Questions submitted prior to the Board in Common Meeting held on the 29th January 2026

	BY WHOM	QUESTION	RESPONSE
Q1	Joel Spink	In light of the changes to Right to Choose commissioning and Shared Care protocols discussed in the Board papers, can the Board provide a definitive statement on the process for patients who, on GP advice, have obtained a private diagnosis that the GP accepts, but who now require a referral to an NHS/Right to Choose provider for ongoing medication? Specifically, what is the immediate continuity of care plan for patients currently blocked from referral who risk being left without medication while these commissioning reviews take place?	Executive Lead – Dr Rachel Gallyot If an individual chooses to access private healthcare, rather than NHS commissioned provision, it is their choice to do so and they should carefully consider any ongoing prescribing, treatment or monitoring that may continue to be required. Staffordshire and Stoke on Trent ICB is fully compliant with Right to Choose legislation and is supporting primary care to ensure referrals are clinically appropriate. Any RTC provider selected is able to provide both an assessment and treatment pathway, so patients are supported effectively. Staffordshire and Stoke-on-Trent ICB have introduced a new referral management service for Adult ADHD requests for assessment with a private provider. This new process is for all GP's to utilise when a patient is requesting an ADHD assessment with a private provider, commonly referred to as Right to Choose (RTC). The purpose of this is to assess this application for an assessment based on the most up to date clinical guidance, national reporting, screening for impairment and ultimately determine whether the patient is eligible for a full assessment for ADHD, as it is clinically appropriate. Once clarified, the process will then move the application forward as a full referral into either the RTC provider requested by the patient, or a suitable alternative. This alternative could either be another RTC provider, or an NHS commissioned service. We encourage GP's to enter into Shared Care Agreements where they are willing to do so. However, as with all Shared Care Agreements, this is entirely voluntary and at the discretion of each individual GP Practice.

			The ICB continue to work with and alongside primary care on RTC and shared care.
Q2	David Jones Patient and Chair of Moorland Medical Centre PPG	Both commissioners (ICBs) and providers have duties to ensure that they have satisfied their statutory duties to involve and consult with patients particularly in the development and consideration of proposals for changes in the way services are provided – commissioning / contracting being one of the major routes for NHS service provision to be changed and improved. The names of the roles of Board members do not readily indicate which individual ICB executive has legal responsibility for this mandatory patient involvement. Could you please clarify both this and the way in which patients can bring their life experiences to strengthen your strategic discussions.	<u>Lead – Paul Winter</u> While job titles for our new Cluster Executives do not have 'Patient & Public Involvement or Engagement' (PPI) in their names, this does not mean any erosion of the ICB's retained statutory duties that will continue to apply in this area. All ICB Executives and their portfolios covering ICB Functions will retain all such statutory duties as part of their Business as Usual remits. Furthermore, Understanding Patient Needs remains at the heart of the NHS Strategic Commissioning Cycle. The patient and public voice will remain integral to the complete, end-to-end Strategic Commissioning process. And will be strengthened as Population Health Management strategies are implemented across our health & care systems. Our new Chief Officer of Strategy & Improving Outcomes is tasked with leading all PHM / Strategic Commissioner statutory duties. And will be supported by a new Substantive Service Change Team that will carry on doing all the great work that the ICBs did as single bodies before December and Cluster arrangements commencing. The PPI and Patient Engagement Team remain a core part of the new Chief of Staff Directorate too. The Chief of Staff replaces the prior Director of Corporate Governance role pre-December. However, their function remains directly aligned to all things PPI and Engagement. 'Matrix Working' and operational links between these two ICB Directorates specifically, and all Directorates in general, will be actively strengthened to ensure all ICB teams link and work well together and keeping the patient & public voice core to all we do in response to our (unchanged) ICB statutory duties of engaging with and involving the public. All of our existing Board and Committee meetings and related processes for engagement remain in place; and nothing has

			changed or will change until any new Health Act has received Royal Assent. For example, Board meetings of the 'Cluster' ICBs going forward will continue to see regular Community Stories or Patient Stories present on the agenda. The patient voice remains as strong as ever to the work of the Strategic Commissioning & Transformation Committee, which remains in place and into which the VCSE Alliance reports. Residents of both ICBs also remain freely able to engage with the Board and its Executive on any PPI or Engagement matter. These remain core to our decision-making processes. The Healthwatch / VCSE Sector representatives hitherto going to separate Board meetings remain as core "Participant Members" on both Cluster ICB Boards, per our Constitutions. Meaning they have continuing rights to be present at all meetings held in public and be integral to ICB decision-making processes.
Q3	David Jones Patient and Chair of Moorland Medical Centre PPG	Based on the following paper: Enc 12: NHS Reset – Governance Update The Board of NHS SSOT is recommended: 1.3.4 b. To COMMIT to developing place boards and place-based working with the respective local authorities in its area. My question is: I presume that improving population health and wellbeing will ultimately be assessed and delivered at the level of the Place Boards. What population would you see being covered by each Place Board, and how will the boundaries of NHS organisation (ICBs, Primary Care Networks and their associated GP Surgeries) and Local Authority boundaries (wards, etc) fit into this structure.	<u>Lead – Phil Smith and Dr Lorna Clarson</u> As we move forward with delivering the NHS 10-year plan and neighbourhood health the ICB is committed to developing Place Boards and Place-based working with the respective local authorities in its area. Place-based Partnership Boards will align with upper tier or unitary local authority and will focus on designing and delivering changes in services to meet the distinctive needs and characteristics of local populations. They will operate as a formal committee of the ICB Board at Place level and reporting to both the ICB Board and the Health & Wellbeing Board. Therefore, at present, in Staffordshire the Place based partnership board would cover 886,284 people and Stoke-on-Trent 263,157 people. This could evolve subject to national discussions around local authority boundaries.

			Place based partnerships will: • Provided leadership for integrated health and care planning and delivery, bringing together NHS, Local Authority, VCSE and community partners. • Agree local Place priorities for neighbourhood care, informed by population need (PHM/JSNA), aligned to ICB strategy and commissioning intentions and Health & Wellbeing Board outcomes. • Apply a population health management approach across all transformation, with a strong focus on prevention, early intervention and reducing inequalities across the life course. • Ensure a person-centred, strengths-based and community asset-led approach underpins service design and delivery. • Ensure NHS and Local Authority commissioning is aligned at Place, including the use of pooled or aligned budgets where appropriate (e.g. Better Care Fund (BCF). • Provide assurance to the ICB Board and Health & Wellbeing Board that locally designed services are delivering agreed outcomes, health inequalities are being addressed, and priorities are being delivered. We are also considering, given the large geography and specific needs of our populations to have sub-committees which work on a smaller geographic footprint bringing in other community partners with an influence on health and wellbeing, such as schools, emergency services and housing associations, and work with people who use services, their carers and local residents. These may cover a population between 100-250,000 people. These will support the development of neighbourhood working where multi-agency teams can come together to deliver better joined-up, proactive and personalised care, building on the work of primary care. Neighbourhoods would cover a population of 25,000 – 50,000 population but most crucially they should be recognisable to the local communities. We are currently working with the members of Health and Wellbeing Boards to outline the governance arrangements for

			place boards and associated sub-committees, whilst being mindful of the proposed changes to local government boundaries. It is anticipated that the operational delivery of the service required at a place footprint. We recognise we are not starting from scratch and will build upon and strengthen the existing partnerships that are in place.
Q4	Ian Syme	Winter Plan Mention is made in the winter plan update enclosure 11 of 'Release to Respond' initiative at UHNM EDs to address the protracted Ambulance handover delays (December 2025 1hr 35mins AVERAGE at UHNM whereas the requirement is 45 minutes MAXIMUM) at specifically Royal Stoke ED. (The still extant standard for Ambulance Handovers at EDs is 15minutes). I understand very similar initiatives elsewhere have been implemented nationally. a. What is at present the Maximum hand over delay at Royal Stoke ED 'allowable' under that 'Release to Respond' initiative as my understanding is at present that is an agreed 60 minute Maximum? b. What is the required trajectory so Royal Stoke ED attains a sustainable 45 minutes or less MAXIMUM Ambulance Handover (a requirement re UEC Plan 2025/25) by 31st March 2026?	<u>Executive Lead – Phil Smith</u> ICB and UHNM Response As noted within the papers UHNM supported by partners across the ICS has launched the 'Release to Respond' initiative from January to support a more sustainable and timely approach to Ambulance Handover. This initiative supports the balancing of demand and risk across UHNM and the wider system, to release WMAS crews to respond to 999 calls in a timely way. Release to Respond commenced on 12th of January and has an agreed phased approach to move to achieving the 45-minute maximum handover. Starting with an aim of 90 minutes maximum handover, the current position for the w/c 26th January is a maximum of 60 minutes with this to be phased down to a maximum of 45 minutes from w/c 2nd February. These timings have been developed with WMAS collaboratively. We are also mindful that there has been and likely will be, need to pause this work in the light of a specific increased patient safety risk across UHNM or in response to a specific patient need, but we are aiming to revert to the agreed timelines as soon as is safe and practicable to do so. In line with the requirements of the DHSC & NHSE Urgent & Emergency Care Plan 25/26, the current trajectory (noted above) has the intention to achieve and sustain the 45-minute maximum handover from early February 2026 ahead of the March deadline.
Q5	Ian Syme	Safety - sepsis	<u>Executive Leads – Heather Johnstone/Vanessa Whatley</u>

		I understand that emergency Ambulance Service crews have a screening tool for Sepsis and that WMAS do “Pre Alert for Sepsis’ when conveying to any ED. Is the ICB assured that such ‘Pre Alerts for Sepsis’ are acted upon in a timely manner by EDs receiving the ICB catchment area patients given extensive Ambulance Handover delays throughout the patch and how are such assurances obtained by the ICB?	UHNM have provided assurance that Pre Alerted patients do go straight through into the department for assessment, they are then admitted or deemed suitable to wait, which is on occasion back with the ambulance crew. The ICB receives the ambulance handover delays information, meets monthly at CQRM where information is shared and also has a monthly UEC Harms review meeting with all partners where information is shared to support learning as a system.
Q6	Ian Syme	Safety and Maternity A Staffordshire Area Coroners recent Prevention of Future Deaths Report 2026-0033 sent to UHNM NHS Trust and NHSE has emphasised grave concerns regarding Sepsis screening of a pregnant lady which resulted in the Ladies death. The coroner gave a neglect rider at the conclusion of the inquest. There is a specific National Early Warning Score Matrix for Prenatal women that must be used in all Hospital Departments yet despite this that Matrix was not used in UHNMs A&E. That matrix is only implemented in UHNMs Maternity Unit. a. Have the ICB now sought full assurance from UHNM that the aforementioned National Early Warning Score Matrix for prenatal women is being fully used in all departments as per guidance including UHNMs A&E /ED? b. Given the Prevention of Future Deaths Report as per above will the ICB now seek assurance from all its acute providers serving its catchment population including those not within the ICBs geographical boundaries that those providers are fully implementing in all departments the aforementioned Matrix for prenatal women natal women?	<u>Executive Leads – Heather Johnstone/Vanessa Whatley</u> Maternity Early Warning System (MEWS) is fully embedded within Maternity Services. UHNM are currently working upon achieving compliance with the introduction of MEWS into ED & portals. A request has been placed with the IT provider (system C) to upgrade the current ED/Portal modules which will include MEWS. In the meantime UHNM are exploring the introduction of a paper based approach which needs to be balanced with the risk of shifting from the electronic record currently used within ED/Portals. Assurance has been given that the standard National Early Warning System (NEWS) is in place within ED and Portals which supports the identification of early warning signs of patient deterioration. All clinical staff have also received safety memos which highlight the importance of ensuring that there is a specific matrix that needs to be followed for pregnant women. Expert advice can be sought by any clinician 24/7 from the Maternity team in the event that a patient presents.