Questions submitted prior to the Board in Common Meeting held on the 30th April 2026

	BY WHOM	QUESTION	RESPONSE
Q1	Ian Syme	1. Cluster Board Meetings held in Public I note the calendar for the ICB Cluster Board meetings held in public is now published for 2026/27 fiscal year. 50% of Board meetings are slated to be held at a Telford Shropshire venue and 50% are to be held at a Stafford Staffordshire venue. The total ICB cluster population is approximately 1705000 of which 528000 reside in Shropshire and around 1177000 reside in Staffordshire and Stoke-on-Trent. Thus 31% of the ICB Cluster population are Shropshire resident whilst 69% are Staffordshire/Stoke-on-Trent resident. . The cluster total allocation of funding 2026/27 approx £3.7 Billion has 31% of Cluster allocated funding applying to Shropshire (£1.14 Billion) and 69% of Cluster funding applicable to Staffs/Stoke-on-Trent (£2.55 Billion). (i) Why does the ICB cluster see fit to split Public Board meetings 50/50 between Shropshire (Telford) and Staffordshire (Stafford) which is most certainly not a proportionate approach given the former SSOT ICB population is both in revenue allocation and population more than double that of Shropshire? (ii) Further ; as a Northern Staffordshire resident why does the Cluster Board see fit to completely ignore holding their meetings in the patch in which I and around 500000 people live which of course contains the only city within the cluster namely	Lead – Ian Green / Simon Whitehouse Thank you for your note and for setting out the population and allocation context across the ICB Cluster. We will continue to review this decision and will consider the points that you have raised. **1) Access and transparency are not dependent on where the room is** All Cluster Board meetings held in public are **available to observe online via Microsoft Teams**. This means residents from **any part of the Cluster footprint**—including North Staffordshire and Stoke-on-Trent—can observe proceedings without travelling. This is now standard practice across the NHS, with ICBs commonly offering public access **in person and via Teams**. This approach is supported by NHS guidance on Teams as a **secure** platform and one that improves accessibility through features such as the ability to invite non-NHS attendees, reduce travel, and enable options such as captioning and recording. We do recognise that not everyone is comfortable with, or has access to, the digital option and we will continue to be mindful of that. In addition, we publish Board papers and minutes to support public access to information and accountability, consistent with NHS England's governance expectations for ICBs (including holding meetings in public as part of transparency arrangements). **2) Why the meetings are not "population-proportioned" (50/50 split)**

		Stoke-on-Trent; Stoke-on-Trent having a scale and magnitude of deprivation and health inequalities thats not reflected elsewhere within the Cluster catchment population?	The location pattern for Board meetings held in public is not intended to be a mathematical proxy for population size or revenue allocation. The Cluster Board is responsible for governance across **both** constituent systems and must remain visibly connected and accountable across the whole geography. NHS England's governance framework for ICBs emphasises that governance arrangements should be **proportionate**, facilitate **transparent decision-making**, and support effective system leadership across different geographies. The Board's decisions and performance are also assessed against statutory duties and the core purposes of an ICS, which include both **tackling unequal outcomes and access** and **enhancing productivity and value for money**—so our approach must balance fairness, accessibility, and stewardship rather than applying a simple population formula to meeting venues. **3) Cost and stewardship: avoiding venue hire is a deliberate decision** A key driver of the venue approach is **cost control and responsible stewardship of public money**. HM Treasury guidance is explicit that public bodies have a fiduciary duty to use public funds responsibly and to meet standards including **value for money** and **avoiding waste and extravagance**. Against that backdrop, we have deliberately prioritised: • **NHS/public sector estate** where suitable facilities exist, and • **virtual access via Teams** to maintain public accessibility without incurring unnecessary external venue costs. This is a practical application of the "value for money" principle: enabling transparency while minimising non-essential spend, so resources can be focused on patient care. **4) Sustainability and travel: reducing unnecessary journeys matters** Reducing travel where it does not add value is also consistent with NHS expectations on sustainability. NHS England's Net Zero travel strategy sets out the NHS commitment to decarbonisation and

			explicitly recognises **digital communication** as the highest-priority option in the sustainable travel hierarchy. So providing robust online access (Teams) is not only about convenience and inclusion; it is also consistent with wider NHS sustainability expectations. **5) Stoke-on-Trent / North Staffordshire: the concern is understood — and will inform our approach** We recognise and do not dispute the significance of Stoke-on-Trent and North Staffordshire, including the well-evidenced challenges around deprivation and health inequalities. Tackling inequalities is a **core purpose** of the ICS and a statutory expectation against which ICBs are assessed. We therefore agree that public visibility and engagement in areas facing the greatest inequalities is important. **Why we are not currently scheduling routine meetings in Stoke-on-Trent:** the practical constraints are primarily the availability of a venue that is: • appropriate for public governance (capacity, accessibility, security), • available at the required times, and • **does not require paid external hire** (in line with value for money expectations). **What we will do next:** we will keep the pattern of venues under review and will actively consider adding Stoke-on-Trent locations **where we can secure suitable NHS/public sector accommodation without incurring additional venue hire costs**, and where it can be delivered without increasing the cost burden on the system. In the meantime, we will ensure: • the Teams joining details remain clear and easy to access, • papers are published in line with our transparency duties, and • the public question process remains open and properly managed so that questions from any part of the Cluster—

			particularly communities experiencing the greatest inequalities—can be raised and answered in public.
Q2	Ian Syme	2 <u>UEC Agenda Item 05 ICB Operational Plans</u> (i) The frontispiece to this agenda item in the table 'Implications' states "CQC/Patient Safety "No patient safety implications in the report. Considering the March 2026 Cluster Board papers identified SBAF red risk 25 (the highest RAG risk allocated) for SSOT ICB re Ambulance Handover Delays. Neither UHNM or SaTH are planned (within the Cluster 3 year performance plan) to attain the National UEC Plan June 2025 of a MAXIMUM Ambulance Handover of 45 minutes and are RED RAG rated for that particular metric. Its well known and well evidenced that extended Ambulance Handovers at ED portals are extremely detrimental to conveyed individuals. (a) How does the cluster justify the 'no safety implications' as per above given the inability of both SaTH and UHNM to attain the standard of Ambulance handovers being within 45mins at their respective ED portals in 2025/26 and the Cluster plan for 2026/27 is that that standard is now planned to be non compliant.? (ii) Cluster 3year performance plan UEC The National UEC Plan published June 2025 is very specific in as much that Hospital ED portals are required to finalise an Emergency Ambulance Handover within 45 minutes and that acute NHS Hospital Trusts must also plan to further reduce delays at EDs to attain the still extant 15mins handover as defined 13 years ago in NHS Standard Contract 2013/2014. Both SaTH and UHNM are subject to 'Enforcement of Undertakings' regarding their UEC services.	<u>Lead – Phil Smith / Claire Skidmore</u> (i)(a) The paper referred to in the question is a summary of the submitted plans and does not introduce or approve any service changes. As such, the statement reflects that there are no additional patient safety implications arising directly from the submission of the plan. The plans submitted were accompanied by Board Assurance statements which were agreed by the Board prior to submission. As an ICB we fully recognise the risks related to ambulance handover delays and as such this is recorded on the ICB risk register with a score of 25. This is reviewed monthly and is in line with level of risk across SSOT and supported by WMAS. (ii)(a & b) **Response covers both question a and b combined.** The enforcement of undertakings agreed with NHS England (NHSE) in relation to Urgent and Emergency Care (UEC) operational performance sit with University Hospitals of North Midlands NHS Trust (UHNM), and plans were agreed by NHSE as part of this undertaking in line with their Statutory and Regulatory responsibilities. These plans included an expectation that delivery would be supported through joint development with Staffordshire and Stoke-on-Trent Integrated Care Board (SSOT ICB), West Midlands Ambulance Service (WMAS), and other system partners as required however, the statutory responsibility for monitoring remains with NHS England regional colleagues. Due to sustained operational pressures, and increased demand, the targets proposed by UHNM and agreed with NHSE have not been achieved. Ambulance handover delays are not attributable to a single point in the pathway but are the result of a range of interrelated factors across the whole system. Notwithstanding this, incremental improvements in ambulance handover performance have been observed over the past six months, indicating that some of the actions implemented are beginning to have a positive

		Enforcement of Undertakings SaTH 29/8/2024 and also 24/3/2026 both included UEC amongst other provision requiring dramatic improvement and a specific re Ambulance Handover Delays in the 24/3/26 'undertakings Enforcement of Undertakings UHNM September 2025 again highlighted urgent improvement to its UEC Services. In UHNMs case a plan and projections to attain a 45minutes Ambulance Handover at UHNMs ED portals by end March 2026 was agreed with NHSE. UHNM did not attain that agreed standard by March 31st 2026! (a) Considering that the Enforcement of Undertakings is still 'live' can the Cluster please explain why plans for the next 3 years re Handover delays seemingly breach the 45 minute agreed planning in the undertakings agreement between NHSE and UHNM? (b) Considering the national UEC Plan June 2025 is to ensure that all Ambulances are released within 45 minutes Maximum at ED portals and is required of all NHS Acute Trusts how is it that the ICB cluster is planning to flout this requirement for the next 3 years within its plans?	impact. While this level of performance remains an unacceptable position, the system continues to refine and strengthen its collective response, with refresh of robust system-wide plans to further improve performance. In relation operational planning submissions, it is important to recognise that the 2026/27 planning round differed from previous years in terms of how plans were structured and submitted. In this planning cycle, there was no requirement to submit a single, consolidated system plan covering all elements of performance and delivery across the Integrated Care System. Instead, the submission was structured around individual organisations which included ICB-led financial, workforce and performance plans, with separate provider-level workforce, finance, activity and performance trajectories agreed directly between NHS England and providers. Within that context, a number of metrics, including several within urgent and emergency care, were not formally part of the ICB submission itself. As set out in the paper, some of the metrics presented in the planning tables are clearly identified as provider metrics, included to give a complete picture of system performance but not forming part of the ICB's submitted commitments. Despite this change in the planning framework, the ICB's teams, worked closely with providers to understand and review their submitted trajectories. This included engaging with providers on how their plans had been derived, the assumptions underpinning them, and whether they represented credible and deliverable improvement from current baseline performance. This is particularly relevant in areas such as urgent and emergency care, where provider organisations hold direct operational responsibility and have, in many cases, agreed trajectories directly with NHS England through established oversight mechanisms. The role of the ICB in this context is therefore not to set provider trajectories directly, but to act as a strategic commissioner, ensuring there is a clear understanding of system performance, risks, and improvement trajectories across the whole system. The

			plan presented to the Board reflects a composite position, bringing together ICB-submitted plans, and provider-level submissions. UHNM's plan was subject to scrutiny and challenge by the ICB and NHSE and the final version sets a more ambitious target to reduce handover times than that which was originally proposed. The plan was approved by NHSE on the basis that it set out a credible path to overcoming the challenges described above and will put UHNM on course to achieve a maximum handover time of 45 minutes in the future. The ICB will continue to work with UHNM and NHSE to ensure that the Trust is supported to exceed its planned levels of performance wherever possible.
Q3	Bex Bromley Emily Evans	Bex Bromley, OCA Infant Feeding Volunteer Coordinator and Emily Evans, Breastfeeding Network Service Manager would like to jointly submit the following question. a) How does the Integrated Care Board intend to merge, review and monitor existing infant feeding strategies? b) Will the ICB commit to ensuring all trusts within the area deliver accredited infant feeding programmes such as UNICEF Baby Friendly Initiative (BFI) Accreditation as recommended in the NHS Long Term Plan? c) Is there or will there be a dedicated lead for Maternity and postnatal care within the ICB who can engage with all relevant services including trust leads, 0-19 leads, family hub services and VCSE's?	<u>Lead – Vanessa Whatley / Heather Johnstone</u> a) All aspects of perinatal care are reviewed and monitored by a dedicated maternity board. Work has already taken place to merge this meeting to incorporate all key providers of maternity services into one meeting and this will be the main forum through which infant feeding strategies are reviewed and monitored. b) All main providers of maternity services used by the STW and SSOT Cluster are already UNICEF BFI accredited. We will continue to support them in their work to sustain this achievement. c) Under the leadership of the CNO there is a dedicated lead midwife and a small team of staff whose roles include responsibility for all aspects of perinatal care which includes oversight of postnatal care. This team work closely with the MNVP leads to ensure strong engagement with all relevant stakeholders.