility limits the usefulness of short-term actions.	- The Local Maternity and Neonatal System (LMNS) and the Trust (UHNM) will continue to monitor the Avoidable Term Admissions into Neonatal Units to review trends, learning and themes to inform future quality improvement work. - No further planned actions at this stage.

Community Transformation

Programme	Measure Name	Currency	ICB / Provider	Reporting period	Current Month & direction from previous month		Target	Variance	Plan / baseline	Variance	Trend from April 2024 to current month
Community Transformation	Palliative and End of Life Care (PEoLC): Prevalence rate of patients on palliative care registers to 1%.	%	ICB	Jan-26	0.9%	⇒	n/a	-	1.0%	-0.2%	
	Increase patients receiving all 8 care processes for Diabetes, receiving 3 treatment targets - Type 1 (Year to Date Cumulative)	%	ICB	Jan-26	41.9%	▲	n/a	-	37.6%	4.3%	
	Increase patients receiving all 8 care processes for Diabetes, receiving 3 treatment targets - Type 2 (Year to Date Cumulative)	%	ICB	Jan-26	51.1%	▲	n/a	-	48.8%	2.3%	
	Long-term conditions: Ensure referrals are made to the National Diabetic Prevention Programme – support for patients who are pre-diabetic	Number	ICB	Jan-26	630	▲	n/a	-	520	110	
	Urgent community response (LTC): Ensure patients commence on the National Diabetic Prevention Programme (NDPP) following referral	Number	ICB	Jan-26	465	▲	n/a	-	261	204	
	Reduction in number of conveyances for falls by WMAS	Number	ICB	Jan-26	734	▼	n/a	-	736	-2	
	Falls, Reduction in number of falls related emergency admissions - 65+	Number	ICB	Jan-26	163	▼	n/a	-	272	-109	
	Care Home, Reduction emergency admissions - 65+	Number	ICB	Jan-26	877	▼	n/a	-	898	-21	
	Reduction emergency admissions - all 65+	Number	ICB	Jan-26	6,889	▼	n/a	-	6,950	-61	

Key to arrows showing direction from previous month		Key to variation Colour	
▲	Improved with a higher value than the previous month,	Red	Negative impact / unwanted variation
▼	Improved with a lower value than the previous month	Green	Positive impact / desired variation
▲	Deteriorated with a higher value than the previous month	Yellow	No change / equal
▼	Deteriorated with a lower value than the previous month	Black	Not applicable / not available
⇒	Equal to the previous month		
n/a	not available		

Community Transformation Local Metrics off Plan and Actions

Programme Area	Metric	Drivers for underperformance	Top 3 Planned actions provided by portfolio
Community Transformation	Local Metrics: Prevalence rate of patients on palliative care registers to 1%.	Driver identified previously remains: Palliative care identification across the ICB has plateaued to the expected level for the ICB population, with a slight seasonal dip over winter, suggesting the system may have reached a natural ceiling.	Action reported previously remains: Continue monthly monitoring of palliative care register prevalence, recognising that current levels may reflect a natural ceiling for the population, and assess any emerging trends that may warrant further action.

Improving Population Health

Programme	Local Measure Name	Currency	ICB / Provider	Reporting period	Current Month & direction from previous month		Target	Variance	Baseline	Variance	Trend from April 2024 to current month
Improving Population Health	Children and Young People - Vaccination uptake - MMR2, at 5 years	% (quarterly)	ICB	Sep-25	89.5%	▲	n/a	-		-	
	Children and Young People Vaccination uptake - Pertussis maternal vaccination	%	ICB	Sep-25	79.4%	▲	n/a	-	62.9%	16.5%	
	Hypertension (CVD007HYP): Patients treatment to recommended age specific thresholds	% (quarterly)	ICB	Sep-25	68.3%	▲	n/a	-	66.8%	1.5%	
	Cholesterol (CVD003CHOL):Patients with QRISK 20% or more treated with lipid lowering therapy	% (quarterly)	ICB	Sep-25	65.7%	▲	n/a	-	64.1%	1.6%	
	Respiratory: Flu Vaccinations (65+years)	%	ICB	Dec-25	75.3%	▲	n/a	-	75.2%	0.1%	
	Respiratory: COVID Vaccinations (75+years)	%	ICB	Dec-25	65.4%	▲	n/a	-	64.1%	1.3%	

Key to arrows showing direction from previous month	
▲	Improved with a higher value than the previous month,
▼	Improved with a lower value than the previous month
▲	Deteriorated with a higher value than the previous month
▼	Deteriorated with a lower value than the previous month
↔	Equal to the previous month
n/a	not available

Key to variation Colour	
Red	Negative impact / unwanted variation
Green	Positive impact / desired variation
Yellow	No change / equal
Black	Not applicable / not available

Notes on data:

- No updates for this section this month
- Update from the Portfolio 9th December 2025; the criteria changed for COVID vaccinations - only 75+ year olds are now eligible.

Enclosure No: 10

Report to:	Integrated Care Board							
Date:	26 March 2026							
Title:	Transition Committee March 2026 Update							
Presenting Officer:	Simon Whitehouse, Chief Executive Officer							
Author(s):	Paul Edmondson-Jones, Transition Director & Kirsten Owen, Associate Director of Special Projects							
Document Type:		Action Required (select):						
Report	☒	Business Plan	☐	Information (I)	☒	Discussion (D)	☐	
Strategy	☐	Policy	☐	Assurance (S)	☒	Approval (A)	☐	
Other	☐	(please describe)		Ratification (R)	☐	(check as necessary)		
Is the decision within SOFD powers & limits					Yes	☐	No	☒
Any potential / actual Conflict of Interest?					Yes	☐	No	☒
<i>If Y, the mitigation recommendations:</i>		<i>E.g. Staff have Financial + Non-Financial Professional Interests which can be managed by recording those in minutes and allowing presence in discussions with recusals from formal decisions</i>						
Any financial impacts: ICB or ICS?					Yes	☐	No	☒
<i>If Y, are those signed off by and date:</i>		<i>E.g. Chief Finance Office, dd-mmm-yyyy</i>						
Any impacts on ICB Undertakings?					Yes	☐	No	☒
<i>If Y, are those signed off by and date:</i>		<i>E.g. Chief Finance Office, dd-mmm-yyyy</i>						
Appendices:	None							

(1) Purpose of the Paper:

This paper provides the Board with a coherent and up to date overview of how the various aspects of the transition programme are progressing across all of the major workstreams. It explains how governance arrangements are operating, highlights the role of key leaders, and summarises developments in workforce changes, operating model design, CSU transition, and merger related governance work.

It also updates the Board on risks, interdependencies and readiness for the next phase of transition. In essence, it provides the Board with assurance that the programme remains on track, it identifies where the pressure points are, and how oversight mechanisms are functioning. The paper sets out the safe and effective progress toward merger, subject to NHSE approval.

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

(3) Implications:	
Legal / Regulatory	<i>This paper describes how the ICB is establishing the future organisation to ensure it fulfils the Statutory Duties and adheres to NHSE Statutory Guidance</i>
CQC / Patient Safety	<i>n/a</i>
Financial (CFO-assured)	<i>The work of the transition committee supports the ICB organisational financial planning and delivering the national directive around ICB running costs</i>
Sustainability	<i>n/a</i>
Workforce / Training	<i>n/a</i>
Equality & Diversity	<i>n/a</i>
Due Regard: Inequalities	<i>n/a</i>
Due Regard: wider effect	<i>The transition committee has regard to ICB employees health and wellbeing</i>

(4) Statutory Dependencies & Impact Assessments:					
	Completed?			If N - N/A, Rationale	If Y, Outcome / Date Reported & Signed off
DPIA	Yes	No	N/A	<i>This is an update on the work of the transition committee.</i>	<i>Reported to IG Committee: Click or tap to enter a date.</i>
	☐	☐	☒		
EIA	Yes	No	N/A	<i>This is an update on the work of the transition committee.</i>	<i>Outcome and date of completion: Click or tap here to enter text.</i>
	☐	☐	☒		
QIA	Yes	No	N/A	<i>E.g. per QIA Policy, that it doesn't impact quality of services This is an update on the work of the transition committee.</i>	<i>SRO sign-off, outcome & date of completion: Click or tap here to enter text.</i>
	☐	☐	☒		
Has there been Public / Patient Involvement?				Yes	No
				☐	☐
				N/A	☒
				<i>Click or tap here to enter text.</i>	

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

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

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

The transition programme remains broadly on track, supported by strengthened governance through the Transition Steering Group, Programme Group and the joint Transition Committee, which together ensure effective oversight and alignment across both ICBs.

Progress continues across all major workstreams: voluntary redundancy rounds have reduced the need for compulsory changes; Management of Change processes for senior and clinical roles are underway; and the future operating model is now reaching maturity, reflecting statutory responsibilities and revised assumptions about locally retained functions. The CSU transition is advancing through TUPE, due diligence and operational readiness planning, with risks actively managed. Governance and merger preparation are progressing, enabled by approved constitutional changes and increasing alignment of committees and reporting.

The risk register and transition glide path continue to offer a consolidated view of programme risks and milestones, supporting Board assurance that the transition is proceeding safely and coherently.

(7) Recommendations to Board:

- ☒ To **ASSURE** both BOARDS that the Transition Committees is managing the complex transition work programme, is tracking and managing the issues and risks associated with the transition.

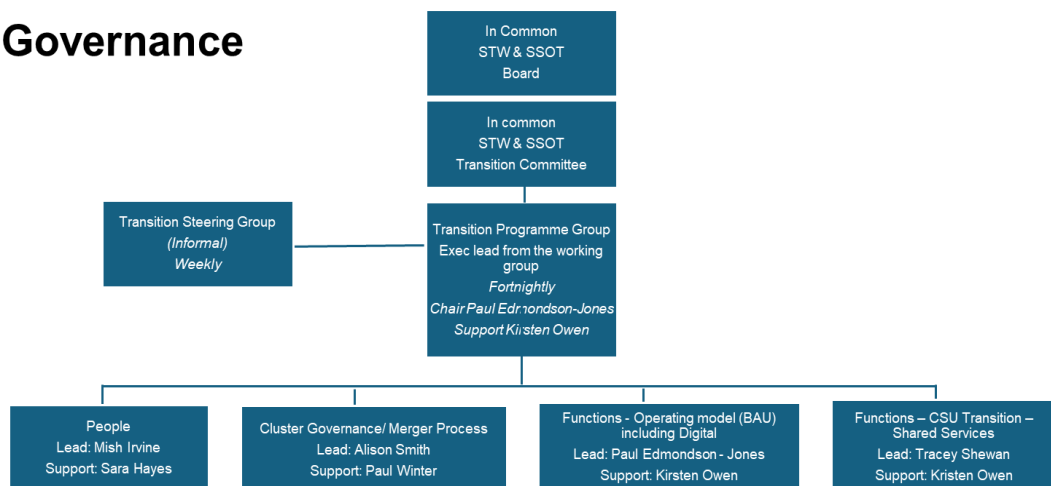
1.0 Transition Committee March 2026 Update

- 1.1 The Transition Committee continues to provide strategic oversight of the cluster transition, ensuring both ICBs move safely and coherently toward the new operating model and future merger. The programme remains complex, but progress across the key workstreams is broadly on track, supported by strengthened governance and close alignment with regional and national expectations.

2.0 Overall Governance and Programme Structure

- 2.1 The transition programme is underpinned by a clear governance framework. At the top sits the Transition Steering Group, which provides informal but regular senior oversight, supported by the Transition Programme Group, which coordinates delivery across all workstreams and ensures that risks, dependencies and critical-path issues are surfaced promptly.
- 2.2 The Transition Committee, meets in common across both ICBs, remains the primary forum for formal oversight and assurance, drawing together Executive leads from People, Functions & Operating Model, Governance & Merger, and CSU/Shared Services transition. This structure ensures that technical, operational and organisational elements are aligned and that decisions flow effectively between feeder groups and Boards.

Cluster Governance



- 2.3 Within this model, Paul Edmondson-Jones plays a central system-wide role, leading the Functions & Operating Model workstream and maintaining direct links with other regional Transition Directors and the NHS Regional Transition Leads, ensuring local work aligns with national design principles and emerging regional direction.

3.0 People and Workforce

- 3.1 The voluntary redundancy programme continues to progress as planned and has significantly reduced the scale of compulsory reductions required. Management of Change processes for senior leadership and clinical/professional roles are underway, with a strong emphasis on inclusive, multi-professional leadership and continuity of key statutory functions.

Comprehensive staff support, engagement and wellbeing arrangements remain in place throughout the process.

4.0 Operating Model and Functions

Work to define the future operating model is now reaching maturity, with draft structures being refined to reflect and ensure that we fulfil all our statutory responsibilities, the commissioning strategy and revised assumptions about which functions remain local rather than transferring to regional teams. This workstream is also ensuring clarity on future accountability arrangements and aligning function-level planning with the overall transition glide path.

5.0 Financial path to £19.40

- 5.1 The cluster ICB is tasked with delivering against the national running cost requirement of approximately £19.40per head of population. The Board are asked to note that this figure has been revised to £19.55per head of population in recognition of the NHS pay award.
- 5.2 This will be achieved through a combination of current vacancies that have been held and will be disestablished as part of the change programme, voluntary and compulsory redundancy across multiple phases, and significant restructuring of CSU-related services, where costs are expected to fall by at least 50% ahead of transfer.
- 5.3 the Board are asked to note that there will be transitional double-running costs persist into Q2 due to notice periods for senior roles. These are offset through further efficiency measures. Overall, the programme remains on a trajectory to meet the required recurrent running cost target during 2026/27.
- 5.4 The Board should note that, should a merger not be agreed by NHS England, there will continue to be double running costs beyond the end of this financial year.

6.0 Transferring Functions

- 6.1 Following the recent changes in the national policy on Model ICB “review for transfer” functions December 2025, it has now been confirmed that only 4 out of the initial 18 functions will transfer away from the ICB.
- 6.2 The Operating Model group is mapping these functions that will remain and ensuring that these are built into the developing future operating model so that the design stays aligned with national expectations, statutory duties and the needs of the local system.

7.0 CSU Transition and Shared Services

- 7.1 The CSU transition remains a major component of programme delivery. TUPE processes have commenced, due diligence is ongoing, and induction and operational readiness plans are in place.
- 7.2 Some service areas continue to be affected by the CSU’s own internal VR programme, but these risks are being actively managed.
- 7.3 There is an induction day being planned to welcome CSU colleagues into the ICB Cluster and both the CEO and CFO are planning to be at that as part of the programme. It is important that CSU colleagues are recognised as being an important part of the future of the

organisation and have an important part to play in ensuring our future success. We look forward to welcoming colleagues into the teams.

- 7.4 There continues to be an ongoing dialogue at both national and regional level regarding the apportionment of stranded costs and redundancy costs for CSU services and colleagues. The Board continues to hold the view that these costs are not ICB costs and should be covered by NHS England as part of the transition. This is aligned to the views of the other ICBs across the Midlands.

8.0 Governance, Merger Preparation and Board Alignment

- 8.1 NHS England has approved constitutional changes that allow partner member appointment processes to progress. Work is underway to ensure strong Local Authority and provider involvement within the constraints of nationally mandated reduced voting seats, and further refinement is being undertaken to prepare for the formal merger in 2027.
- 8.2 Committee alignment, joint working, and standardised reporting/templates are now embedded, and plans are evolving towards fully joint committees are being developed. The upcoming Board Development Session will support further clarity on future governance arrangements.

9.0 Risk, Quality and Assurance

- 9.1 The risk register is being refreshed to reflect the dynamic environment, including CSU-related risks, staff capacity, statutory function clarity and transition-related quality risks. The ICB Transition Glide Path and programme SITREPs provide a consolidated view of key milestones and remain central to the Transition Committee ability to provide assurance on transition progress to the Board.

10.0 Recommendation to the Board

- 10.1 To **ASSURE** both BOARDS that the Transition Committee is managing the complex transition work programme, is tracking and managing the issues and risks associated with the transition.

Simon Whitehouse
ICB Cluster CEO

Board Assurance Committee

“Triple A” Escalations & Highlights Assurance Report

Report To:	ICB Boards in Common
Date:	26 th March 2026
Reporting Committee:	Finance Committee in Common – Part 1 (ICB) & Part 2 (System)
Date of Meeting:	25 th February 2026
Meeting Quorate Y/N?	Yes (both)
Presenter:	Mike Lawton, ICB Deputy Chair
Author:	Kelly Weatherill, Executive Assistant

Summary of Key Discussions & Decisions from the Committee Meeting

ALERT – the “Top 3 Issues” ref. Alignment to ICB Objectives & Core Functions

Finance Committee in Common Part 1 (ICB)

ICB Finance Performance

STW Month 10 Finance Report – Capital

Primary care Utilisation and Modernisation Fund – The following schemes have been deferred to 2026/27 - Bridgnorth Medical Practice along with the Woodside scheme, PCUMF (Primary Care Modernisation and Utilisation Fund) will therefore underspend by £752k in year (national capital programme - outside of ICB CDEL).

Finance Committee in Common Part 2 (System)

System Finance Performance

STW Monthly Revenue and Efficiency Report – Month 10

The overspend against plan for bank expenditure continues to grow with the system reporting a £10.7m bank overspend YTD, this is partially offset by additional income.

Across the system two organisations are reporting an adverse variance to the planned underlying exit rate - RJAH are £0.7m adverse to plan and SATH £1.3m adverse to plan. Both providers have confirmed that these shortfalls will be addressed in setting the financial plans for 2026/27.

ADVISE – the “Top 3 Issues” ref. Alignment to ICB Objectives & Core Functions

Finance Committee in Common Part 1 (ICB)

Planning & Contract Sign Off Update

STW Medium-Term Financial Plan Refresh and 2026/27 Operational Planning

Following the December submission, all system partners have agreed the prioritised capital schemes within the indicative system allocation for all elements of Strategic Capital. On February 12th, compliant revenue and capital plans were submitted for the ICB statutory body, the Strategic Capital and ICB capital programme and all STW providers. Compliant revenue financial plans were submitted by SCHAT and RJAH (subject to contract income), however SATH submitted a non-compliant revenue plan with a deficit of £8.6m.

SSoT 2026/27 Planning Submission – Finance, Activity, Performance and Workforce

As part of the national 2026/27-2028/29 planning process, SSoT submitted its required planning components in line with the national deadline on 12th February. These included finance, activity, performance and workforce returns, five-year commissioning plan, together with the Board Assurance Statement updates. The Committee were updated on the areas of compliance and the one area of non-compliance relating to the percentage of patients waiting within 18 weeks (RTT).

Finance Committee in Common Part 2 (System)

System Finance Performance

STW Monthly Capital Report

Capital expenditure YTD is £33.2m behind plan, the Committee were provided a breakdown of organisational positions and assurance that this will recover by year end.

SSoT Provider Collaborative Assurance Update

The Committee noted the report and the ongoing work undertaken in the Provider Collaborative which consists of three priority areas agreed by system Chief Executives:

- UEC/Community Transformation to support Winter
- Back Office Transformation
- Neighbourhood Health

The update focussed on the two priority areas for 2025/26 (Neighbourhood Health and UEC/Community and Corporate Services Transformation Programmes) as well as the plans for developing the programme of work for 2026/27. Of which the areas of focus will include:

- Hospital to Community
- Corporate Services
- One Public Estate

STW System Vacancy Panel Update (SVAP)

The Committee were presented with an update regarding the STW System Vacancy Assurance Panel. The paper outlined three recommendations that were recently approved by the STW People Collaborative and were shared with the Finance Committee for formal ratification.

The recommendations were outlined as follows:

- SVAP is stood down as a weekly meeting in its current format as a control and assurance mechanism
- A new process for sharing vacancies is agreed by SVAP members in order that the benefits of a collaborative approach are not lost
- If at any time, it appears that there is a relaxation of grip and control at organisational level, SVAP is reintroduced as a control mechanism.

The Finance Committee formally ratified the decision.

ASSURE – the “Top 3 Issues” ref. Alignment to ICB Objectives & Core Functions

Finance Committee in Common Part 1 (ICB)

ICB Finance Performance

STW Month 10 Finance Report – Capital

The ICB's CDEL BAU capital plans for 2025/26 are progressing in line with plan. All forecast expenditure remains within the available allocation.

STW Month 10 Finance Report - Revenue and Efficiency

The ICB is expected to deliver breakeven at Month 10 YTD this a £1.7m favourable variance to plan and a £2m favourable variance to plan by year end. The ICB is reporting year to date £5.2m delivery of efficiency ahead of plan and due to individual commissioning case management efficiency and receipt of prior year benefits.

SSoT Month 10 Finance Report

SSoT ICB reported a YTD £4.4m surplus position against the £8.9m plan. The favourable variance to plan is due to the crystallisation of mitigations to the position, offset by a £0.7m shortfall of Continuing Healthcare efficiency delivery in month. The final quarter's deficit support funding has been received by the system which means the full £95m has been allocated. A break-even forecast outturn position continues to be reported.

SSoT 2025/26 Efficiency Report

Current performance at month 10 indicates that the level of plans implemented or fully developed by SSoT ICB reflects a positive position (£150.3m/88%) however, a £17.9m risk to delivery has remained throughout the financial year which has necessitated for the identification of mitigations, mostly non recurrent in nature. The ICB remains committed to achieving the £169.9m efficiency target in-year.

Finance Committee in Common Part 2 (System)

System Finance Performance

STW Monthly Revenue and Efficiency Report

The 2025/26 month 10 system position is a YTD adverse variance to plan of £3.6m, and the system is reporting an expected FOT of £2.3m favourable variance to plan albeit with risks and mitigations identified. YTD system efficiency delivery is £85m compared to a plan of £78.1m. The system is £6.9m ahead of plan, mainly due to delivery in the ICB and additional efficiency programme savings.

SSoT System Performance Summary Report

The Committee received an update on the key headlines in relation to Finance, Performance and Workforce. This included specific and detailed updates on system finance, efficiency programme, workforce and sickness absence, and feedback from the System Capital Group which had taken place on 20th February 2026.

The Committee was updated on the month 10 system financial position which is currently reporting an £8.4m deficit, representing a £3.2m favourable variance against the planned £11.6m deficit (£1.0m favourable at month 9). YTD this includes deficits of £4.5m for the ICB, £6.8m at UHNM and offset by a surplus of £2.0m at MPFT and £0.9m NSCHT. All organisations continue to forecast a break-even position.

The efficiency programme is £28.0m behind plan which is £19.0m behind trajectory, with 7% of schemes remaining 'high risk'. UHNM is the main outlier with £16.7m (32%) of total high-risk schemes, representing a delivery risk.

Key Risks & Mitigations (ref. System Board Assurance Framework: SBAF)

The Committee were presented with the System Board Assurance Framework (SBAF) for Q4 2025-26 for oversight and assurance. The Committee were also presented with updates relating to the ICB and System Risk Registers.

<i>Policies & Procedures Approved</i>

The Committee did not receive or approve any policies this month; nor did any papers received under the Business Cycles of both parts have any likely future impacts on current policy matters.

<i>Decisions to be Escalated to ICB Board</i>

There were no items for escalation originating from Part 1 or Part 2 of the Finance Committee.

Board Assurance Committee “Triple A” Escalations & Highlights Assurance Report

Report To:	ICB Boards in Common
Date:	26 March 2026
Reporting Committee:	Audit Committee in Common
Date of Meeting:	22 January 2026
Meeting Quorate Y/N?	Y
Presenter:	Roger Dunshea
Author:	Paul Winter/Sara Rogers

Summary of Key Discussions & Decisions from the Committee Meeting

ALERT – the “Top 3 Issues” ref. Alignment to ICB Objectives & Core Functions

Risk Registers

A discussion was held around as the organisations begin meeting in common, a consistent and shared approach to governance and processes will be required. Work has commenced to align key areas including risk strategies, the System BAF (SBAF), and standardised processes such as joint systems and scoring matrices. The Audit Committee will maintain oversight of this transition, ensuring that risk registers accurately reflect the evolving structure of the ICB and that appropriate audit assurance is in place. Committee members and both internal auditors will be involved throughout, including through the ongoing MIAA audit of the risk and BAF process. While the changes will be evolutionary, they will be delivered at pace, with further progress updates and interim engagement with members to support alignment and avoid unnecessary redesign.

ADVISE – the “Top 3 Issues” ref. Alignment to ICB Objectives & Core Functions

Review of Waivers for Single Contract Tenders

Members received the report which summarised all Single Tender Waivers (STW) for SSoT ICB from 1 October 2025 to 31 December 2025. Further information was requested from members on the rationale for the STW awarded to Staffordshire University: To evaluate the impact of the Locality Improvement Framework (LIF) across 12 localities in Staffordshire and Stoke-on-Trent, supporting continuous learning and system-wide improvement in tackling health inequalities. **(STW/2025/038, value £396,138)**

SSoT/STW ISFE2 Project Progress Update

The new national finance ledger system, ISFE2, went live on 1 October 2025 across both Staffordshire and Stoke-on-Trent (SSoT) and Shropshire, Telford and Wrekin (STW) ICBs. While implementation has been successful, the transition has been more complex than anticipated, with several nationally recognised system issues currently being addressed. Assurance has been provided that year-to-date financial figures and statutory accounts remain accurate, and month-end positions have been reviewed for both ICBs. Current system issues primarily affect advanced functionality, such as planning, budgeting, forecasting, automated statutory accounts production, and reporting efficiencies, meaning some manual workarounds are required in the interim. From an external audit perspective, the mid-year implementation will create a one-off increase in audit work, as auditors will need to review both the original ledger and the new system for the financial year. However, this does not impact the integrity of financial reporting, and final accounts and audit processes are expected to be delivered at a level comparable to previous years, with national teams working to resolve remaining issues ahead of the next financial year.

SSoT Audit Committee Effectiveness Report 25/26

Members noted the outcome of SSoT ICBs Audit Committee Effectiveness Survey (Nov–Dec 2025), which confirmed the Committee continues to operate effectively and provides substantial assurance, with no significant issues identified and no improvement plan required. Feedback relating to the transition to “in common” working will be reflected in updated, consolidated Terms of Reference for SSoT and STW.

ASSURE – the “Top 3 Issues” ref. Alignment to ICB Objectives & Core Functions

STW – Internal and External Audit Procurement

Members received and noted the report which provided an overview of the procurement process to secure internal and external audit services for 2026/26. Internal Audit and Counter Fraud services will be provided by Mersey Internal Audit Agency (MIAA) from 1st April 2026. External Audit services will continue to be provided by Grant Thornton from 1st July 2026.

SSoT ICB-ICS IG Data & Digital Committee Update

Members received an update from the SSoT Data, Digital and IG Committee held in December which was expected to be the final SSoT-only meeting, with February anticipated to be the first meeting held jointly with STW. Shared IG and informatics support arrangements should help enable alignment between the two organisations.

The Committee discussed a national cyber incident involving a third-party provider of outsourced phlebotomy and pathology services. Work is ongoing with the provider to understand the potential local impact and whether the issue affects the ICB directly or partner organisations. The matter will remain under review.

Progress towards completion of the Data Security and Protection Toolkit remains on track ahead of the June deadline, with MIAA audits planned. Some IG service capacity pressures within the CSU were noted but have not affected compliance to date.

STW Information Governance Update

The Chair of the IG Subcommittee, Claire Skidmore, reported that work on the 2025/26 Data Security and Protection Toolkit (DSPT) is underway, with both ICBs taking a consistent approach and internal audit support in place to ensure readiness. Training compliance remains strong, with positive uptake of new cyber awareness training.

A lessons learned review following a recent system provider incident highlighted the need for a unified cyber response plan and stronger cyber resilience scrutiny within procurement processes. Work is now underway with procurement leads to strengthen these arrangements.

Key Risks & Mitigations (ref. System Board Assurance Framework: SBAF)

Policies & Procedures Approved

None

Decisions to be Escalated to ICB Board

None

Board Assurance Committee “Triple A” Escalations & Highlights Assurance Report

Report To:	ICB Boards in Common
Date:	26 March 2026
Reporting Committee:	Remuneration Committee in Common
Date of Meeting:	20 th January 2026
Meeting Quorate Y/N?	Yes
Presenter:	Shokat Lal
Author:	Stacey Robinson

Summary of Key Discussions & Decisions from the Committee Meeting

ALERT – the “Top 3 Issues” ref. Alignment to ICB Objectives & Core Functions

N/A

ADVISE – the “Top 3 Issues” ref. Alignment to ICB Objectives & Core Functions

N/A

ASSURE – the “Top 3 Issues” ref. Alignment to ICB Objectives & Core Functions

The Staffordshire and Stoke-on-Trent Remuneration Committee and Shropshire, Telford and Wrekin Integrated Care Board Remuneration Committee met in common to discuss the following:

Voluntary Redundancy Scheme

The Committees received an update in relation to the previously approved Voluntary Redundancy Scheme with assurance provided around the robust decision-making process. The Committees agreed to proceed with the scheme in line with option 3 detailed within the paper.

VSM Pay Award – Chief Transformation Officer

The Committees received a follow up paper to the VSM Pay Award paper that was previously considered in September 2025. Following a review of the VSM Pay Guidance the Committee were notified that the cost-of-living award should have been applied to this role. The Remuneration Committee approved the cost of living pay award following reconsideration of the strategy.

VSM Salary Cluster Chief Finance Officer

The Committees received a follow up paper to the VSM Salary for Cluster Executive Directors previously approved in November 2026, noting that there was a requirement to submit a business case to NHS England for approval when salary is of a certain level. This was not clear when the VSM Pay Strategy was initially applied. Appropriate retrospective actions have been taken in discussion with the NHSE national and regional team.

<i>Key Risks & Mitigations (ref. System Board Assurance Framework: SBAF)</i>

<i>Policies & Procedures Approved</i>

N/A

<i>Decisions to be Escalated to ICB Board</i>

N/A

Board Assurance Committee “Triple A” Escalations & Highlights Assurance Report

Report To:	ICB Boards in Common
Date:	26 March 2026
Reporting Committee:	Strategic Commissioning and Transformation Committee
Date of Meeting:	4 March 2026
Meeting Quorate Y/N?	Yes
Presenter:	Mike Lawton, Non-Executive Director`
Author:	Sara Rogers/Vanessa Ridout

Summary of Key Discussions & Decisions from the Committee Meeting

ALERT – the “Top 3 Issues” ref. Alignment to ICB Objectives & Core Functions

1. Wheelchair Procurement (Extraordinary Committee held on 23 February 2026)

The contract is offered on a block basis, and payment will be unaffected by activity levels. The contract will have a maximum block value of £2,730,000 per annum, plus VAT. This is the ICB’s financial envelope/budget. The total value for the initial three year period would therefore be £8,190,000, plus VAT. The total value for the initial three year period, plus the optional two year extension period, would be £13,650,000, plus VAT. The evaluation was made solely on the price submission for Years 1 to 3 as this is the initial contract period. The Contract Value for years 4 and 5 were not evaluated, but the appointed Bidder is expected to remain within the block value + VAT, should the contract be extended to years 4 and 5.

The Committee were assured that the Evaluation Process had met the requirements of the Provider Selection Regime as set out in the Contract Award Recommendation Report.

The Committee approved the recommendation that the contract for this service is awarded to Ross Auto Engineering Limited (trading as Ross Care) as they achieved the highest score overall, and their bid fell within the financial envelope for this service (as advertised within both the tender notice on FTS and the tender documentation for this procurement).

The ICB’s financial envelope for the three year contract period was £8,190,000, therefore Ross Auto Engineering Limited (trading as Ross Care)’s bid came in £584,123 less than the maximum block value at £7,605,877. The total awardable value, inclusive of the optional extension period, is £12,676,460.

The Board is required to ratify the delegated decision made by the Committee to Approve the Contract Award to Ross Auto Engineering Limited (trading as Ross Care) for 3 years with an optional two year extension period and is included in the decisions to escalate section of this report.

2. Proposal for Procurement of Integrated Community Equipment Service (ICES) contract

The Committee approved the proposal to commence the procurement of the ICES contract. The ICES is jointly commissioned by the ICB Stoke-on-Trent City Council and Staffordshire County Council through the Better Care Fund, governed by Section 75 agreements that have now expired and requires renewal.

Five options have been considered. Direct award and contract variation carry significant legal risk, while maintaining the current rolling contract perpetuates unacceptable risk. A full competitive tender is not considered proportionate, given resource constraints, anticipated timescales, and likely limited market interest. The preferred option is therefore to re-procure the service via a compliant

procurement framework, providing legal assurance, faster mobilisation, alignment with LGR timelines, and continuity of service.

This approach would enable award of a 2+1+1 year contract potentially extending to the end of 2029. Both Local Authorities support this option in principle. Post-award, Staffordshire County Council has indicated willingness to resume contract management, subject to novation and agreement of associated legal and management costs, offering capacity relief and potential VAT efficiencies for the ICB.

3. Individual practice issue – The Committee were advised of a confidential practice issue.

ADVISE – the “Top 3 Issues” ref. Alignment to ICB Objectives & Core Functions

NHS Reform

Committee were provided with the following updates:

- Consultation on senior leadership management of change (Band 9 → 8C) has closed with strong feedback, so it will be extended by one week before finalising structures and moving to recruitment. The next phase of organisational change launches 23 March, starting a 45-day consultation on structures. At the same time, there will be consultation on hybrid working and office-based arrangements.
- Leaders and non-executive board members reviewed and aligned on the operating model as a strategic commissioner. Work is also underway to manage the closure of CSUs, including absorbing some staff/functions and exploring shared services (e.g., procurement, data) for efficiency.
- Board subcommittees have been agreed, and supporting groups are being designed, particularly for SCTC, which will gain a broader remit including strategy, prevention, market management, and intelligent payer functions. Partners may be consulted to ensure meetings add value.
- Staffordshire and Stoke-on-Trent Place Boards are being established, with the goal of being operational by April to support local delivery and decision-making.

Provider Collaborative Update

Through the Finance and Performance Committee, progress is reviewed on in-year delivery, including UEC community transfer transformation, respiratory work, urgent care coordination, and the development of neighbourhood teams across the area, with strong progress in Stoke and East Staffordshire and new models emerging in the south. Corporate services remain the biggest challenge, particularly deciding what should be delivered at SSOT or cluster level. Over the past few months, alongside the strategic planning cycle and with ICB colleagues, work has focused on clarifying the role of the provider collaborative within the wider system. A February event with provider executives confirmed support for continuing the collaborative but with clearer priorities, particularly driving community transformation between NSCHT, MPFT, and UHNM, recognising the need to address workforce, estates, and IT. Collaboration on corporate services will continue selectively where it adds value, while neighbourhood team progress will depend on stronger partnerships with primary care, the voluntary sector, and local authorities. Proposals are being developed on future resourcing, roles, and governance, including a more strategic board and a pan-system executive delivery group, alongside wider system discussions led by the ICB on the long-term structure for Staffordshire and Stoke-on-Trent.

ASSURE – the “Top 3 Issues” ref. Alignment to ICB Objectives & Core Functions

Steady on Your Feet (SOYF) the Committee received a briefing paper which detailed information regarding the implementation of a one-year pilot for the Steady On Your Feet (SOYF) digital falls-prevention platform. SOYF delivers evidence-based tools to support early identification of falls risk, personalised prevention plans, and improved coordination across community and clinical pathways. The platform includes digital self-assessment, tailored action planning, strength and balance resources, and guidance on reducing home hazards. SOYF is already in use across multiple NHS and Local Authority areas and aligns with NICE NG249 guidance, supporting SSOT ICB priorities for prevention, healthy ageing, independence, and reducing avoidable admissions.

SSoT Primary Care Forum Triple A Report

Key points from the Primary Care Forum included:

- There were no alerts for the Committee.
- Finance remains in a healthy position
- SMS Costs Across General Practice had been submitted to PCF for approval. A significant system wide program to reduce SMS expenditure with practices has delivered improvements since August. The recommendation was to approve £50k from the primary care budget, which will avoid recharging practices for this financial year. The Primary Care Forum recommended approval of £50,000 to support the SMS cost pressure across GP in this financial year.
- GP IT Futures & Tech Innovation Framework (TIF) Replacement Framework – Practice Migration Request - the paper was presented to consider the implications to the ICB of the new framework that will replace GP IT Futures and Tech Innovation Framework (TIF) with national changes to GP clinical system frameworks underway. The Primary Care Forum recommended approval to pause all clinical system migrations pending assurances regarding functionality and system-wide compatibility. No new system changes are supported until the new framework is launched in 2026/27.
- Challenging Behavior Security Service (CBSS) contact update – the PCF recommended approval to allow the existing contract to come to a natural end on 31st March and devolve a proportion of the budget and commissioning responsibilities to SAS providers, with the service provision to mainstream general practices being withdrawn. This recommendation is subject to the completion of both a QIA and an EIA. A six month extension of the existing contract was approved to provide sufficient time for a safe and effective handover.
- Pharmacy, Optometry and Dental Services (PODs) - An update was provided on the Special Schools Eye Test Service, which continues to progress through ongoing engagement with schools and the local authority. The Clinical Waste Procurement tender has now been launched. New contractual arrangements for orthodontic services are required by 30th September, a Direct Award C under the Provider Selection Regime has been approved by the JCG, and the ICB is working closely with the OoWM to ensure alignment of future contracting arrangements.
- Commissioning Intentions and Planning for 2026/27 - A presentation was shared on the Primary Care Commissioning Intentions including Investments and risks, the narrative towards the 5-year strategic commissioning plan and the Medium-Term Planning requirements.
- General Practice Update - One practice issue was discussed; ongoing support is being provided to this practice.
- Burntwood Development Update - The scheme is progressing with ongoing engagement with MPs and local councillors. Confirmation of the anticipated completion dates for planning permission from Entrust is expected to be finalised by 31st May 2026.
- Staffordshire and Stoke on Trent Quality & Contracting Variation Oversight Group (QCVOG) Report (for assurance) An informative update was given providing key highlights from the report. The Primary Care Forum considered and are assured with the QCVOG Report.

Key Risks & Mitigations (ref. System Board Assurance Framework: SBAF)

Q4 2025/26 System Board Assurance Framework – The Committee considered each risk level and were assured the assessment accurately reflects the current position, and that the actions identified

are sufficient to either reduce the risk level or provide additional assurance, with particular focus on SBAF 3 and 4.

Policies & Procedures Approved

- ☒ There were no policies or procedures requiring approval.

Decisions to be Escalated to ICB Board

1. Wheelchair Procurement

The Board is required to ratify the delegated decision made by the Committee to Approve the Contract Award to Ross Auto Engineering Limited (trading as Ross Care) for 3 years with an optional two year extension period.

The ICB's financial envelope for the three year contract period was £8,190,000, therefore Ross Auto Engineering Limited (trading as Ross Care)'s bid came in £584,123 less than the maximum block value at £7,605,877. The total awardable value, inclusive of the optional extension period, is £12,676,460.

Board Assurance Committee “Triple A” Escalations & Highlights Assurance Report

Report To:	ICB Boards in Common
Date:	26 March 2026
Reporting Committee:	Quality and Performance Committee STW
Date of Meeting:	05 February 26
Meeting Quorate Y/N?	Yes
Presenter:	Cheryl Etches, Non-executive Director and Committee Chairperson
Author:	Vanessa Whatley, Chief Nursing officer, NHS STW

Summary of Key Discussions & Decisions from the Committee Meeting

ALERT – the “Top 3 Issues” ref. Alignment to ICB Objectives & Core Functions

- Diabetes and Urgent and Emergency care remain the highest risks; however, the committee was advised of some progress, 12-hour performance and 4-hour urgent and emergency care metrics at SaTH achieved the best December performance since 2021 and there is an improved diabetic foot screening offer and ambulance offloads to come in line with national. Both risks are under review. However, there remains significant work to progress with intense system oversight and mitigation.
- High Neurodevelopmental waiting list & workforce gaps are contributing to a significant backlog. While this is national issue local mitigations and action is in place and impact on the waiting lists being monitored. Workforce shortages across CAMHS, Neurodevelopmental, speech and language, orthotics and specialist roles such learning disability nurses are being addressed though local, regional and national actions.
- Limited provision for CYP palliative care (16–17 years) is being addressed through a system group and escalated to the NHSE Midlands Specialist Commissioning Team. A system solution is in discussion.

ADVISE – the “Top 3 Issues” ref. Alignment to ICB Objectives & Core Functions

- The Committee advises of improved system governance of childrens and young people’s (CYP) care and delivered improvements across elective care, community long waits, asthma and epilepsy pathways, safeguarding, SEND, and multi-agency oversight, however ongoing gaps are acknowledged in: specialist palliative care (16–17 years) as per risk, a specialist phlebotomy service for children and young people with learning disabilities and autism and paediatric dental surgery capacity.
- A remedial action plan is in place to address CYP mental health access which was reported as approximately 17% below target. Staff recruitment is a key action and is underway and monitored via an action group with exec oversight.
- SaTH has implemented 203 of the 210 actions from both independent maternity review (Ockenden) reports. The remaining seven actions are either descoped as for organisations other than SaTH to enact or are on track for completion.

- The DadPad pilot project, jointly funded by the Local Maternity and Neonatal System (LMNS) and MPFT perinatal mental health team, has been launched. A six-year licence will support fathers with practical information, improve mental health literacy, and embed father-inclusive care across the perinatal pathway.

ASSURE – the “Top 3 Issues” ref. Alignment to ICB Objectives & Core Functions

- Cancer performance is showing that the Faster Diagnosis Standard is at 86% (target 74.3%) and the 62-day backlog is reduced below plan.
- The Mental health average length of stay for inpatients improved significantly (52 days vs target of 60 days).
- SaTH have eliminated all children and young peoples waits over 52 weeks and now working towards a target of under 40 weeks.

Key Risks & Mitigations (ref. System Board Assurance Framework: SBAF)

Policies & Procedures Approved

- ☑ The committee supported the Cardiovascular, Renal and Metabolic (CVRM) Strategy.

Decisions to be Escalated to ICB Board

- ☑ No Decisions to be escalated.

Board Assurance Committee “Triple A” Escalations & Highlights Assurance Report

Report To:	ICB Boards in Common
Date:	26 March 2026
Reporting Committee:	Shropshire Integrated Place Partnership (ShIPP)
Date of Meeting:	12 February 2026
Meeting Quorate Y/N?	Yes
Presenter:	Tanya Miles, Chief Executive, Shropshire Council
Author:	Rachel Robinson, Executive Director of Public Health (DPH), Shropshire Council

Summary of Key Discussions & Decisions from the Committee Meeting

ALERT – the “Top 3 Issues” ref. Alignment to ICB Objectives & Core Functions

1. CAMHS Transformation – Critical Dependencies & Trajectory Requirements

Following the update on the CAMHS transformation - ShIPP has requested visibility of **school coverage trajectories** for Mental Health Support Teams (MHST) to meet the ambition of reaching **all Shropshire schools by 2029**. This will require sustained resource planning and ICB input.

2. Governance Structure Clarity and Alignment

The HWBB/SHIPP priorities workshop identified the need to clarify governance functions, membership, and future configuration. Work is required to ensure appropriate alignment across the system and preparation for the new HWBB Strategy (2027–2032) with clear priorities agreed for 2026 for the final year of the strategy for HWBB and SHIPP. This includes a call to action around suicide prevention, a combined, strategic alignment to improve place-based delivery through neighborhoods including multi-professional teams providing a joined-up approach.

3. Systemwide Independent Patient Voice Provision

ShIPP agreed that formalising an **independent Healthwatch-led patient voice group** is essential for system governance. This is currently not in place and needs Board oversight, a group is being pulled together to consider a way forward.

ADVISE – the “Top 3 Issues” ref. Alignment to ICB Objectives & Core Functions

1. Adoption of Marmot Principles for Shropshire

There is consensus to adopt the Marmot approach, with emphasis on adaptations for rurality and long-term positioning as a “Marmot Place”.

2. HWBB/ShIPP Priorities for 2026 & Strategy Refresh

The partnership identified several strategic priorities requiring further refinement—these will shape the transition between the current (2022–27) and new (2027–32) Health & Wellbeing strategies. Priorities to focus on 2026 were identified as:

- Suicide Prevention – HWBB in March
- Healthy Weight Strategy (inc. childhood obesity) – update
- Workforce (AAA) – to be scheduled
- Neighbourhoods – strategic alignment and mapping process re. delivery

- Digital – should be golden thread through all subjects

New HWBB 5 year strategy

- A timeline is being mapped and consideration of the Prevention Framework, Inequalities Strategy & Health Weight Strategy and Marmot Principles to update progress prior to refresh.

Progress updates to HWBB will continue every 6 months

3. Communications – Referral Pathway Clarification

The CAMHS team committed to disseminating updates on referral pathways, including clarifying that GP referrals continue to be accepted, with a request to provide this through GP newsletters.

ASSURE – the “Top 3 Issues” ref. Alignment to ICB Objectives & Core Functions

1. CAMHS Service Transformation – Positive Progress

The Committee received strong assurance about the phased implementation of the CAMHS contract, including prevention-focused and integrated pathways.

2. Planning & Development Work for HWBB, ShIPP & Accelerator Group

Good progress was reported on aligning priorities, governance review, and stakeholder engagement in preparation for the strategy refresh but more work is to be done during the next 6 months.

3. No New System Risks Identified

The Committee confirmed no risks were raised at this meeting, indicating stable risk management for the issues discussed.

Key Risks & Mitigations (ref. System Board Assurance Framework: SBAF)

No risks were raised or escalated at this meeting.

Policies & Procedures Approved

None reported for this meeting.

Decisions to be Escalated to ICB Board

No decisions for escalation.

Board Assurance Committee “Triple A” Escalations & Highlights Assurance Report

Report To:	ICB Boards in Common
Date:	26-03-2026
Reporting Committee:	Telford and Wrekin Integrated Place Partnership (TWIPP)
Date of Meeting:	18-03-2026
Meeting Quorate Y/N?	Y
Presenter:	David Sidaway Chief Executive TWC / Chair of TWIPP
Author:	Louise Mills Neighbourhood Health Lead (TWC / ICB)

Summary of Key Discussions & Decisions from the Committee Meeting

ALERT – the “Top 3 Issues” ref. Alignment to ICB Objectives & Core Functions

The TWIPP meeting on March 18th brought together committee and accelerator group member and wider partners in a workshop to discuss and align our priorities for: neighbourhood health, prevention and early intervention in the context of the left shift ambition. The meeting was well attended by 50+ senior leaders, operational managers and commissioners from across TWIPP partner organisations, including: the NHS Trusts, PCNs, local authority adult social care, children & families and public health, and the community and voluntary sector.

ADVISE – the “Top 3 Issues” ref. Alignment to ICB Objectives & Core Functions

➤ **Key Strategic Themes Discussed**

- Neighbourhood Health as a shared system priority
- Acute and Community Interface – Shifting Care Closer to Home
- Mental Health Transformation
- MSK and Pain Pathway Redesign
- Community Pharmacy’s expanding role
- PCN priorities
- Role of the Voluntary & Community Sector
- Telford & Wrekin Council commitments, including needs-led community service offers.

➤ **Collaborative System Priorities**

- Group discussions focused on: scalable innovative prevention offers, shifting specialist activity safely into community settings, and identifying pathways most ready for neighbourhood delivery.

➤ **Outcome: 90-Day Pledges**

- Partners outlined their individual neighbourhood health commitments for the next 90 days, supported by cross-system collaboration.

ASSURE – the “Top 3 Issues” ref. Alignment to ICB Objectives & Core Functions

- The TWIPP March workshop clearly demonstrated strong whole-system alignment on local priorities from senior leadership through to operational delivery partners - around prevention, neighbourhood health and community care upstream shift.
- Partners shared clear priorities and highlighted shared opportunities.
- Strong commitment to collaborative action was given by all attendees through their individual pledges.

The TWIPP Committee will consider the output of the workshop at its May meeting, and in the meantime, leads will further connect to drive delivery of integration. A high-level neighbourhood health delivery plan will be developed for TWIPP, linking to the Health & Wellbeing Strategy and in the context of implementation of the new Neighbourhood Health Framework, published on 17 March.

Key Risks & Mitigations (ref. System Board Assurance Framework: SBAF)

Policies & Procedures Approved

N/A

Decisions to be Escalated to ICB Board

- Opportunity to align with relevant neighbourhood health funding streams prioritisation

Board Assurance Committee “Triple A” Escalations & Highlights Assurance Report

Report To:	ICB Boards in Common
Date:	26 March 2026
Reporting Committee:	STW People, Culture & Inclusion Committee
Date of Meeting:	18 February 2026
Meeting Quorate Y/N?	N
Presenter:	Mish Irvine, Chief of Staff
Author:	Ellen Shaw

Summary of Key Discussions & Decisions from the Committee Meeting

ALERT – the “Top 3 Issues” ref. Alignment to ICB Objectives & Core Functions

STW Pharmacy Workforce Strategy: The Strategy highlights the challenges for the pharmacy workforce in relation to recruitment and retention and training capacity, particularly in view of the anticipated growth as part of the neighbourhood model. It has been co-produced by members of the STW Pharmacy Faculty that is acting as the delivery hub. The Faculty has already experienced some success with the fill rate for Foundation Trainee Pharmacist places increasing from 54% to 93%. The Committee acknowledged that the work of the Faculty is entirely voluntary and no funding is available to increase capacity which may present a risk going forward. The Committee approved the Strategy but noted that governance arrangements for its delivery were not in place. The PCI recommends that the ICB Board supports the Strategy, notes the critical role of the Pharmacy Faculty in its delivery and agrees governance arrangements.

Launch of the Work Well Programme: The committee was updated on a new 3- year DWP-funded programme intended to provide early intervention for people either struggling to retain employment or short-term unemployed due to health-related barriers. Whilst delivery is focussed on partnership working, there will be a small ICB infrastructure to support it with the STW/SSOT Chief of Staff acting as the Executive Lead. Partner engagement was delayed whilst the ICB team was agreed but will now commence at pace. A submission setting out the delivery model and metrics, aligned to both the neighbourhoods work and the Core20Plus, is due to DWP on 13th March. Funding value is c£6M for the Cluster over the three-year period.

Role of the PCI Committee in relation to NHS Reform: The Chair confirmed that the PCI Committee is now being stood down pending new governance arrangements and the impact of the STW/SSOT ICB Cluster that will involve a joint committee and a single non-exec Chair. Workshops are being scheduled to explore the role and purpose of the Committee going forward including opportunities for further collaboration and the critical input from non-NHS partners. Members acknowledged that greater clarity was required on the respective roles of ICBs, providers and NHSE in relation to the People Strategy and Plan such as workforce planning and delivery, training & education and ED&I. The Committee recognised the excellent work achieved to date through collaborative working and thanked all those involved in its delivery.

ADVISE – the “Top 3 Issues” ref. Alignment to ICB Objectives & Core Functions

System Vacancy Panel: PCI members had agreed remotely in December to stand down the System Vacancy Panel as it had achieved its original objective to enhance grip and control over the recruitment process. The recommendation had previously been approved following submission of a report and discussion at the People Collaborative. The Finance Committee had also been advised of the decision. The PCI committee could not formally ratify the decision as the meeting was not quorate but confirmed its endorsement whilst noting that processes had been put in place to continue to benefit from a collaborative approach to the review of system vacancies.

Online Learning Management System (LMS): Following previous discussions, members were advised that the online LMS being managed by the STW ICB People team, would be taken offline on 20th Feb in view of the revised ICB model and the significantly reduced capacity in the ICB. Extensive communications had been sent out well in advance alongside a review of all users to determine likely impact. It has been confirmed by the host software provider that all data is being handed back to users and / or destroyed in line with the General Data Protection Regulation.

ASSURE – the “Top 3 Issues” ref. Alignment to ICB Objectives & Core Functions

Freedom to Speak Up: Previous discussions had been prompted by an alert from auditors regarding the governance around Freedom to Speak Up processes. The Committee received assurance that providers are managing Freedom to Speak Up locally and a number of audits have taken place to confirm this. The ICB Audit Committee receives information and themes and an annual report is being produced for FTSU themes relating to the ICB itself. As part of the cluster arrangements, a self-assessment has been done against national standards. The future governance arrangements will require clarification and this will form part of the discussion regarding the future role of the PCI.

Equality, Diversity & Inclusion Review of Governance: The Committee was assured that the EDI group has agreed to adopt the SSOT approach to the Workforce Race Equality (WRES) and Workforce Disability Equality Standard (WDES) reporting. A paper will be submitted to the Board in June. Work is also underway to complete the Public Sector Quality Duty which is an ICB internal requirement. A separate paper is being developed to consider how the data within EQIAs can best be used to integrate ED&I requirements with the commissioning process.

Key Risks & Mitigations (ref. System Board Assurance Framework: SBAF)

Policies & Procedures Approved

STW Pharmacy Workforce Strategy approved.

Decisions to be Escalated to ICB Board

- The Committee noted that governance arrangements for delivery of the Pharmacy Workforce Strategy were not in place and recommends that the ICB Board notes the critical role of the Pharmacy Faculty in its delivery and agrees governance arrangements.

Board Assurance Committee

“Triple A” Escalations & Highlights Assurance Report

Report To:	ICB Boards in Common
Date:	26 March 2026
Reporting Committee:	Staffordshire & Stoke-on-Trent ICB Quality & Safety Committee
Date of Meeting:	18 th February 2026
Meeting Quorate Y/N?	Y
Presenter:	Siobhan Heafield, Non-Executive Member and Committee Chair
Author:	Tracey Finney, Executive Assistant

Summary of Key Discussions & Decisions from the Committee Meeting

ALERT – the “Top 3 Issues” ref. Alignment to ICB Objectives & Core Functions

No items of alert identified.

ADVISE – the “Top 3 Issues” ref. Alignment to ICB Objectives & Core Functions

Looked After Children Health Assessments

The committee received an update on the current risks, compliance and progress against the recovery plan for Looked after Children (also known as Children in Care).

The committee were informed the overall picture is not showing any consistent improvement or clear direction of a reduction in trajectory. However, assurance was given that discussions are taking place with MPFT with regard to possible changes to their service model and the adaptation of a more structured reporting mechanism. The service specification from Shropshire, Telford and Wrekin ICB has also been shared with a view to maximising learning from the Cluster approach.

Safeguarding Adults & Children

The committee were advised changes in workforce across the ICB and providers may impact on contributions to statutory partnership boards. However, assurance was given that statutory duties would continue to be prioritised.

Compliance for child safeguarding level 3 training at UHNM is currently at 67%. The committee was advised the Trust had experienced some challenges with data collection which are being rectified and had also been unable to release staff for training whilst under critical incident. Assurance was given the Trust’s safeguarding team remains available to all staff for supervision and advice.

The committee agreed compliance should continue to be monitored by the new cluster committee replacement.

System Quality Group

The committee were informed that escalation had been received with regard to delegated health tasks. This applies to the care home and community care sector. The concerns raised initially related to peg feeds but has now become apparent this will apply to many other aspects of care. Advice received from the CQC stated there needs to be a registered delegator (such as a registered nurse or GP) responsible for the delegation of tasks and the

training and competency assessment of each carer. Assurance was given a working group has been set up to explore the issues, risks and mitigations and will report back to the System Quality Group.

The committee were advised concerns had been raised by MPFT in relation to the impact of changes to the management of CHC which continues to evolve as part of the quality and financial improvement work which has been underway since 2024. Assurance was provided that actions are in place and discussions are being held with system partners.

Concerns with regard to demand and capacity for the community nursing service were brought to the committee's attention. This is due to a number of factors, however assurance was given the Trust had set up a working group to bring together and identify all the actions that need to be undertaken.

The committee were informed of some areas of concern in relation to UHNM data from the Sentinel Stroke National Audit Programme (SNNAP) which measures how well stroke care is being delivered. The committee were asked to note the scoring criteria used by SNNAP had changed in 2024 and targets are a national challenge with no hospital scoring A where previously this had been 15-20% of hospitals. The committee were advised the Trust had been open and transparent in discussions at CQRM and actions are being taken. Monitoring will continue at CQRM.

ASSURE – the “Top 3 Issues” ref. Alignment to ICB Objectives & Core Functions

Final Staffordshire & Stoke-on-Trent (SSOT) Quality & Safety Committee

This meeting was the final meeting of the SSOT Quality and Safety Committee which was first formed following the establishment of ICBs in 2022. Under the leadership of the Chief Nursing Officer and a Non-Executive Chair, this committee has operated effectively from the outset as the forum through which numerous quality and safety matters impacting on local patients, service users and their families have been identified, managed, addressed and improved and it leaves a respected track record of quality assurance and improvement which is respected both inside and beyond the ICB. The Committee is now ceasing as the new Cluster bring together Committees in Common under new governance arrangements. The Chair and Executive Lead for the Committee are confident that they are handing over the Committee with a strong reputation for delivery and improvement and look forward to this work continuing under the new operating model.

Children & Young People's Mental Health Local Transformation Plan

The committee received a refreshed Children & Young People's Mental Health Local Transformation Plan which had been developed in partnership by the ICB, local authorities, mental health providers and voluntary community sector providers across the system. The plan set out a number of priority areas including access, prevention, crisis and complex needs, neurodevelopment, care-experienced young people, and co-production.

The committee agreed future monitoring of the plan would be required in the new cluster quality committee.

The committee **endorsed** the Children & Young People's Mental Health Local Transformation Plan and publication on the ICB website, subject to adding a preface advising that governance arrangements would be reviewed under new ICB cluster arrangements.

Quality & Safety Committee Effectiveness Survey

The committee received the report which provided the outcome from the committee self-assessment survey carried out in November and December 2025. It was noted there were six responses from twenty-three members which was considered acceptable. The committee agreed the report be used in planning for the new cluster committee. There were no areas of significant concern and no surprises in terms of most matters had already been identified for improvement action by the Chair and Executive lead and this information will be fed into the development workshop for the establishment of the new committee.

Health & Social Care Integrated Support Protocol

The committee received the Health & Social Care Integrated Support Protocol which had been co-produced with both local authorities and will improve outcomes and experience for patients whilst also supporting the ICB in its statutory duties.

The committee noted the protocol had been presented and approved at both the Staffordshire and Stoke-on-Trent Joint Commissioning Boards.

The committee suggested the title should be amended to make it clear the protocol is for adults only. The protocol states that patients should ordinarily live in and have a Staffordshire GP and the committee suggested a line be added to say that where patients do not have a Staffordshire GP their needs may be met by exception.

The committee **approved** the Health & Social Care Integrated Support protocol subject to the suggestions above. **The ICB Board will need to ratify this decision.**

Complaints, MP Letters & Concerns Policy

The committee received the Complaints, MP Letters & Concerns Policy which had undergone a scheduled review. Minor amendments had been made, primarily to remove Midlands & Lancashire CSU from the process following the AACC service being in-housed to the ICB.

The committee **approved** the Complaints, MP Letters & Concerns Policy. **The ICB Board will need to ratify this decision.**

Continuous Quality Improvement (CQI)

The committee were assured the CQI network had grown to over 800 members and is nationally regarded.

The committee were advised there have been some challenges in terms of engagement with the CQI subgroups, and it is recognised that both SSOT and STW need to explore and be clear on their scope in the future.

The committee were informed of good engagement from provider Trusts with the operational excellence programme and the quality improvement training programme accredited by the Centre for Sustainable Healthcare.

Quality Impact Assessment (QIA)

The committee received an update on QIA activity during the reporting period October 2025 – January 2026. A total of fourteen QIA's were completed at gateway 1 and 2. Nine were undertaken before decision and five retrospectively. Of the five, two were related to urgent commissioning decisions involving transfer of provider contracts and three due to delays in engaging with or fully understanding the QIA process. The committee received assurance

that training sessions for ICB staff continue to be held to raise awareness of the QIA process with a particular emphasis on the requirement for a QIA to be a prospective not retrospective task.

The committee were informed work has begun on the efficiency programmes for 2026-27 and meeting have taken place with scheme leads. However, it is too early to determine if there will be any potential quality impacts and this will be carried into the new committee for future monitoring.

Quality Impact Assessment (QIA) Policy

The committee received the QIA policy which had been revised to incorporate good practice principles from the National Quality Board, recommendations from the independent review carried out by NHSE and feedback from ICB staff. Key updates include a revised scope and definition of 'retrospective', strengthened links with patient and community engagement, adoption of the RASCI model for system wide QIAs, and reference to the Equality and Health Impact Assessment Process.

The committee **approved** the Quality Impact Assessment Policy. **The ICB Board will need to ratify this decision.**

Perinatal Quality Surveillance

The committee were advised a case from UHNM had recently been heard by the coroner. The conclusion of the inquest was natural causes with a neglect rider. A Prevention of Future Deaths report was published as the coroner was concerned that the Maternity Early Warning Score (MEWS) matrix was not being used at the time of the incident in ED and across the whole of the hospital. Assurance was given that work is taking place to roll MEWS out across the maternity unit using the K2 electronic maternity information system. However, a different system is used across other parts of the hospital, and a working group has been established to find a solution to adding MEWS to the electronic record. In the meantime, a paper system will be used, the risks around this were acknowledged and will be added to the Trust's risk register.

The committee received assurance that UHNM have met all ten safety actions for the Maternity Incentive Scheme year 7.

The committee were informed that University Hospitals of Derby and Burton (UHDB) have received the CQC report from an inspection carried out in December 2024. The Trust has been rated as requires improvement which is an improvement from the previous rating of inadequate. The Trust has applied to remove all section 31 conditions.

Quality Oversight Dashboard

The committee's attention was drawn to the wheelchair service where an improving trajectory is being seen.

The committee were informed that LeDeR performance has been sustained and SSOT is now in the top percentile nationally.

The committee had previously been made aware of some concerns in relation to the number of restrictive interventions reported by MPFT. It was identified this was due to the way data was being captured and had been resolved with a data cleanse.

Key Risks & Mitigations (ref. System Board Assurance Framework: SBAF)

The committee reviewed the recommendations from the system and ICB risk registers and issue logs and agreed the following:

- **Approved** closure of risk 1239 neonatal consultant.
- **Approved** reduction in risk score for risk 1609 infant and neonatal mortality provided that ongoing monitoring takes place.
- **Approved** closure of issue 1510 Maternity & Neonatal Voices Partnership.
- **Approved** reduction of risk score for issue 1238 paediatric audiology from 20 to 12.
- **Approved** reduction to residual risk score for risk 1620 cessation of maternity and neonate senior advocate pilot.
- **Did not approve** the closure of issue 1236 wheelchair service. The committee noted a similar risk was on the risk register and agreed a review of both the issue and risk should be undertaken before a final decision on closure was made.

Policies & Procedures Approved

- ☑ The committee **approved** the Health & Social Care Integrated Support Protocol
- ☑ The committee **approved** the Complaints, MP Letters & Concerns Policy
- ☑ The committee **approved** the Quality Impact Assessment Policy

Decisions to be Escalated to ICB Board

No decisions to be escalated.

Board Assurance Committee “Triple A” Escalations & Highlights Assurance Report

Report To:	ICB Boards in Common
Date:	26 March 2026
Reporting Committee:	Staffordshire and Stoke-on-Trent Health and Care Senate
Date of Meeting:	12 February 2026
Meeting Quorate Y/N?	N
Presenter:	Dr Rachel Gallyot, Interim Chief Medical Officer and Senate Chair
Author:	Dr Rachel Gallyot

Summary of Key Discussions & Decisions from the Committee Meeting

ALERT – the “Top 3 Issues” ref. Alignment to ICB Objectives & Core Functions

None.

ADVISE – the “Top 3 Issues” ref. Alignment to ICB Objectives & Core Functions

1: Virtual Approvals – Integrated Medicines Optimisation Group (IMOG) Approvals – October 2025 and November 2025 track items

There was no Senate meeting held in December. The IMOG papers were shared with the Senate members and were virtually approved.

- a) Several NICE TAs were reviewed for NHSE commissioned specialist drugs and were added to the formulary as RED drugs for specialist only prescribing in secondary care. A NICE TA for Betula verrucosa was considered, for treating moderate to severe allergic rhinitis or conjunctivitis caused by tree pollen, when initial treatments such as antihistamines and nasal corticosteroids have failed and there is a positive test of sensitisation to a member of the birch homologous group. The dose is one tablet daily at a cost of £80.12 per month. IMOG has temporarily recommended a RED status as there is little experience of its use. Manufacturers recommend the drug should be initiated under specialist supervision.
- b) IMOG approved the updated clinical pathway for Severe Rheumatoid Arthritis and Moderate Rheumatoid Arthritis.
- c) IMOG approved RAG rating changes, removals and additions to the Staffordshire and Stoke on Trent ICS Formulary Chapter 2 (cardiovascular).
- d) UHNM Currently use dalteparin as the first-line low molecular weight heparin (LMWH). The Trust is planning to switch to enoxaparin (Arovi®) as the first-line preparation w/c 20th October 2025 part of efficiency plans. IMOG Approved AMBER I formulary status for enoxaparin for medical venous thrombo-embolism and AMBER E for cancer associated thrombosis. The associated ESCA was also approved.
- e) ICB Medicines Optimisation team has developed Valproate and Topiramate prescribing templates and associated guide to support practices to improve the safety of prescribing of these drugs in women of childbearing age, which is shared with the Senate for information.
- f) IMOG approved the local Asthma Treatment Guidance in Adults in the meeting held on 5th November 2025 (fast track item). The adult asthma guidelines comprise of:
 - Asthma treatment guidance -Adults (Appendix 09). There is a significant difference to previous NICE guidelines. There is a move away from using short

acting bronchodilators and to using a combination of long-acting bronchodilator with a corticosteroid. Another important change in the local guidance is to change the formulary status of Trimbrow inhaler from Amber R to Green. Timbow is a combination of a long-acting beta-agonist bronchodilator, antimuscarinic long-acting bronchodilator and a corticosteroid. This product is recommended for use when asthma control is suboptimal with all other interventions. The status change to green would mean that patients could be managed in primary care to a greater extent before requiring a referral to a specialist. IMOG members also agreed that it would be useful to initiate this product whilst a patient was waiting for referral.

- Uncontrolled asthma management for adults (Appendix 10). This guideline provides advice on changing treatment of patients who are being managed as per previous NICE guidance but have suboptimal asthma control. No changes in treatment are required in patients who are well controlled on existing treatment (based on previous NICE guidance) but note that sole use of short-acting bronchodilator is no longer recommended.

Note: Financial impact analysis on changes in treatment guidelines has been carried out by the ICB Medicines Optimisation Team. This has been discussed with ICB finance teams. The potential impact is considered as normal inflation in drug expenditure which is covered by the annual drug budget setting process.

- IMOG supported the use of the Salbutamol Patient Group Direction (PGD) (Appendix 11). This PGD will enable practice nurses to issue a salbutamol inhaler to patients who come to the practice for spirometry but have not had an inhaler prescribed yet or have forgotten to bring their inhaler. It is presented to the Senate for information.

The Senate had **virtually approved** decisions a) to d) and f) and noted items e) to g) from the October integrated Medicines Optimisation Group (IMOG) meeting and that decision was **endorsed** in the meeting.

2: Integrated Medicines Optimisation Group (IMOG) - Approvals November and December 2025

IMOG Meeting 5th November 2025

- Several NICE TAs were reviewed for NHSE commissioned specialist drugs and were added to the formulary as RED drugs for specialist only prescribing in secondary care.
- There has been a national change in drug tariff for prescribing of erectile dysfunction drugs with the removal of stipulations that certain drugs can only be provided if certain criteria are met. Therefore, generic tadalafil and generic vardenafil are no longer restricted and can be prescribed, when clinically indicated. The branded versions remain on the restricted list. The local formulary will be updated accordingly but, as it does not have vardenafil, no changes will be made to that drug.
- Anti-influenza drugs, oseltamivir and zanamivir, previously had thresholds in place meaning they were only available for prescribing during the winter months, when influenza infections were at a certain level. Those restrictions have been removed, and they can now be prescribed year-round for at-risk groups only. This change will be reflected in the formulary, and the local antimicrobial guidance document will be updated.
- The MPFT Tissue Viability Team presented a case for using a new product, called Jobst Farrow Wrap, which is a bandaging system for leg ulcers. The team highlighted

benefits around improved cost effectiveness and reduced nursing time and IMOG approved its addition to the wound care formulary.

- e) The Asthma treatment guidance in adults was fast tracked for approval and virtually approved by the Health and Care Senate members.

IMOG meeting held 3rd December 2025

- f) Several NICE TAs were reviewed for NHSE commissioned specialist drugs and were added to the formulary as RED drugs for specialist only prescribing in secondary care.
- g) A generic version of Dapagliflozin an SGLT2 used for type 2 diabetes, heart failure and renal failure is now available which has resulted in a dramatic reduction in the price, with savings of £0.5m per month being made. Following consultation with the relevant clinicians it has been decided that Dapagliflozin should become the drug of choice, in that class of drugs on the formulary because it is the most cost-effective product.
- h) An application was submitted by UHDB for the status of Cinacalcet, for primary hyperthyroidism to be changed from RED status to AMBER-I, to align with Derbyshire where the drug is available for GPs to prescribe, following initiation by consultants and stabilisation of the patient. There is a monitoring requirement but there is a small number of patients involved, and it was assessed that this would not present a significant workload increase in primary care and it was accepted as an AMBER-I drug without any significant investment. A fact sheet is being produced for Cinacalcet to provide information and guidance to GPs.
- i) IMOG approved guidance documents for stoma including a Position Statement on Stoma Accessories and Recommended Prescribing Quantities for Stoma Products. These documents were produced working with Stoma nurses and provide guidance to general practice about the items that should not be prescribed, because they are for cosmetic reasons, and also recommendations around the quantities of accessories that should be prescribed.
- j) The MPFT Learning Disability Team presented a case for making melatonin available on the formulary for treating insomnia in adult patients, with a learning disability, which is having an impact on their behaviour. The alternative options are benzodiazepines, which are not promoted, and the NICE approved hypnotic daridorexant, which is expensive. Melatonin is inexpensive and would only be used if non-pharmacological measures were unsuccessful, so it is not going to increase costs. IMOG approved Melatonin as AMBER-I.
- k) IMOG approved the addition of Caresens Air to the formulary, which is a cost-effective Continuous Blood Glucose Monitoring sensor, suitable for non-complex patients. The Diabetes Team have been consulted and were happy for it to be included in the policy.
- l) IMOG approved the Over-the-Counter Administration in Social and Home Care Settings SSOT Guidance and Position Statement. The purpose of the guidance is to explain that there is an expectation that social care providers would support patients, with their over-the-counter treatments, and that patients would be empowered and supported to choose treatments themselves, or on the recommendation of a community pharmacist or prescriber, so that it is not a barrier to the implementation of self-care policies.

Following the presentation the following clarification points were provided: -

- Assurances were provided that the patient cohort for Cinacalcet monitoring is a small number and that LMC representatives were at the IMOG meeting and were sufficiently reassured regarding the numbers and the workload.
- The use of Dapagliflozin as a first line SGLT2 was supported, however, concerns were raised regarding the lack of resourcing available in terms of monitoring and funding the

treatment and that the frequency of reviews was a definite shift of work into primary care.

- Discussions will be undertaken outside of the meeting regarding further investigation into an issue raised regarding care homes not undertaking oxygen saturation and blood pressure monitoring.
- Clarification was provided that the Over-the-Counter Administration in Social and Home Care Settings SSOT Guidance and Position Statement was for patients receiving social care in their own homes and that the carers should be helping the patients buy the OTC items, which would be at the patients cost.
- Clarification was provided that the rationale for making Cinacalcet available as an AMBER-I was for patients who cannot have surgery, or where surgery has been unsuccessful, which is clearly explained in the fact sheet, so it should not result in an increase in prescribing through people choosing to prescribe over referring for surgery.

The Senate approved IMOG decisions a) to d) from the meeting on 5th November and decisions f) to l) from the meeting held on 3rd December 2025.

The meeting was not quorate due to there being no representation from Adult Social Care. The approvals were sent to Adult Social Care, for ratification, and this was received from Lee Calvert on 20th February 2026.

ASSURE – the “Top 3 Issues” ref. Alignment to ICB Objectives & Core Functions

None.

Key Risks & Mitigations (ref. System Board Assurance Framework: SBAF)

1: The Senate received the Q2 update of the SBAF and Risk Register for information.

Policies & Procedures Approved

None discussed.

Decisions to be Escalated to ICB Board

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

Board Assurance Committee “Triple A” Escalations & Highlights Assurance Report

Report To:	ICB Boards in Common
Date:	26 March 2026
Reporting Committee:	Finance and Performance Committee (System & ICB)
Date of Meeting:	28th January 2026
Meeting Quorate Y/N?	ICB – Yes System - No
Presenter:	Mike Lawton, Non-Executive Member and Committee Chair
Author:	Kelly Weatherill, Executive Assistant

Summary of Key Discussions & Decisions from the Committee Meeting

ALERT – the “Top 3 Issues” ref. Alignment to ICB Objectives & Core Functions

There were no items to alert the ICB Board from the meeting.

ADVISE – the “Top 3 Issues” ref. Alignment to ICB Objectives & Core Functions

System Finance and Performance Committee (formerly Part A)

Chief Finance Officer Update

The Committee received an update from the Chief Finance Officer in relation to national and regional context. The report covered:

- Regional and national financial position
- Additional updates on 25/26 post month 9 reporting
- Update on NHS financial arrangements for 2026/27 and 2027/28

System Performance Summary Report

The Committee received an update on the key headlines in relation to Finance, Performance and Workforce. This included specific and detailed updates on system finance, efficiency programme, workforce and sickness absence, and feedback from the System Capital Group which had taken place on 16th January 2026.

The Committee was updated on the month 9 system financial position which is currently reporting a £15.0m deficit, representing a £1.0m favourable variance against the planned £16.0m deficit (£1.0m favourable at month 8). Year-to-date, this includes deficits of £12.4m for the ICB, £6.1m at UHNM and offset by a surplus of £2.9m at MPFT and £0.6m NSCHT. All organisations continue to forecast a break-even.

Developing the medium term plan and 2026/27 operational planning

The Committee received an update on the 2026/27 operational planning round, which detailed the ICB 2026/27 progress towards the final submission deadline of 12th February 2026 and a high level timeline up to the submission.

In terms of finance, the ICB’s primary focus remains the development of efficiency plans, with all draft PIDs required by 31st January. Good progress is being made across key areas of influenceable spend, particularly within CHC and Prescribing.

In terms of performance & activity, the focus remains on addressing areas of non-compliance.

Provider Collaborative Assurance Update

The Committee noted the report and the ongoing work undertaken in the Provider Collaborative which consists of three priority areas agreed by system Chief Executives:

- UEC/Community Transformation to support Winter
- Back Office Transformation
- Neighbourhood Health

The update focussed on the two priority areas for 2025/26 (Neighbourhood Health and UEC/Community and Corporate Services Transformation Programmes) as well as the plans for developing the programme of work for 2026/27.

The report concluded that provider and ICB colleagues have offered support to prioritise a programme of work looking at the Left Shift agenda. The scope and route to delivery for this Hospital to Community Programme is currently being finalised and will be focused around UHNM's footprint in the first instance. There has also been an agreement to complete a final exercise on the Corporate Services programme to determine where and how providers will engage in the STW Programme in 26/27, given their very different starting points.

Finance & Performance Committee Effectiveness Report

The Committee were informed of the outcomes of the Committee Effectiveness Survey that was carried out between November and December 2025. The Committee discussed the key messages and contents of the survey, taking account of the wider programme of ICB reform, organisational change, and the development of future committee arrangements.

ICB Finance and Performance Committee (formerly Part B)

Month 9 Finance Report & 2025/26 Efficiency Report

The Committee received the Month 9 ICB financial position which reported a YTD £0.2m surplus position against the (£12.4m plan. The ICB's risk position for the final period of 2025/26 reflects three key areas of financial variability, which are being actively managed through the Portfolio Assurance Framework, whilst an informed judgement has been incorporated into our 'likely' risk position. These being: Overperformance against Indicative Activity Plans, Continuing Healthcare run-rate improvement, and the recurrency of the October Prescribing run rate increase. It was therefore recommended that a break-even forecast outturn position continues to be reported. Deficit support funding has been received by the system in full including Q4 (£95.0m).

In terms of the efficiency programme, the level of plans implemented or fully developed by the ICB reflects a positive position (£150.3m/88%) however, a £7.8m risk to delivery remains. The key driver being a £17.9m shortfall in developed schemes. Mitigations to offset this shortfall alongside any emerging risk continue to be identified through the Portfolio Assurance Meetings.

Budget Setting Update

The Committee were presented with the update which sought support ahead of formal approval by the Integrated Care Board (ICB) of the 2026/27–2028/29 Financial Plan, in advance of submission to NHS England on 12th February 2026.

The proposed submission is consistent with the draft financial plan presented on 17th December 2025 and is based on the following key assumptions:

- A balanced revenue position within the confirmed resource allocation
- Full compliance with the Mental Health Investment Standard and capital allocations
- Delivery of a £76.7m efficiency requirement (6.2%) in 2026/27

The Committee supported the work completed to date on the plan, noting the actions that are still required and that the final plan will be presented to Board for approval prior to submission to NHS England. The Committee will be provided with an updated assessment of risk exposure and efficiency plan robustness for 2026/27 following the 31st January 2026 efficiency plan deadline.

ASSURE – the “Top 3 Issues” ref. Alignment to ICB Objectives & Core Functions

There were no further items of assurance to report to the ICB Board from January’s Committee meeting.

Key Risks & Mitigations (ref. System Board Assurance Framework: SBAF)

The System Risk Register is a bi-monthly update to the Committee. The next update will be due at the next Committee meeting taking place in February.

Policies & Procedures Approved

The Committee did not receive or approve any policies this month; nor did any papers received under the Business Cycles of both parts have any likely future impacts on current policy matters.

Decisions to be Escalated to ICB Board

There were no escalations to Board Assurance Committees or to the ICB Board.

Enclosure No: 22

Report to:	Integrated Care Board							
Date:	26 March 2026							
Title:	Q4 2025/26 System Board Assurance Framework (SBAF) Update							
Presenting Officer:	Mish Irvine, Chief of Staff / Paul Winter, Associate Director of Corporate Governance							
Author(s):	Lia Pitarokoili, Head of Governance / Angela Porter, Governance Manager							
Document Type:		Action Required (select):						
Report	☒	Business Plan	☐	Information (I)	☐	Discussion (D)	☒	
Strategy	☐	Policy	☐	Assurance (S)	☒	Approval (A)	☐	
Other	☐	(please describe)		Ratification (R)	☐	(check as necessary)		
Is the decision within SOFD powers & limits					Yes	☐	No	☒
Any potential / actual Conflict of Interest?					Yes	☐	No	☒
<i>If Y, the mitigation recommendations:</i>		<i>E.g. Staff have Financial + Non-Financial Professional Interests which can be managed by recording those in minutes and allowing presence in discussions with recusals from formal decisions</i>						
Any financial impacts: ICB or ICS?					Yes	☐	No	☒
<i>If Y, are those signed off by and date:</i>		<i>E.g. Chief Finance Office, dd-mmm-yyyy</i>						
Any impacts on ICB Undertakings?					Yes	☐	No	☒
<i>If Y, are those signed off by and date:</i>		<i>E.g. Chief Finance Office, dd-mmm-yyyy</i>						
Appendices:	SBAF Q4 2025/26 report							

(1) Purpose of the Paper:

This paper presents the consolidated System Board Assurance Framework (SBAF) for the Cluster of NHS Shropshire, Telford and Wrekin ICB and NHS Staffordshire and Stoke-on-Trent ICB.

The document sets out a single, coherent set of nine strategic risks derived from the rationalisation and merger of the legacy SBAFs from both organisations. The consolidation process was undertaken to support clustering arrangements and to strengthen system-wide oversight, assurance and strategic risk management.

No strategic ambition/objective or strategic risk has been removed unless its substance has been fully retained within a merged risk statement. Where risks addressed the same underlying

system issue, they have been combined to eliminate duplication while preserving the integrity of each organisation's statutory responsibilities.

The purpose of this paper is to:

- Present the consolidated SBAF for discussion and assurance
- Confirm the methodology used to merge and rationalise legacy strategic risks
- Support a clear and coherent system-wide risk narrative for the Integrated Care Board

(2) History of the paper, incl. date & whether for A / D / S / I (as above):	Date
SSOT and STW ICB Board Assurance Committees (D-S)	February 2026

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

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

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

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

(6) Executive Summary, incl. expansion on any of the preceding sections:
This document sets out a consolidated set of strategic risks for the two ICBs, bringing together the legacy SBAFs of STW ICB and SSOT ICB into a single framework containing nine strategic risks. The legacy SBAFs were reviewed side-by-side to identify common strategic intent and overlapping risk drivers. Where objectives or risks addressed the same underlying operational or system challenge, they were merged in order to avoid duplication, improve clarity of assurance reporting and present a single, coherent narrative. Throughout this process, no strategic objective or strategic risk has been removed unless its substance has been fully retained within a consolidated risk statement. The four SSOT Strategic Ambitions have been carried forward, reflecting full alignment with the three STW Strategic Objectives. Each strategic risk within the consolidated SBAF includes a dedicated page setting out the respective positions of STW and SSOT. This ensures transparency of organisational context while supporting progression towards a unified assurance framework. As part of the rationalisation process, the former STW updates for SBAF 2 and SBAF 3 have been incorporated within SBAF 1 (STW) and SBAF 7 (STW) respectively and therefore do not appear as standalone risk entries. SBAF 6 represents the merger of two legacy organisational financial risk positions (sustainable finances and efficiency & productivity / achieving financial balance and capital resource plans). At present, there remains variation in assessed risk levels within this composite risk for both

organisation and the current risk levels reflect a blended position as seen in the relevant section of the appended report.

This consolidated SBAF represents an important step towards a mature, aligned SBAF while recognising that full methodological and appetite alignment will continue to develop over the coming months.

The SBAF is refreshed annually. The next formal iteration is scheduled for Q1 2026/27 and will incorporate further refinements arising from the clustering arrangements.

(7) Recommendations to Board:

The ICB Board is asked to note the methodology used to consolidate the SBAF, discuss and confirm whether the SSOT and STW risk levels and assurance assessments are an accurate reflection of the position and discuss and confirm the adequacy of those controls and assessments.

System Board Assurance Framework (SBAF)

Quarter 4 2025/26

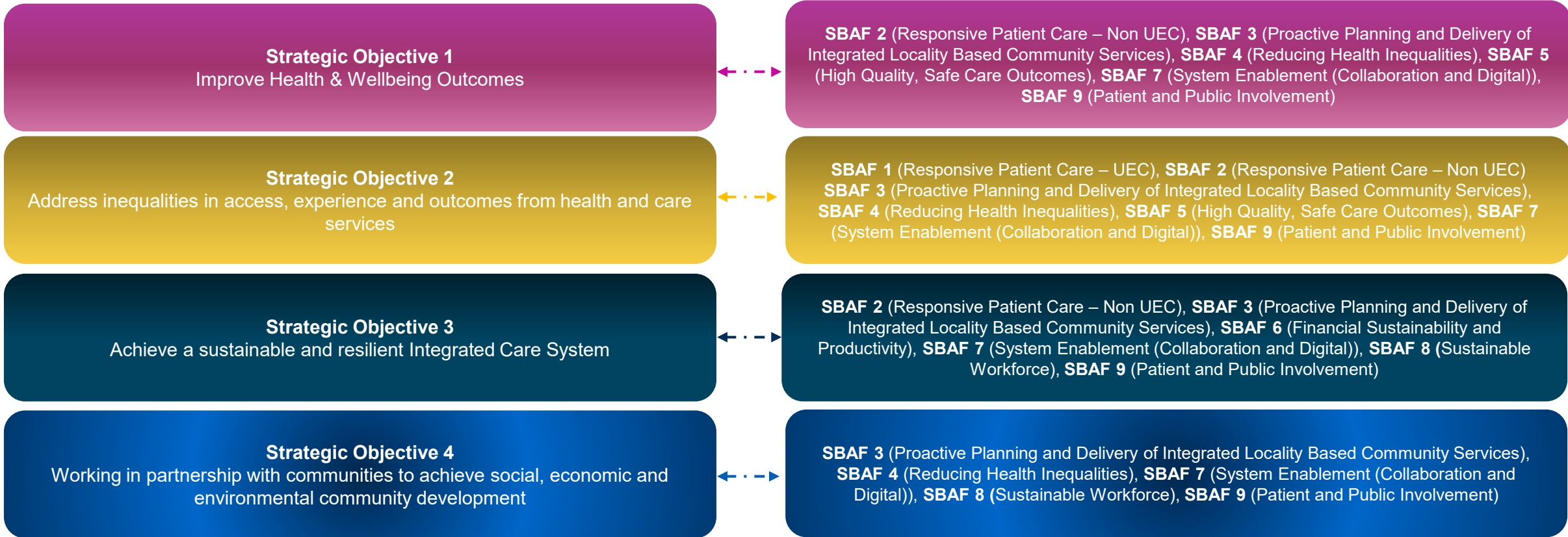
Cluster Strategic Objectives

Strategic Objective	Derived From (Alignment with) SSOT Strategic Ambitions	Derived From (Alignment with) STW Strategic Objectives
Strategic Objective 1 Improve Health and Wellbeing Outcomes	SSOT Strategic Ambition 1	STW Strategic Objective 2: Improving Population Health • Best start in life • Healthy weight • Alcohol, drugs, domestic abuse • Mental health and wellbeing
Strategic Objective 2 Address Inequalities in access, experience and outcomes from health and care services	SSOT Strategic Ambition 2	STW Strategic Objective 1: Reducing Health Inequalities • Wider determinants • Tackling health inequalities
Strategic Objective 3 Achieve a Sustainable and Resilient Integrated Care System	SSOT Strategic Ambition 3	STW Strategic Objective 3: Improving Health and Care • Prevention and early detection • Improved treatment outcomes • Urgent and Emergency Care • Integrated person-centred care within communities – strong focus on primary and secondary care
Strategic Objective 4 Work in Partnership with Communities and System Partners to achieve social, economic and environmental community development	SSOT Strategic Ambition 4	All three STW Strategic Objectives

Associated Cluster ICB Strategic Risks

SBAF No.	Strategic Risk (Merged)	Source SBAF / Notes on Merging
SBAF 1	Responsive Patient Care – Urgent & Emergency Care	SSOT SBAF 1 STW SBAF 6
SBAF 2	Responsive Patient Care – Non-UEC Care (e.g., Elective, Cancer Diagnostics, Community/Mental Health/Primary Care)	SSOT SBAF 2 STW SBAF 6
SBAF 3	Proactive Planning & Delivery of Integrated Locality-Based Community Services and Population-Based Care	SSOT SBAF 3 STW SBAF 1 (sustaining collaboration & partnership) STW SBAF 6 (external shocks impacting community services)
SBAF 4	Reducing Health Inequalities	SSOT SBAF 4 STW SBAF 3
SBAF 5	High Quality, Safe Care Outcomes	Carried forward from SSOT SBAF 5 No equivalent explicit STW risk, though quality consequences reflected across STW strategic risks
SBAF 6	Financial Sustainability & Productivity	SSOT SBAF 6 & 7 STW SBAF 2a & 2b
SBAF 7	System Enablement – Collaboration & Digital	STW SBAF 1 STW SBAF 5
SBAF 8	Sustainable Workforce	SSOT SBAF 8 STW SBAF 4
SBAF 9	Patient & Public Involvement	Carried forward intact from STW SBAF 8 No equivalent explicit SSOT risk

Cluster Strategic Objectives & Associated Cluster ICB Strategic Risks



Cluster Risk Assessment

	Seven Strategic Risks are assessed as High this quarter, reflecting the continued operational, financial and workforce pressures across the system, alongside reform and transformation demands.
	SBAF 6: Financial Sustainability and Productivity reflects a merged position from SSOT and STW, and there is currently a variance in underlying risk assessments. SSOT assesses core financial sustainability as Low , but efficiency and productivity delivery as High . STW assesses both financial sustainability and efficiency/productivity as High . The current SBAF position therefore represents a blended view.
	Risk levels across most Strategic Risks have remained unchanged since Q3 2025/26 . The only movement this quarter is a reduction in the risk level for SBAF 6: Financial Sustainability and Productivity (SSOT) and SBAF 8: Sustainable Workforce (SSOT).
	Strategic Objective 2: Address inequalities in access, experience and outcomes from health and care services and Strategic Objective 3: Achieve a sustainable and resilient Integrated Care System remain the most threatened objectives this quarter.
	The majority of Strategic Risks continue to be rated as having ' Partial Assurance ', indicating that whilst mitigating controls and improvement plans are in place, further delivery and demonstrable impact are required to reduce risk exposure.

SSOT Linked Operational Risks

Visual Risk Matrix Overview: The table represents a comprehensive breakdown of risks across the SBAF strategic objectives.

SBAF 1 Risk Title		Risk Score	SBAF 4 Risk Title		Risk Score	SBAF 6 Risk Title		Risk Score
1197	D2A Capacity	15	1173	Choice of place of Birth	6	1205	Potential Counter Fraud Risk	9
1206	A&E Four Hour performance	6	1457	Gaps in AHP workforce on UHNM neonatal unit	16	1457	Gaps in AHP workforce on UHNM neonatal unit	16
1503	NHS Reform Requirements	9	1503	NHS Reform Requirements	9	1503	NHS Reform Requirements	9
1504	ICB Statutory duties & functions - delivery	9	1504	ICB Statutory Duties & Functions - delivery	9	1504	ICB Statutory Duties & Functions - delivery	9
1505	ICB Statutory duties & functions - reassignment	9				1505	ICB Statutory Duties & Functions - reassignment	9
1506	ICB Capacity and capability to lead the ICS	4	1505	ICB Statutory Duties & Functions - reassignment	9	1506	ICB Capacity & Capability to lead the ICS	4
1507	ICS Capacity and capability to support system working	9				1507	ICS Capacity & Capability to support system working	9
1526	Planned care national and local performance standards not achieved	16	1506	ICB Capacity & Capability to lead the ICS	4	1527	Incomplete delivery of the 2025/26 ICB Efficiency Programme	12
1541	Relocation of GP OOH's Face to Face locations from Royal Stoke and County Hospital	9	1507	ICS Capacity & Capability to support system working	9	1528	Delivery of the 2025/2026 System Financial Plan	15
1551	System Surge Capacity	20	1554	Poor Communication between Primary Care and Maternity Services identified in the postnatal period.	9	1551	System Surge Capacity	20
1619	Ambulance Handover Delays	25	1578	ICB Management of Change 50% workforce / headcount reduction	12	1578	ICB Management of Change 50% workforce / headcount reduction	12
SBAF 2 Risk Title		Risk Score	SBAF 5 Risk Title		Risk Score	1612	Increased risk of potential complaints and legal challenge	12
1219	UHNM Electronic Patient Records (EPR)	20	1609	Infant and Neonatal mortality	12	1526	Planned care national and local performance standards not achieved	16
1503	NHS Reform Requirements	9	1173	Choice of place of Birth	6	1176	Digital Cyber Security	16
1504	ICB Statutory Duties and Functions - delivery	9	1202	"Looked After Children" - Initial Health Assessment/ Review Health Assessment - (IHA/RHA) Compliance (regulatory)"	9	1180	NHS Provider License	10
1505	ICB Statutory Duties and Functions - reassignment	9	1239	Neonatal consultant Workforce	12	SBAF 8 Risk Title		Risk Score
1506	ICB Capacity and capability to lead the ICS	4	1430	Inadequate provision of Epilepsy Nurse Specialists to meet quality requirements across system for children	16	1191	Employee Health, Wellbeing and Experience	16
1507	ICS Capacity and capability to support system working	9	1444	Demand for paediatric dietetic services continues to outstrip current capacity across the system. This is coupled by inequity of service offer both from a community / inpatient perspective.	20	1239	Neonatal consultant Workforce	12
1551	System Surge Capacity	20				1253	Digital Workforce Recruitment and Retention	6
1554	Poor Communication between Primary Care and Maternity Services identified in the postnatal period.	9	1457	Gaps in AHP workforce on UHNM neonatal unit	16	1444	Demand for paediatric dietetic services continues to outstrip current capacity across the system.	20
SBAF 3 Risk Title		Risk Score	1503	NHS Reform Requirements	9	1503	NHS Reform Requirements	9
1219	UHNM Electronic Patient Records (EPR)	20	1504	ICB Statutory Duties & Functions - delivery	9	1504	ICB Statutory Duties & Functions - delivery	9
1503	NHS Reform Requirements	9	1505	ICB Statutory Duties & Functions - reassignment	9	1505	ICB Statutory Duties & Functions - reassignment	9
1504	ICB Statutory duties & functions - delivery	9	1506	ICB Capacity & Capability to lead the ICS	4	1506	ICB Capacity & Capability to lead the ICS	4
1505	ICB Statutory duties & functions - reassignment	9	1507	ICS Capacity & Capability to support system working	9	1507	ICS Capacity & Capability to support system working	9
1506	ICB Capacity and capability to lead the ICS	4	1551	System Surge Capacity	20	1511	Ability to deliver the 25/26 Operational Workforce Plan	16
1507	ICS Capacity and capability to support system working	9	1554	Poor Communication between Primary Care and Maternity Services identified in the postnatal period.	9	1512	Ability to deliver required ICB & NHS Infrastructure reductions	9
1554	Poor Communication between Primary Care and Maternity Services identified in the postnatal period.	9	1578	ICB Management of Change 50% workforce / headcount reduction	12	1513	Impact of focussing on and implementing NHS Reform, ICB redesign and clustering on SSOT ICB and System work	16
			1609	Infant and Neonatal mortality	12	1514	Ability to deliver the workforce transformation and change required within 10 year plan and Provider Collaborative	12
1562	Wheelchair Procurement- Inherited waitlist	9	1612	Increased risk of potential complaints and legal challenge	12	1515	Impact on culture, behaviour and leadership of uncertain and significantly financially challenged environment	16
1563	Wheelchair procurement - ICB reform	4	1613	Essential Shared Care Agreements (ESCAs) being declined by General Practices	12	1551	System Surge Capacity	20
			1620	Cessation of Maternity and Neonate Senior Advocate Pilot	12	1578	ICB Management of Change 50% workforce / headcount reduction	12
			1627	Risk of harm, associated with failure to achieve safe and timeliness of AACCC service delivery	9	1612	Increased risk of potential complaints and legal challenge	12

STW Linked Operational Risks (SORR)

Visual Risk Matrix Overview: The table represents a comprehensive breakdown of risks across the SBAF strategic objectives.

SBAF 1 Responsive Patient Care - Urgent and Emergency Care			Risk Score	SBAF 6 Financial Sustainability and Productivity			Risk Score	SBAF 7 System Enablement (Collaboration and Digital)			Risk Score
1637	ICS Delays in Urgent and Emergency Care		20	1639	ICS Financial Sustainability		20	1640	ICS Emergency Planning, Resilience and Response (EPRR)		16
1640	ICS Emergency Planning, Resilience and Response (EPRR)		16	1653	ICS Estates Infrastructure risk		20	1644	ICS Cases of Clostridioides Difficile		16
1678	Financial Position of Shropshire Council		16	1655	ICS Revenue and Financial Plans 25/26		16	1645	ICS System Digital Operating Model		9
SBAF 2 Responsive Patient Care - Non UEC Care (e.g. Elective, Cancer Diagnostics, Community/Mental Health/Primary Care)			Risk Score	1656	ICS Impact of Government Reform - Impact of Transition on System Partners		20	1646	ICS Information Availability Across the System		9
1678	Financial Position of Shropshire Council		16	1657	ICS Impact of Government Reform - Impact of 10 year plan and dissolution of key health and social care organisations (e.g.. NHS England, Healthwatch) within the system.		20	1647	ICS Lack of System Digital Inclusion		9
SBAF 3 Proactive Planning and Delivery of Integrated Locality Based Community Services			Risk Score	1660	ICB Financial Sustainability		20	1648	ICS Lack of System Capacity and Funding to Support digital Clinical Risk		16
1678	Financial Position of Shropshire Council		16	1661	ICB Contract Notice by Providers		12	1650	ICS Share Care Prescribing		16
SBAF 4 Reducing Health Inequalities			Risk Score	1665	ICB support services Provided by the CSU		12	1651	ICS System-wide Cybersecurity Operating Model and Strategy		12
1638	ICS Diabetes Management		20	1666	ICB Local Care Transformation Programme Now called Neighbourhood Implementation programme		12	1653	ICS Estates Infrastructure risk		20
1649	ICS Adult ADHD Waiting Lists		16	1667	Hospital Transformation Programme		12	1656	ICS Impact of Government Reform - Impact of Transition on System Partners		20
1650	ICS Share Care Prescribing		16	1668	General Practice Locally Commissioned Services		12	1657	ICS Impact of Government Reform - Impact of 10 year plan and dissolution of key health and social care organisations (e.g.. NHS England, Healthwatch) within the system.		20
1653	ICS Estates Infrastructure risk		20	1669	Lack of ICB Clinical Safety capabilities and unclear ICS Clinical Safety capabilities to enable digital clinical risk management		12	1660	ICB Financial Sustainability		20
1654	ICS Risk of Increase in TB Cases		16	1670	ICB Emergency Preparedness, Resilience and Response (EPRR)		16	1662	ICB Counter Faud		9
1656	ICS Impact of Government Reform - Impact of Transition on System Partners		20	1671	Implementation of the Provider Selection Regime (PSR)		12	1679	ICB Cyber Security		12
1657	ICS Impact of Government Reform - Impact of 10 year plan and dissolution of key health and social care organisations (e.g.. NHS England, Healthwatch) within the system.		20	1673	Provider Accreditation - Independent Sector		16	1665	ICB support services Provided by the CSU		12
1658	ICS Paediatric End of Life Care		16	1674	ICB Revenue and Financial Plan		12	1666	ICB Local Care Transformation Programme Now called Neighbourhood Implementation programme		12
1659	ICS Capacity for Child Protection Medicals		16	1676	Impact of Government Reform - ICB Workforce.		20	1667	Hospital Transformation Programme		12
1660	ICB Financial Sustainability		20	1677	Impact of Government Reform - Transition.		16	1668	General Practice Locally Commissioned Services		12
1661	ICB Contract Notice by Providers		12	1678	Financial Position of Shropshire Council		16	1669	Lack of ICB Clinical Safety capabilities and unclear ICS Clinical Safety capabilities to enable digital clinical risk management		12
1662	ICB Counter Faud		9					1670	ICB Emergency Preparedness, Resilience and Response (EPRR)		16
1679	ICB Cyber Security		12					1671	Implementation of the Provider Selection Regime (PSR)		12
1665	ICB support services Provided by the CSU		12					1673	Provider Accreditation - Independent Sector		16
1666	Local Care Transformation Programme Now called Neighbourhood Implementation programme		12					1674	ICB Revenue and Financial Plan		12
1667	Hospital Transformation Programme		12					1676	Impact of Government Reform - ICB Workforce.		20
1668	General Practice Locally Commissioned Services		12					1677	Impact of Government Reform - Transition.		16
1669	Lack of ICB Clinical Safety capabilities and unclear ICS Clinical Safety capabilities to enable digital clinical risk management		12					SBAF 8 Sustainable Workforce			Risk Score
1670	ICB Emergency Preparedness, Resilience and Response (EPRR)		16					1641	ICS System Chief People Officer		12
1671	Implementation of the Provider Selection Regime (PSR)		12					1642	ICS Deputy Chief People Officer Capacity		16
1672	ICB Information Governance Breach Risk		9					1643	ICS Capacity (including appropriate administrative capacity) to deliver the 10 People outcomes		16
1673	Provider Accreditation - Independent Sector		16					1663	People Leadership for the ICB as an Employer		12
1674	ICB Revenue and Financial Plan		12					1664	Capacity and expertise to deliver the wider people agenda for the ICB (apart from CSU HR & Recruitment contract provision).		12
1675	Workforce Efficiency Requirements		12					1671	Implementation of the Provider Selection Regime (PSR)		12
1676	Impact of Government Reform - ICB Workforce.		20					1676	Impact of Government Reform - ICB Workforce.		20
1677	Impact of Government Reform - Transition.		16					SBAF 9 Patient and Public Involvement			Risk Score
1678	Financial Position of Shropshire Council		16					1652	Patient and Public Involvement		12

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

Rationale for Risk Level, Current Performance - Highlights

Throughout Q3 the key priority areas for improvement remain 4-hour Emergency Department (ED) performance towards achieving 78% by March 2026, 12-hour ED performance, reducing ambulance handover delays and therefore improving category 2 performance. Performance has been impacted by increased attendances, earlier than anticipated Infection Prevention (IP) demand, and workforce challenges, however a continued focus on delivery is required to support delivery of our operational planning commitments and subsequent risk reduction. Our UEC governance infrastructure continues to ensure collective leadership and system oversight of delivery and improvement, with all system partners. Additional support is in place both at a provider (UHNM) via GIRFT/ECIST and at a System Level via Tier 1 meetings.

During the quarter the focus for the portfolio has been focussed on mobilising and delivering the system winter plan and mitigating schemes that have faced challenges in mobilisation. The winter plan has enhanced oversight in place via Winter Oversight Group with a multi-faceted approach to the plan with leads from all key components of the system in place in a pillared approach. Daily oversight is provided by the SCC with strategic calls also in situ to support operational challenges alongside the designation of a SSOT Winter Director in place. The system escalation plan refreshed in Q3 has continued to be embedded across providers and supports daily escalation in parallel to the winter plan. The focus has now moved to development of the timely de-escalation plan in Q4 and planning the system lesson learning event for Q1 of 26/27.

During Q3 the system developed a Home for Christmas plan, which achieved an 80% occupancy within the Acute bed base for the Festive period. This plan was developed by all system partners, with a daily action tracker and trajectories in place, achieving 78% occupancy on Christmas Eve. Following this, the system has developed a Release to Respond plan, to support reduced ambulance handover delays within UHNM. This plan has been developed in a phased approach to delivery and will be monitored by the SCC.

Delivery of the UEC Improvement plan is ongoing and oversight is provided through UEC Governance. Key Delivery milestones and dependencies are monitored and reported through our governance to ensure oversight of the plan. The plan includes key deliverable of the Integrated Care Coordination Centre (ICC), Urgent Treatment Centres and the Discharge to Assess productivity review.

Gaps in Controls and Assurances

- Residual bed capacity gap.
- Operational pressures resulting from the implementation of enhanced IP measures, which may temporarily reduce available capacity.
- Workforce deliverability across all areas of UEC pathway.
- Surge beyond the predicted peak.
- Service delivery challenges linked to sustained IPC practices within the Care Home sector.
- Unforeseen demand due to major incident.
- Individual organisation risk management.

SO2: Address inequalities in access, experience and outcomes from health and social care services

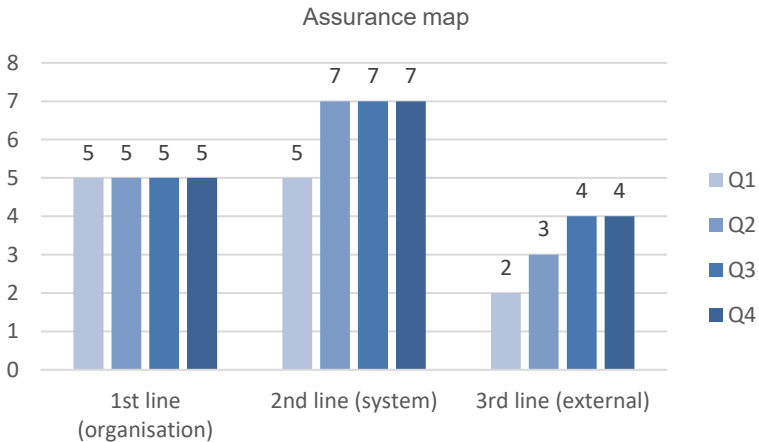
Assurance, Risk Level and Risk Tolerance Statement

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

Summary Future Actions Plan

No	Action Required
1	Delivery of System UEC Improvement Plan against trajectory
2	System surge planning
3	Integrated Care Coordination

Outcome: Full Assurance Status of the SO and the Risk Score will be reduced



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

Rationale for Risk Level, Current Performance - Highlights

STW ICB and individual NHS organisations have annual EPRR work programmes in place to ensure there is a continuous cycle of improvement. These work plans cover review and updates of policies and plans, training, exercising, business continuity management systems and incident response arrangements.

STW ICB and individual NHS organisations will soon commence the annual cycle of self-assessment against the NHS Core Standards for EPRR. These self-assessments will be reviewed by STW ICB and NHSE during September with final outcomes of the assessment and assurance levels confirmed in early October. The final assurance level achieved for 2024 as an ICB was of Partial compliance, which was an improvement from non-compliant in 2023. STW ICB continues to work with all organisations to develop individual and systemwide improvement plans. These improvement plans will be overseen by the ICB EPRR Senior EPRR Lead reporting to the ICB Accountable Emergency Officer (AEO) via the West Mercia LHRP, the Strategic Commissioning and Productivity Committee and Board.

Detailed review of Greener NHS progress in STW against the NHSE national objectives and priorities carried out in Aug 24 and discussed with NHSE regional leads. Plan to enhance link to ICS Infrastructure group (chair – ICB Director of Finance). Follow up review with NHSE in late autumn 24, with objective of improving ICS rating.

An update on UEC Improvements was provided to the Board at its meeting on 24 Sep 25 as context for the System Winter Plan, which was approved at that meeting, along with a Board Assurance Statement that was submitted to NHSE national team. System-level management of UEC operational risk and escalation is a key feature of the winter plan.

New Cluster Executives and teams have been asked to review and amend content following feedback from Board Development session at the end of 2025.

Gaps in Controls and Assurances

- Limited ICB and individual NHS organisations EPRR resources
- No existing system level EPRR frameworks, policies, plans for organisations to align own policies and plans to enhance a coordinated response.
- Lack of documented Standard Operating Procedures for the System Coordination Centre (SCC)
- Low level of compliance with NHS Core Standards for EPRR.
- Gaps in uptake of EPRR mandatory training STW and Herefordshire and Worcestershire from the West Mercia LHRP and HEPOG. An emerging issue as at end of May 2025 to be resolved will be future structures required under the NHSE/ICB reset alignment with SSOT.

SO2: Address inequalities in access, experience and outcomes from health and social care services

Assurance and Risk Level

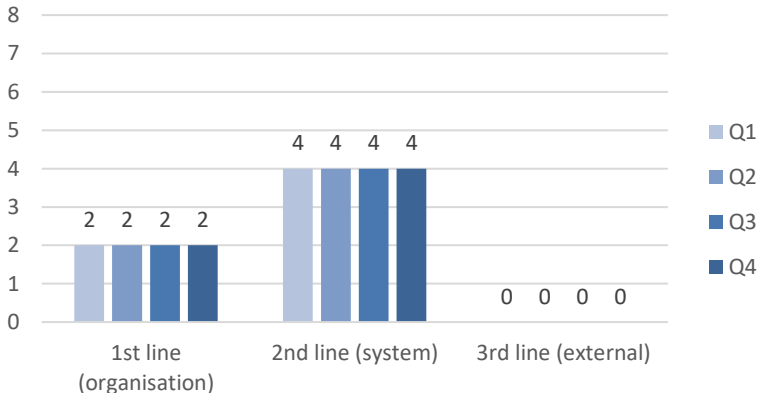
	Q1	Q2	Q3	Q4
Partial Assurance	High	High	High	High

Summary Future Actions Plan

No	Action Required
1	Produce system level EPRR policies, frameworks and plans for organisations to align own policies and plans.
2	Finalise LHRP work programmes in conjunction with H&W. Working closely to drive work programmes.
3	Monthly meeting with ICB and provider EPRR Leads
4	Accountable Emergency Officers to review EPRR resourcing, to ensure adequate to meet duties placed on them under NHS Action 2006 and Care Act 2022
5	System wide EPRR exercises
6	Completion of annual Core Standards for EPRR and Self- Assessment against NHSE/CQC Regulatory Framework

Outcome: Full Assurance Status of the SO and the Risk Score will be reduced

Assurance map

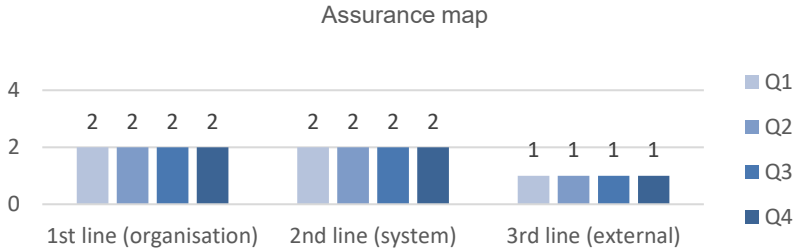


SBAF 2: Responsive Patient Care – Non UEC Care - SSOT
(e.g. Elective, Cancer Diagnostics, Community/Mental Health/Primary Care)
Finance Committee | Chief Officer System Development & Integration

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

Rationale for Risk Level, Current Performance - Highlights
Progress continues to be made on reducing long wait patient cohorts. At the end of September 2025 there were 139 patients waiting over 65 weeks, which reduced to 63 patients at the end of November 2025. However, progress over the winter period has been behind trajectory, due to winter pressures on the bed base, which led to some patients needing to have planned appointments postponed. Any cancellations were prioritised to minimise the impact on the patients waiting the longest and those of highest clinical need. Outpatient appointments have been maximised as well as activity at UHNM County Hospital. Work continues to clear the longest waiters and in quarter4, UHNM have been awarded sprint funding from NHSE for outpatient appointments and patients waiting over 52-weeks, which will help mitigate against the winter pressures.
For cancer, the main driver for being off plan is the recovery from the number of referrals being higher than predicted for some tumour sites, most notably skin at UHNM. A number of funding requests have been supported by the West Midlands Cancer Alliance for UHNM, which includes support to the skin pathway. Additional subcontracted activity has been procured to clear the backlog of patients waiting for their first appointment and onward minor operation. Activity is monitored on a daily basis with improvements now starting to be seen in quarter 4.

Gaps in Controls and Assurances
ICB team to maintain focus on development of speciality pathways, to ensure that patients are following the most appropriate pathway, with the most appropriate tests and treatment setting.



SO1: Improve Health and Wellbeing Outcomes	SO2: Address inequalities in access, experience and outcomes from health and social care services
SO3: Achieve a sustainable and resilient Integrated Care System	

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

Summary Future Actions Plan	
No	Action Required
1	Develop plan for focused speciality review with end of end pathway approach
2	System capacity and demand review
3	System collaborative for contracts to develop plans for efficiency and delivery of elective activity
4	Additional capacity investment to increase activity and productivity and clear remaining >65 week waits
5	Provider indicative activity plans set that balance the national operational planning standards with levels of financial resources available
6	Excluded Restricted Procedure (ERP) reflected in all provider contracts
Outcome: Full Assurance Status of the SO and the Risk Score will be reduced	

SBAF 3: Proactive Planning and Delivery of Integrated Locality Based Community Services -SSOT
Strategic Commissioning & Transformation Committee | Chief Officer System Development & Integration

If we do not deliver integrated community services based on population need, then services will remain reactive and generic and not sensitive to the needs of the population, leading to increasing demand, rising acuity and worsening outcomes for the population.

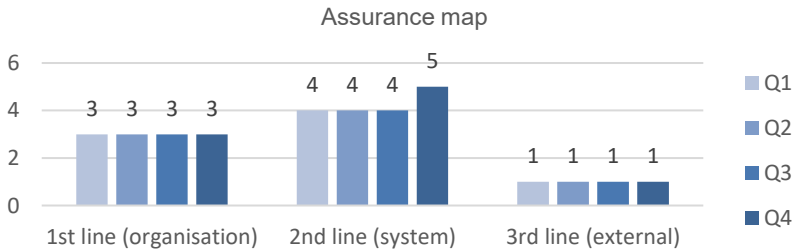
Rationale for Risk Level, Current Performance - Highlights
Mental Health Urgent & Emergency Care (UEC): Urgent mental health support is available via 111, supported by national investment in ambulance services and alternative crisis provision such as crisis cafes and safe havens. A 24/7 Crisis Assessment Centre at St George’s Hospital (MPFT), including a Section 136 Suite, provides an alternative to ED. A 24/7 crisis text service launched in October 2025. Work continues to recommission a crisis alternative and step-down facility. Community Mental Health Transformation: Transformation is aligned to the NHS neighbourhood health model, focusing on whole-person, community-based care for people with severe mental illness. MPFT is piloting a 24/7 community mental health model integrated with neighbourhood teams across four pilot areas. Within the Integrated Community Equipment (ICE) contract, targeted initiatives, including the development of a new eligibility framework, refinement of decision-making panels, and sustained engagement with frontline teams, are driving improvements in service sustainability. In parallel, the ongoing review and realignment of the Better Care Fund (BCF) ensures that resources are strategically deployed to meet population needs and strengthen system resilience. Phase 2 of the BCF review will focus on those schemes not reviewed in phase 1 and include some more detailed evaluations of schemes already reviewed where significant overspends and inefficiencies are apparent. Work is underway to strengthen frailty, falls prevention, care home support, Home First and Discharge to Assess (D2A) pathways, promoting a preventative, community-based model of care. Neighbourhood multidisciplinary teams (in neighbourhoods of 30–50k populations) are being developed to integrate primary, community, social and secondary care. Focus is on complex needs cohorts (2–4% of the population), including frailty, palliative care, complex conditions and high ED users, aiming to shift care from hospital to prevention and early intervention. Neighbourhood health maturity matrix completed and submitted to NHSE, workplans in place to develop against maturity matrix. The ICB has been invited to take part in the Regional Good practice neighbourhood multidisciplinary team working for individuals of all ages with Palliative Care and End of Life Care (PC&EOLC) needs. A system wide review of Frailty and Falls services is being undertaken in order to deliver a consistent service offer which focuses on prevention of falls, proactive and reactive service offer. 2025/25 BCF underspend allocated to support Hospice admission avoidance, enhanced care home admission avoidance schemes, clinical input to developing Integrated neighbourhood teams and falls prevention programme.

Gaps in Controls and Assurances
- Risks and Issues highlighted through normal Governance routes. - Development of Provider Collaborative will impact Governance and roles and responsibilities.

SO1: Improve Health and Wellbeing Outcomes	SO2: Address inequalities in access, experience and outcomes from health and social care services
SO3: Achieve a sustainable and resilient Integrated Care System	SO4: Working in partnership with communities to achieve social, economic and environmental community development

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

Summary Future Actions Plan	
No	Action Required
1	Agree neighbourhood footprint aligned to PCNs and early implemented sites
2	Agree changes to Stoke Joint Commissioning Boards (JCB) governance
3	Alignment of Community Transformation Programmes to the Better Care Fund (BCF) to maximise value for money and implementation of neighbourhood health
Outcome: Full Assurance Status of the SO and the Risk Score will be reduced	



SBAF 4: Reducing Health Inequalities -SSOT
Strategic Commissioning & Transformation Committee | Chief Officer Strategy & Improving Outcomes

If the system does not prioritise and coordinate targeted action and resource allocation to reduce health inequalities, then avoidable differences in access, experience and outcomes will persist or worsen, resulting in poorer health outcomes and increased demand and cost pressures across the system.

Rationale for Risk Level, Current Performance - Highlights

Early targets for progress to reduce health inequalities were set against the agreement of an Integrated Care Partnership Strategy which was published at the end of March 2023. Evaluation of the reduction of health inequalities will be over a longer period (c. 10 years) and the target risk will be reviewed on this basis. The foundations to achieving this have been progressed in terms of the Integrated Care Partnership Strategy, Health Inequalities Strategy, Alcohol Strategy, procurement of a strategic partner to support the scale, spread and sustainment of a Population Health Management approach for SSOT that will positively impact on HI, establishment of the Improving Population Health (IPH) Portfolio Board, agreement of localities inside the two Place’s aligned with UTLA’s, and the launch of the Locality Improvement Framework (LIF) at Q1 2025/26. The LIF invests £2.2m in localities, providing a basis to incentivise integrated locality working based on population need and reducing health inequalities. Each locality will have an allocation of funding that it will be able to use for projects that will have clear and measurable impact on health outcomes, following changes in lifestyle and behaviour by working together as integrated community services. Sprints have taken place across all 12 localities to use the data to segment the population and identify cohorts who have poor outcomes. Letter received from Department of Health and Social Care (DHSC) and NHS England (NHSE) outlining their reflections on SSOTs progress against the Core20Plus5 framework and the five strategic healthcare inequalities priorities. Their assessment drew on the information provided during a full day visit, as well as operational plans, system strategies, stocktake reports, and Quarterly System Review Meetings (QSRM) submissions. The scale, spread and sustainment of a PHM approach across SSOT continues to aid the understanding of the population and inequalities being experienced. The linked data-set available in Pathfinder now has 101 GP Practices signed up to share data (76%). Ground-Up work is heavily supported by PHM in terms of understanding health issues, population cohorts and supporting the coming together of Partners to design neighbourhood, community and place-based interventions to improve outcomes, e.g. LIF, WorkWell, COPD in Mining Communities, Obesity Pathway Improvement Programme (OPIP), Place Expansion for Stoke and East Staffordshire

Gaps in Controls and Assurances

Maintaining stakeholder relationships, engagement, involvement and commitment to ICP Strategy aims by all ICP partners.

SO1: Improve Health and Wellbeing Outcomes
SO2: Address inequalities in access, experience and outcomes from health and social care services

SO4: Working in partnership with communities to achieve social, economic and environmental community development

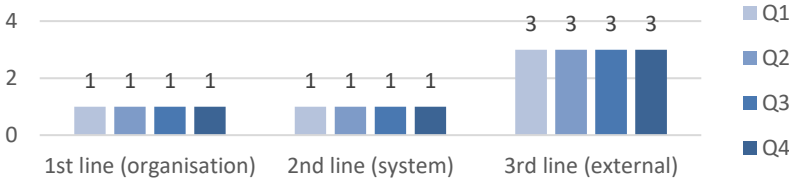
Assurance, Risk Level and Risk Tolerance Statement					
Acceptable Assurance	Q1 High	Q2 High	Q3 High	Q4 High	Tolerance is low as reducing health inequalities and working in partnership impacts on 3 of the 4 Strategic Objectives. The target date is long-term and as such risk scoring would be expected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

Summary Future Actions Plan

No	Action Required
1	Develop HI Outcomes Framework
2	LIF Delivery
3	Impact Sustainability

Outcome: Full Assurance Status of the SO and the Risk Score will be reduced

Assurance map



SBAF 4: Reducing Health Inequalities -STW
Strategic Commissioning & Productivity Committee, Strategy & Prevention Committee | Chief Officer Strategy & Improving Outcomes

If the system does not prioritise and coordinate targeted action and resource allocation to reduce health inequalities, then avoidable differences in access, experience and outcomes will persist or worsen, resulting in poorer health outcomes and increased demand and cost pressures across the system.

Rationale for Risk Level, Current Performance - Highlights

Q2 monitoring of STW System wide Health Inequalities improvement plan indicates 74% of planned deliverables in the Healthcare Inequalities Implementation Plan have been completed within the planned delivery period.

Themes contributing to delays – Key themes contributing to delays in plan delivery relate to capacity and the availability of granular information to support targeted improvement work (specifically the rates of completed ethnicity fields in patient records and the recording of housing status). Improvement work is being driven through mutually agreed Data Quality Improvement Plans (DQIPs) within Provider contracts and the development of front-line resources which focus on why asking for key patient data is important and how to ask.

The incorporation of weighted health inequalities at the highest level of weighting into the strategic hard decisions process provides assurance that the ICB continues to prioritise this area in its decision-making processes.

A refreshed Integrated Impact Assessment template and Policy have been developed and approved which strengthens the ICBs ability to demonstrate how it has considered Health Inequalities in its decision-making processes. IIA or EQIAS are mandated for all requests for commissioning working group papers, including external requests for funding considerations or changes to services.

Publication of the National Statement on Information on Health Inequalities – NHS England published a refreshed National Statement on Information on Health Inequalities on 19 November 2025. The updated statement outlines recommended measures to monitor improvements in reducing inequalities in access, experience, and outcomes for both adults and children. During Q4 the statement will be reviewed locally, core metrics reassessed, and meaningful measures incorporated into structured quarterly reports for the System Health Inequalities and Prevention Group.

Ongoing training in Core 20 Plus approach continues across the System led by the Health Inequalities team. Following the decision to cease a national ambassador programme, a local programme has been established which will assist in delivery of action 2 above.

A new action 3a has been added to address the gap in quantitative health inequalities metric reporting which will strengthen assurance of the ICBs progress and focus on this priority .

Summary Future Actions Plan	
No	Action Required
1	Gain assurance that providers have appointed health inequalities leads. Ensuring contribution to objectives outlined in schedule 2N. Including preventative programmes identified within the remit of the long-term plan prevention and Core20 PLUS5 key areas.
2	Demonstrate commitment to improving education and awareness across all levels of the organisation on health inequality and barriers to access.
3	Complete User Testing of PHM /health inequalities dashboard.
4	Incorporate metric reporting into performance dashboard to Quality and Performance Committee
5	Use internally developed dashboards and external data sources to identify key priorities for 5-year planning and Population Health / Neighbourhood Health improvement plans to quantify and track predicted improvements in known inequality gaps in access to, experience of and outcomes from healthcare interventions

Outcome: Full Assurance Status of the SO and the Risk Score will be reduced

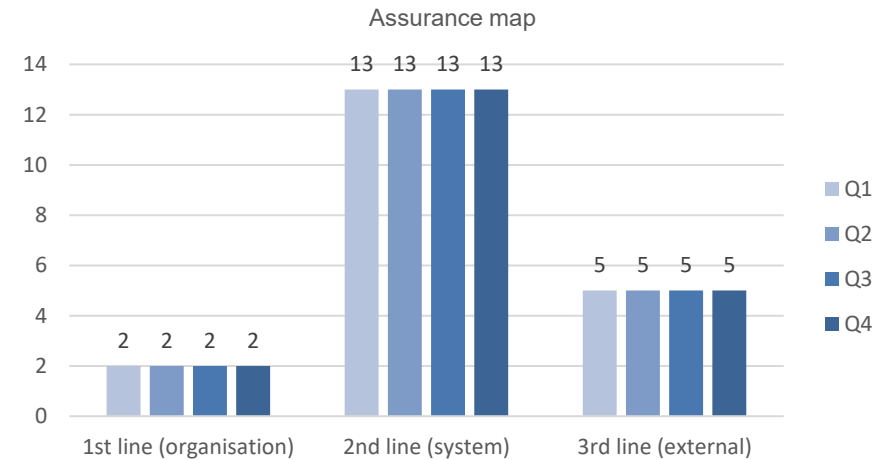
SO1: Improve Health and Wellbeing Outcomes

SO2: Address inequalities in access, experience and outcomes from health and social care services

SO4: Working in partnership with communities to achieve social, economic and environmental community development

Assurance and Risk Level				
Acceptable Assurance	Q1 High	Q2 High	Q3 High	Q4 High

- Gaps in Controls and Assurances
- Assurance re system governance and internal organisational health inequalities prioritisation processes.
 - Assurance re capability building in relation to knowledge and awareness of health inequalities.
 - Quantitative Health Inequalities Metric Reporting to demonstrate reduction across healthcare inequalities contributing to gap in Life and Health Life Expectancy.



SBAF 5: High Quality, Safe Care Outcomes - SSOT
Quality & Safety Committee | Chief Nursing & Therapies Officer

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

Rationale for Risk Level, Current Performance - Highlights

UEC: A full TOR has been approved by the UEC Programme Board for the establishment of The UEC System Learning and Harm Determination Process Group. The Group has since met twice to share learning to support continuous improvement across the pathways. Monthly reporting has been established to both the UEC Programme Board and the System Quality Group.

Perinatal Services: The Local Maternity and Neonatal System (LMNS) is coming to end of oversight of the Year 3 of the three-year maternity and neonatal improvement plan. Commissioning intentions set out to ensure maintenance of improvement achieved for 2026 onwards. Progress continues to be made on the system-wide infant mortality review, with a draft action plan due for publication. To support delivery, a newly formed, smaller high-level leadership group has been established. Public consultation on the future of midwifery-led birth units concluded in August, and a report of findings was developed and reviewed. It was identified that there was an area requiring further understanding and as a result there are a further four weeks of engagement with the public to seek views on the arrangements in place for GTT and Anti-D since March 2020. The LMNS is completing Year 3 of its improvement plan with commissioning intentions set to sustain progress. Collaboration with Shropshire, Telford & Wrekin supports shared learning. The infant mortality review is progressing with a draft action plan due. Workforce risks remain, although recruitment is positive. Digital MEWS is being implemented within Maternity Services. National recommendations following a maternal death are on track, and further public engagement on midwifery-led birth units is underway.

IHA/RHA: Cluster working arrangements are now established, and both MPFT and the ICB(s) are reviewing the service specification to clarify expectations.

QIA: NHS England, upon the request of the ICB, undertook an independent 'Quality Assurance Review' of SSOT ICB's QIA Process. The final report determined that there was Significant Assurance that SSOT QIA process was robust and sustainable.

Wheelchair Services: A Remedial Action Plan was agreed in November 2025. The total number of service users waiting over 18 weeks for wheelchair assessment and delivery has decreased for the past two consecutive months. Notably, there are now no service users waiting 65+ weeks - marking the first occurrence of this since January 2023 - and the total open caseload has reduced by 338 service users over this period.

Paediatric Hearing Screening Improvement Programme: The harm-based cohort review is complete. SME-supported clinics are underway to support the identification of any missed hearing impairments and ensure the right pathway is in place for any child affected. Duty of Candor is active, with National Children's Deaf Society support available. It is expected that the clinics will continue throughout Q4 with a full summary of outcomes reported through the National Improvement Programme and local Children and Young Peoples Programme Board within Q1 26/27.

Right Care, Right Person: Quality Safety Committee and the ICB Board have received the final RCRP report. Key improvements identified by system partners include establishing clear governance, creating a system-wide approach to improve communication, and relaunching RCRP to ensure consistent understanding across the system.

Gaps in Controls and Assurances

- Maintaining Patient safety and achieving fundamentals of care within UEC pathways during periods of pressure requires further work.
- Risk and potential harm which may be as a result of delays within specific community services requires an agreed improvement plan to be put into place, subsequent monitoring.
- Improving workforce efficiency within Community Paediatric services is necessary to support achievement of the IHA/RHA targets

SO1: Improve Health and Wellbeing Outcomes

SO2: Address inequalities in access, experience and outcomes from health and social care services

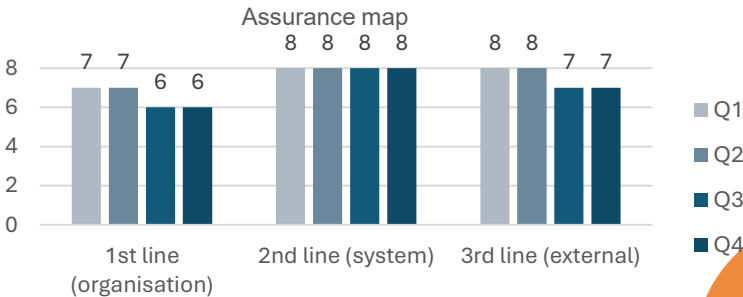
Assurance, Risk Level and Risk Tolerance Statement

Acceptable Assurance	Q1 High	Q2 High	Q3 High	Q4 High	The system will prioritise quality and safety over performance and finance to prevent patient harm but will tolerate moderate risk levels resulting from system pressures.

Summary Future Actions Plan

No	Action Required
1	Collaboration with system partners and regional and national ICBs to look at innovative ways of improving the IHA challenges locally, regionally and nationally.
2	Collaboration with system partners and regional and national ICBs to look at innovative ways of improving the RHA challenges locally, regionally and nationally
3	ED Harms oversight approach with UHNM established which will see bi-monthly visits to ED supporting continuous learning and improvement approach.
4	Collaborative approach to understanding and mitigating risk and potential harm resulting from delays within specific service provision.
5	Maternity Transformation plan in place which outlines a 3-year approach to improving services.
6	Develop a SSOT Multi-Agency Thematic Review/Deep Dive into ongoing incidents around the RCRP process.
7	System approach to improving outcomes of patients who are CHC eligible.

Outcome: Full Assurance Status of the SO and the Risk Score will be reduced



SBAF 6: Financial Sustainability and Productivity -SSOT
Finance Committee | Chief Finance Officer

If financial cost pressures are not controlled and recurrent efficiency and productivity improvements are not delivered, then the system will fail to achieve its statutory financial duties, resulting in long term financial instability, financial intervention, reduced local decision-making and adverse impacts on services and waiting times.

Rationale for Risk Level, Current Performance - Highlights

At Month 9, the System is reporting a £15m deficit, representing a £1.1m favourable variance against the planned £16m deficit (£1m favourable at Month 8). Year-to-date, this includes deficits of £12.4m for the ICB, £6.1m at UHNM and is offset by a surplus of £2.9m at MPFT and £0.6m NSCHT. As a System we are forecasting to meet our year end financial plan of break even, which includes £95m deficit support funding (DSF). Net risk is £7m at Month 9. This net risk is primarily made up of efficiency risk (£0.3m) and additional cost risk (£6.7m). UHNM holds the remaining net risk of £7m aligned to their recovery plan, with all other partners having fully mitigated their positions and looking to support the System position.

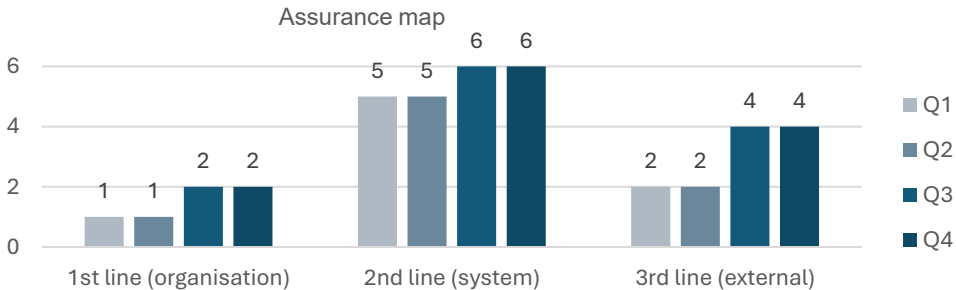
The reported System efficiency delivery YTD is £25.8m behind our submitted plan of £212.9m, this comprises of the ICB (£12.7m), MPFT (£0.2m), NSCHT (£0.2m) and UHNM (£12.7m). As a System this equates to 88% delivery at month 9. YTD delivery leaves 38.7% of the programme to be delivered in Months 10-12.

Following Month 1, System partners were asked to submit recovery trajectories mainly in response to a behind plan CIP delivery. Against the recovery trajectory the System is behind of plan by (£13.7m), with MPFT ahead by £7.7m the ICB behind by (£8.5m), NSCHT by (£0.2m) and UHNM behind by (£12.7m).

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

Gaps in Controls and Assurances

- The System is working to ensure that all new risks are understood, and that efficiency schemes and mitigations are in place in order to deliver the financial plan. In the anticipation of 3-year allocations being issued in the early Autumn, work is beginning on a £ year medium term financial plan which will demonstrate the trajectory to delivering a sustainable financial balance.
- In light of the ICB reset and clustering arrangements, programme management arrangements are under review to include sufficient capacity and capability in the new cluster structure.
- The System is forecasting to deliver recurrent efficiency of £199m against a plan of £225m. MPFT and NSCH are materially in line with plan with the ICB overdelivering by £10m due to CHC. UHNM have a material under delivery of their recurrent efficiency plans of £31m. This will be a key consideration for 2026/27 planning.
- UHNM position aligns to their recovery plan, with mitigations based on non-recurrent items and looking for support from the system.



SO3: Achieve a sustainable and resilient Integrated Care System

Assurance, Risk Level and Risk Tolerance Statement

Sustainable Finances: Acceptable Assurance	Q1 High	Q2 High	Q3 Moderate	Q4 Low	Tolerance is high as costs related to maintaining patient safety and workforce issues may cause additional financial demand / Efficiency and Productivity improvement is an essential ingredient of the System Plan and so a lower risk appetite target has been set.
Efficiency & Productivity: Partial Assurance			Q3 High	Q4 High	

Summary Future Actions Plan

No	Action Required
1	System to focus on identification and delivery of additional efficiency plans to mitigate the current unidentified savings gap primarily through the touch choices workstream.
2	System Finance and Operational Teams to develop a medium-term plan to define the transformational solutions and actions that will ensure the delivery of the integrated care strategy and trajectory for return to financial sustainability.
3	Deloitte/Kingsgate to continue support to a number of projects to reduce the risk to CIP delivery and financial improvement.
4	Provider Collaborative to develop the CIP of £14.2m for Enabling Functions
5	Continue to develop and apply the agreed System approach to improving productivity encompassing all sectors.
6	Further support projects are currently being considered and scoped to further deliver against financial improvement targets/CIP.
7	Primary Care Collaboratives fully in place covering all of SSoT

Outcome: Full Assurance Status of the SO and the Risk Score will be reduced

SBAF 6: Financial Sustainability and Productivity -STW
Finance Committee | Chief Finance Officer

If financial cost pressures are not controlled and recurrent efficiency and productivity improvements are not delivered, then the system will fail to achieve its statutory financial duties, resulting in long term financial instability, financial intervention, reduced local decision-making and adverse impacts on services and waiting times.

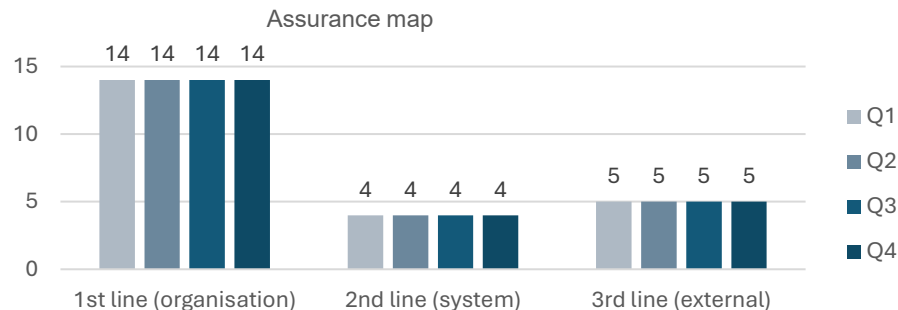
Rationale for Risk Level, Current Performance - Highlights

Section A – Risk of Not achieving Financial Balance (STW ICB and System)
Monthly oversight of the Finance Strategy Implementation Plan in place via the System Finance, Planning and Productivity Group. Refresh of the MTFP to reflect current underlying position, revised HTP planning assumptions, strategic transformation programmes, demand and capacity model and presented to 25/06/2025 ICB Board completed.
Provide MTFP updates to Finance Committee in October/November 2025, Board sign off for the plan submission December 2025, further Finance Committee updates scheduled for January 2026 and April 2026.

Section B - Failure to deliver the System and ICB Revenue and Capital Resource Limit Plans for 2025/26
Revenue: Month 10 £3.6m system adverse variance to plan, ICB £1.7m favourable due to efficiency delivery ahead of plan and prior year benefits, SCHAT £0.3m favourable variance to plan/RJAH on plan, SATH £5.6m adverse variance to plan. FOT expected £2.3m favourable variance to plan after deficit support funding.
Robust monitoring of the recurrent underlying position in year to ensure that this does not deteriorate and that appropriate actions are taken in-year to maintain or improve the recurrent underlying plan.
Capital: Capital plans set in line with CDEL and expected national capital programme funding. Month 10 Capital shows capital spend is £33.2m behind at Month 10 due to Hospital Transformation Programme cash profiling, RAAC and estates safety and decarbonisation and modulars invoices not received. The overall forecast is £2.6m spend above plan due to additional funding received via PDC.

Gaps in Controls and Assurances

- System transformational projects in place but at varying stages of maturity.
- Distance from Target is greater under new Fair Shares target and pace of change is expected to be reduced.
- £83.8m revenue deficit plan pre deficit funding – breakeven after deficit funding - in year with a forecast that does not have risks fully mitigated. This means that there is limited assurance that the financial forecast can be met.
- Current risks are as follows: Bank costs exceeding plan; Efficiency delivery – risk of not delivering to plan; UEC escalation costs not reducing as planned due to UEC pressure and links to discharge; Costs and inflation pressures beyond what was anticipated during budget setting; New NICE appraisals with significant implementation costs; Income Risk if income and activity is not in line with the financial plan.



SO3: Achieve a sustainable and resilient Integrated Care System

Assurance, Risk Level and Risk Tolerance Statement

Achieving Financial Balance	Q1 High	Q2 High	Q3 High	Q4 High
Capital Resource Plans				

Summary Future Actions Plan

No	Action Required
1	Refresh the medium and long-term financial plan for latest financial projections and HTP by Mar 25. MTFP Refresh updates to Finance Committee October/November 2025, January 2026 and April 2026.
2	As part of the Monthly Financial Review processes interpret current financial performance: analyse special variation changes in the run-rate trend of spend for Pay and Non-Pay and key drivers of overspends and underspends; review cost implications of workforce/activity and performance delivery requirements; complete refresh of grip and control assessments to identify and remedy gaps in controls. This will inform accurate forecasting and identification of risks and risk mitigations.
3	Review all requests for pay through the existing Vacancy Control Panels ensuring the completion of the benefits/benefit realisation supports financial delivery and recovery.
4	Review all contingencies, provisions and prior year accruals.
5	Robust monitoring of the recurrent underlying position in year to ensure that this does not deteriorate and that appropriate actions are taken in-year to maintain or improve the recurrent underlying plan.
6	System wide provider and commissioner discussions with Welsh commissioners in relation to Welsh income discussions for provider activity
7	Provider activity management plans to ensure full delivery of activity in line with operational plans.
8	System providers to maximise all commercial income and non-NHS income opportunities.
9	If required - Agree mitigations for potential overspends with budget holders –i.e. deferral of uncommitted capital scheme expenditure. Organisational senior finance team and CPOG to review monthly.
10	If required - Agree mitigations for potential underspends with budget holders -i.e. bring forward pipeline schemes - reviewed monthly by organisational senior finance team with budget holder and via CPOG

Outcome: Full Assurance Status of the SO and the Risk Score will be reduced

SBAF 7: System Enablement (Collaborative and Digital) -STW
System Transformation & Digital Committee | Chief Officer Strategy & Improving Outcomes / Chief Medical Officer

If the system fails to sustain effective collaboration, partnership working and develop digital and data capabilities, then informed decision-making, integrated service delivery and monitoring of outcomes will be limited, resulting in inefficiencies and poorer health and care outcomes for our local population.

Rationale for Risk Level, Current Performance - Highlights

Sustaining a culture of strategic collaboration and partnership working:
Development of provider collaborative and partnerships is now progressing with some dedicated ICB capacity. CiC now in place and key priority areas of work agreed. Provider Collaborative CEOs Group in place. Work programme reporting is embedding and additional workstream areas are being considered. Focus on establishing appropriate resourcing, infrastructure and reporting for the Collaborative is underway. System Transformation and Digital Group in place with CEOs to aid drive in several system wide improvement programmes. New Cluster Executives and teams have been asked to review and amend content following feedback from Board Development session at the end of 2025.
Capacity and Strategy to develop and use digital data and data systems
Since the approval of the ICS Digital Strategy in March 2024, significant progress has been made to address the underlying risks associated with digital and data capacity. A structured approach to digital delivery is now being implemented across the system, supported by a refreshed and costed Digital Portfolio Plan for 2025/26 that directly responds to identified gaps in capability, governance, inclusion, and infrastructure. The ICS Digital Strategy now functions as a system-wide cultural lever, setting the strategic direction for inclusive digital enablement, cyber resilience, and interoperable data.
Key developments include: A reorganised digital portfolio; delivery of mandatory national requirements and maintaining system compliance; Systemwide visibility of high impact programmes including shared care record; drafting of annual delivery plan; increased engagement with providers and local authorities to embed digital thinking; Raised visibility of digital risks and gaps through forums; scoping of system wide information; Possibilities of collaborative procurement and shared ICS resources; restructuring of the ICS digital portfolio; identifying key work on core digital and data capabilities and high priority digital programmes; establishment of the first iteration of ICB digital function and role protocols, with a focus on service; Actively practiced and advocated respectful check and challenge within existing governance structures; Stocktake of digital workstreams and achievements, identifying challenges and opportunities; Annual work plan for 25/26 under construction based on the 7 strategic areas of focus in the strategy.
New Cluster Executives and teams have been asked to review and amend content following feedback from Board Development session at the end of 2025.

Gaps in Controls and Assurances

- Independent assessment (NHSE, CQC).
- Development of provider collaborative and supporting governance structure.
- ICB and ICS Executive roles - remit, authority/span of Data, Digital and Technology (DDAT) decision-making.
- Involvement and alignment of digital and technology requirements in prioritisation, funding allocation, organisational development e.g. workforce literacy, strategic programmes and functional operations and working groups for 2nd and 3rd line assurance.
- Single view of digital/technology spend within the ICB and across the system.
- Insufficient ICS partner reporting into Digital Portfolio.
- Insufficient resources to support delivery of the Digital Portfolio.
- Unclear commitment to implement a Digital Inclusion framework.
- Aligned ICS Digital Procurement Framework and Plan.
- Unclear timeline for an information, data, analytics and intelligence strategy across ICP.
- Lack of system policy on use of AI technologies and embedded solutions.
- System data, digital and technology governance with aligned system digital operating model, evolving from ICB management of change programme.

SO1: Improve Health and Wellbeing Outcomes	SO2: Address inequalities in access, experience and outcomes from health and social care services
SO3: Achieve a sustainable and resilient Integrated Care System	SO4: Working in partnership with communities to achieve social, economic and environmental community development

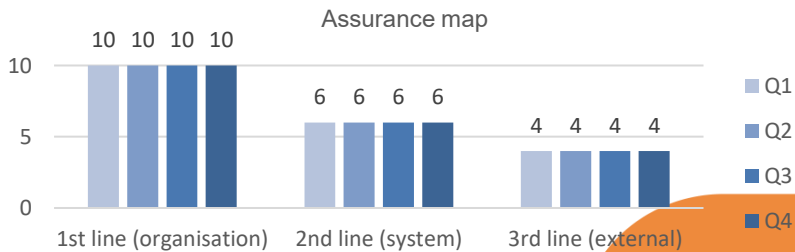
Assurance and Risk Level

Partial Assurance	Q1 High	Q2 High	Q3 High	Q4 High

Summary Future Actions Plan

No	Action Required
1	Self-assessment against NHSE/CQC regulatory framework completed. NHSE Improvement Director attendance at CiC meetings.
2	Finalising Provider Collaborative Committees in Common (CiC) ToR and Joint Working Agreement.
3	ICB CEO co-chair of HWBB's
4	Director of Strategy and Development supporting delivery of JFP priorities and integrated place working.
5	Creation of PC CEOs group reporting to CiC
6	STDG working on collaborative workstreams to drive improvement in areas such as finance, UEC and workforce.
7	Confirm approach and timeline to develop an information and data strategy across ICP.
8	Clarify and agree the ICB and ICS Executive digital roles and commit to Board development programme.
9	Update the IIA t to include digital inclusion and digital sustainability
10	Incorporate Digital voice in prioritisation and decision-making
11	Involve ICB Digital in Infrastructure and Estates programme design, and design of provider collaborative.
12	Commit resources and funding to a system digital operating model for controls that address assurance gaps.

Outcome: Full Assurance Status of the SO and the Risk Score will be reduced



SBAF 8: Sustainable Workforce -SSOT
People, Culture & Inclusion Committee | Chief of Staff

If ICB reform, significant reductions in ICB staffing capacity, and ongoing financial constraints across the ICS limit the ICB’s ability to lead, plan, and coordinate the system workforce agenda, then system-wide recruitment, retention, workforce development, and pipeline planning activity may reduce or become fragmented, resulting in the inability to meet the requirements of the NHS Long Term Workforce Plan, deterioration of employee health, wellbeing and retention, with actual or potential impact on service delivery and quality of care.

Rationale for Risk Level, Current Performance - Highlights

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

All risks reflect the challenging 25/26 Operational Plan, NHS & ICB Infrastructure reductions and Reform.

Risks reflect the progress on NHS Reform, challenges and delays in national process, and risks associated with an increasingly pressured and unstable workforce.

All residual risk scores on the risk register are currently 16 or under.

Review and scrutiny around risks continues via PCI Committee, ensuring risks are reflective of the system-wide health and social care workforce challenges. Deep dive into risks and robust review undertaken in Q4.

In addition to individual risk actions, the overarching continues to be addressed via focused programmes of work, interventions and targeted collaborative work at System and organisational level with evidence of an improved position in several areas including retention, wellbeing and strengthening the future pipeline.

Whilst turnover is stable, sickness absence rates continue to increase (highest rate since Jul-22) – an indication of the current environment. Actions continue at Trust level to prevent further deterioration through prevention and targeted support. System work is currently being monitored and driven via the ICS Employee Experience, Health and Wellbeing Sub-Committee – with alignment to the System Population Health, Health Inequalities and Prevention Strategies. Specific actions have been in place to support our workforce during winter and promotion of staff vaccinations.

In addition, the 2025 Staff Survey Results have just been released and are currently being analysed at Trust and ICB level, with actions being delivered to further improve experience and wellbeing of our workforce.

The ICB/ICS People Delivery Plan for 2025/26 is still being delivered but reviewed in line with the change in roles and responsibilities of ICB and Providers. Conversations are ongoing with CPOs to review current state and agree future vision and direction.

The ICB 5 Year Strategic Plan has been drafted and details the approach and priorities for the ICB People Agenda. It will be refreshed once the new workforce plan is published. The plan considers the overarching workforce risks, challenges and priorities, aligned to the Strategic Commissioning Cycle.

Gaps in Controls and Assurances

- Capacity to meet reporting and assurance requirements from NHSE – some issues with NSCHT workforce reporting capacity and additional support offered.
- Ability to meet demand with financial deficit, workforce controls, supply, future pipeline, and availability of registrants.
- Lack of workforce development funds from NHSE and other sources to support innovative future workforce supply solutions and programmes – no current reporting required to NHSE on funding. Exploring other sources e.g. WorkWell
- Lack of clarity in blueprint alignment of Regional and ICB teams – starting to emerge

SO3: Achieve a sustainable and resilient Integrated Care System

SO4: Working in partnership with communities to achieve social, economic and environmental community development

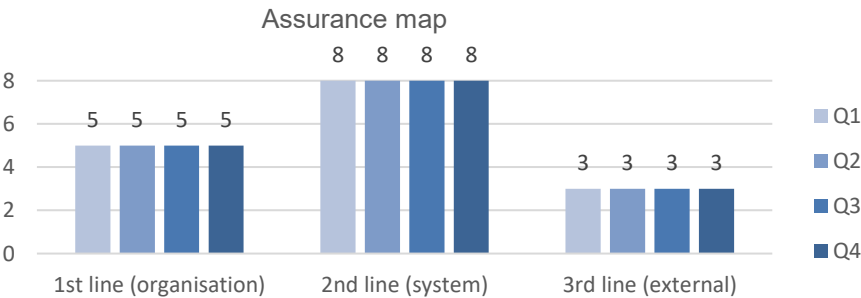
Assurance, Risk Level and Risk Tolerance Statement

Acceptable Assurance	Q1 High	Q2 High	Q3 High	Q4 Moderate	Tolerance is high in recognition of the workforce pressures and financial position. System workforce programme activity has slowed in recognition of ICB Blueprint & future direction, with greater Provider ownership.

Summary Future Actions Plan

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

Outcome: Full Assurance Status of the SO and the Risk Score will be reduced



SBAF 8: Sustainable Workforce -STW
People, Culture & Inclusion Committee | Chief of Staff

If ICB reform, significant reductions in ICB staffing capacity, and ongoing financial constraints across the ICS limit the ICB’s ability to lead, plan, and coordinate the system workforce agenda, then system-wide recruitment, retention, workforce development, and pipeline planning activity may reduce or become fragmented, resulting in the inability to meet the requirements of the NHS Long Term Workforce Plan, deterioration of employee health, wellbeing and retention, with actual or potential impact on service delivery and quality of care.

Rationale for Risk Level, Current Performance - Highlights

A system workforce dashboard is now in place providing robust insights into NHSE workforce data intelligence and oversight to inform against the annual NHS workforce plan. There is a system workforce assurance and planning steering group chaired by the SRO for Reform from which workforce intelligence reports into several system committees and groups including System Transformation Committee, Quality Committee, Finance improvement committee, Agency workforce group, ICS People Culture and inclusion committee and ICS People collaborative.

CEOs had not agreed to invest in the ICB people team infrastructure, further compounded by NHSE financial oversight scrutiny during 24/25. An external review of HR/people services and the ICB people team has been completed, and the teams are now working through an action plan to address the areas highlighted.

People Inclusion and Culture Committee has revised Terms of Reference and meetings are held bi-monthly alternating with People Collaborative with a proposal of 6 meetings per year for Committee and 6 for Collaborative.

A refreshed People Strategy has been produced focusing on delivery of the operational plan workforce targets, considering the recommendations from the external HR review, and acknowledging the evolving external context and reduction in capacity within the ICB people team.

ICB Cluster and appointment of Chief of Staff with responsibility for workforce further helps mitigate this risk and give professional leadership to system wide workforce challenges.

Gaps in Controls and Assurances

- Limited engagement from system CEOs in the development of System People Strategy.
- Limited resource within the System People Team limiting direct delivery and increasing need for Providers and other System Partners to take ownership

SO3: Achieve a sustainable and resilient Integrated Care System

SO4: Working in partnership with communities to achieve social, economic and environmental community development

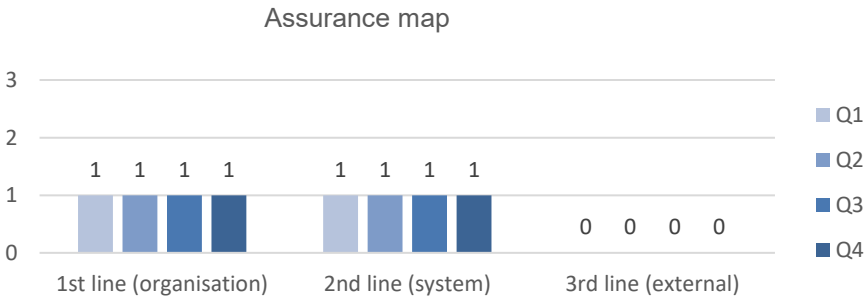
Assurance, Risk Level and Risk Tolerance Statement

Partial Assurance	Q1 High	Q2 High	Q3 High	Q4 Moderate

Summary Future Actions Plan

No	Action Required
1	System CPO's acting as SROs for delivery of the Strategy are supportive of the delivery model set out, this will further evolve through discussions around the Model ICB Blueprint.

Outcome: Full Assurance Status of the SO and the Risk Score will be reduced



SBAF 9: Patient and Public Involvement - STW
Strategic, Commissioning & Productivity Committee, Strategy & Prevention Committee | Chief of Staff

If the ICB fails to meet its statutory duty to involve patients, the public, marginalised groups and to consider the 9 protected characteristics in planning and commissioning arrangements, and in the development of proposals to change or cease existing services, then services will not be tailored to local people's health and care needs, resulting in potential judicial review, discrimination, not meeting the population's health needs, increasing health inequalities and leading to poorer health outcomes

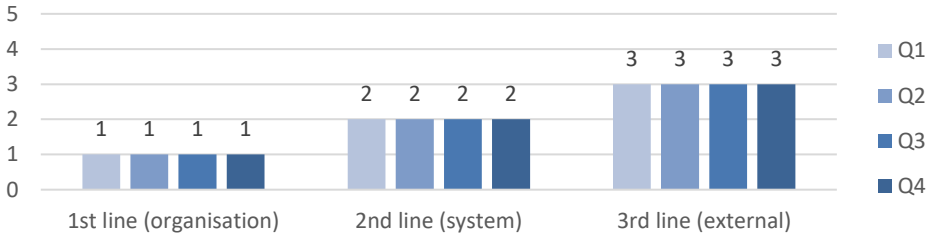
Rationale for Risk Level, Current Performance - Highlights

Communication and Engagement Teams in STW and SSOT are now working under the same interim transitional management structure. Both teams are sharing ways of working and bringing a shared approach where appropriate.

Gaps in Controls and Assurances

- Limited engagement capacity within the ICB comms and engagement team
- Development of advice, guidance and training resources for commissioners, partner organisations
- Involvement strategy refresh required.

Assurance map



SO1: Improve Health and Wellbeing Outcomes

SO3: Achieve a sustainable and resilient Integrated Care System

SO2: Address inequalities in access, experience and outcomes from health and social care services

SO4: Working in partnership with communities to achieve social, economic and environmental community development

Assurance and Risk Level

Partial Assurance

Q1
High

Q2
High

Q3
High

Q4
High

Summary Future Actions Plan

No	Action Required
1	Clustering with SSOT ICB has potential for shared working and maximising capacity/experience and knowledge. Teams are currently starting to work together under interim management arrangements and to explore these opportunities in more detail.
2	Membership of the People's Network will need ongoing focus to ensure diversity to enable engagement on a regular basis with a wide range of citizens.
3	ICB C&E team to develop guidance on statutory consultation and non-statutory engagement and on managing media enquiries.
4	Refresh of Involvement Strategy during 2025. Timeline currently being developed. This needs to consider the implications of the ICB Model Blueprint.

Outcome: Full Assurance Status of the SO and the Risk Score will be reduced