

**Questions submitted prior to the Board in Common Meeting held on the 26<sup>th</sup> March 2026**

	BY WHOM	QUESTION	RESPONSE
Q1	Ian Syme	<p><u>Integrated Performance Report</u></p> <p>Ambulance Handover Delays UHNM particularly Royal Stoke ED portal:</p> <p>At January 29th 2026 ICB Cluster Board meeting I put a question to that meeting regarding 'Release to Respond' Ambulance Handover initiative being implemented at UHNMs Royal Stoke ED portal.</p> <p>In response to my question the cluster informed that as of January 26th 2026 a maximum of 60 minutes phased down to a maximum of 45 minutes from w/c 2nd February 2026 was the trajectory to ensure delays in Ambulance Handover at Royal Stoke ED are within the UEC 2025/26 plan of 45 minutes Maximum.</p> <p>The intention was to attain and sustain a 45 minutes maximum from early February 2026 ahead of the March 2026 deadline.</p> <p>Today's (26/3/26) ICB Cluster Board Paper "Integrated Performance Report Ambulance: UEC metrics off plan Action 2 of 2:"</p> <p>Average (not maximum) UHNM handover times February 2026 being 1h 15m 31secs ie 20m 31secs off plan.</p> <p>I am now aware that WMAS Ambulance lost hours at Royal Stoke ED for February 2026 whilst still substantial are the lowest since August 2025.</p>	<p><u>Lead – Hayley Allison</u></p>

		<p>The ICB SBAF RAG risk re Ambulance Handover Delays is Red 25 ie the highest risk rating attainable.</p> <p>a. Is the ICB still sighted on the achieving of a maximum 45 minutes Ambulance Handover at UHNM ED portal specifically Royal Stoke ED portal ahead of the March 2026 deadline as per the response to my question 29/1/26?</p> <p>b. If the 45 minutes maximum maximum is NOT achieved by the March 2026 deadline when is that standard now projected to be achieved considering that all Acute Trusts have now been required to dramatically reduce Corridor Care whilst still improving Ambulance Handover Times at EDs as per a March 4th 2026 letter PRN02378 from NHSE UEC Director titled 'Additional Actions to virtually eliminate Corridor Care'?</p>	<p>Yes – The system is still actively continuing to work towards achieving the 45-minute ambulance handover standard, including at Royal Stoke Hospital.</p> <p>The system continues to recognise the challenging position in relation to Ambulance Handover delays and are actively working together to support improvement including through demand management, ensuring patients receive care in a timely way in the most appropriate setting. We acknowledge that Ambulance Handover times are not where we would want them to be as a system, however - we have seen continuous improvement on our position during our most challenged winter months, between October 2025 to February 2026, during what is predicted to be some of our most challenging periods.</p> <p>For the most recent Operational Planning process and our medium term plan, our system providers lead the submissions for metrics such as ambulance handover delays. Performance is planned against a variance of factors that impact each metric. A trajectory for significant reduction and improvement in ambulance handovers above 45 minutes by the month of March 2027 for UHNM has been developed.</p>
Q2	Marilyn Gaunt	<p>Please find below my questions to thisxweekj's Board Meeting...</p> <p>a. Does 'Health Heroes' now hold the Home Office licence required to possess and supply controlled drugs to OOH patients in Shropshire, Telford and Wrekin?</p> <p>b. What date is this expected/ when was the licence granted?</p>	<p><u>Lead – Gemma Smith</u></p> <p>Yes</p> <p>24<sup>th</sup> December 2025</p>

		<p>c. Please explain exactly how OOH patients requiring – for example – urgent pain relief have had their needs met in the absence of Health Heroes holding that licence? Some will already have been prescribed relevant medication for ‘just in case’ purposes, but clearly this will not apply to every patient.</p> <p>d. Which provider currently offers the Oncology and Haematology advice line formerly provided by Shropdoc? If there has been or is intended to be a change of provider, can you please explain the arrangements around this and how national regulations or guidance have been applied?</p>	<p>Interim arrangements were in place to provide any controlled drugs from the commencement of the contract, and this process was not required to be used prior to the controlled drugs license being issued by the Home Office.</p> <p>This contract is held by Shrewsbury and Telford Hospitals (SaTH) and therefore this question would need to be redirected for a response to be provided. This is not a service commissioned by the ICB.</p>
Q3	Dylan Harrison	Which of our local NHS organisations in Shropshire, Telford and Wrekin, Staffordshire and Stoke-on-Trent hold contracts with Palantir to progress the NHS Federated Data Platform?	<p><u>Executive Lead – Dr Lorna Clarson</u> The ICB does not itself hold contracts with Palantir to progress the FDP – this is a contract and national system held by NHS England with this particular organisation. As the FDP is a national system that ICBs are expected to be “Local Tenants” (users) of, so we have had no involvement of any type with Palantir about the establishment of the FDP locally. Nor in how it works. We have though engaged with NHS England on the local ICB “instance”, allowing them to remain the Data Controller of local FDP Apps, and in that way maintain control over the local data added nationally to the system by provider organisations in the area for populating the shared tools on the FDP. The ICB currently has no local Apps running on the FDP instance</p>
Q4	Dylan Harrison	At what stage of progression is the Federated Data Platform work in each of our local organisations, and what is the timetable for further progression and full implementation?	<p><u>Executive Lead – Dr Lorna Clarson</u> The Federated Data Platform (FDP) is a collection of national products rather than a single implementation, and uptake across the ICB reflects differing organisational needs and digital maturity. Within the system, some trusts are live with specific FDP products such as Faster Data Flows, inpatient capacity tools and cost collections, while others are contributing data to support system-wide solutions, including the SHREWD replacement and System Coordination Centre pilot. Several organisations already have well-established local data warehouses and alternative solutions in place, meaning FDP adoption is being approached</p>

selectively rather than as a full replacement. There is currently no fixed ICB-wide timetable for full FDP implementation. Further progression will be driven by agreement on priority system-level use cases, clarity on future funding and governance, and assurance that FDP products add value alongside existing investments.

**Timetable for further progression**

There is currently no single ICB-wide timetable for full FDP implementation. FDP adoption is intentionally incremental and driven by:

- Organisational readiness and existing digital investments
- Availability of national FDP products
- Demonstrated value for patients, staff and the wider system

To unlock greater value at system level, further progress will require:

1. Agreement on priority system-wide use cases
2. Clear governance for shared data, access and interoperability
3. Alignment with existing digital strategies and infrastructure
4. Clarity on future funding and resourcing

**Summary of each Organisations current position**

**Midlands Partnership NHS Foundation Trust (MPFT)**

MPFT is currently live with several FDP products, including:

- Faster Data Flows (FDF)
- Inpatient capacity management (as part of the SHREWD replacement)
- Local Cost Collection (LCC)

MPFT continues to review other FDP products as they become available. Any further implementation will be based on suitability, alignment with trust needs and demonstrated value.

**North Staffordshire Combined Healthcare NHS Trust (NSCHT)**

NSCHT's main involvement to date has been contributing data into

			<p>the FDP to support the SHREWD replacement, with mechanisms now in place for ongoing data submission. The Trust recognises that the greatest benefit from FDP is likely to come from system-wide use cases rather than isolated deployments. NSCHT already has an established local data warehouse and supporting infrastructure, and before considering wider adoption would require clarity on system priorities, data standards, funding and future timescales. The Trust has expressed willingness to engage in renewed system-level discussions and will continue contributing data where appropriate.</p> <p><b>University Hospitals of North Midlands NHS Trust (UHM)</b> UHM has previously explored FDP modules to support operational workflows, such as RTT pathways, but usage has reduced due to revised processes and alternative solutions. More recently, UHM has actively supported a pilot of the System Coordination Centre (SCC) FDP module and is considering whether to revisit further FDP modules in areas such as RTT, inpatient and outpatient pathways. While the Trust supports the principle of extending FDP use, including for population health and commissioning, there are currently no confirmed plans or dedicated resources for wider implementation.</p>
Q5	Dylan Harrison	Do both ICB Boards have assurance that Palantir is a principled organisation that will not under any circumstances use patient data in a way that is harmful, or could be seen as compromising human rights law? I draw the attention of Board members to Palantir's role in supporting ICE in the USA and the IDF in its operations in Gaza.	<p><u>Executive Lead – Dr Lorna Clarson</u> The ICB has signed up to the national Data Protection Impact Assessment created by NHS England, in line with the provisions made on their national FDP Portal that pertain to the Privacy Notice which NHS England is required under UK GDPR to provide to the public about how their data is safely being processed in line with all UK GDPR requirements: see NHS England » Security and privacy</p>
Q6	Gill George	Will the Board 'cluster' commit to ensuring that each of our local Healthwatch organisations continues to send a representative to Board meetings (until such time as Healthwatch is abolished)? There is a sense of the voice of patients diminishing in top-level decision making.	<p><u>Executive Lead – Mish Irvine/Paul Winter</u> Yes, we will – absolutely. Thank you for raising this. As was discussed and formally minuted at our January Boards in Common meeting held in Stafford (see minutes 012.3 and 012.7), both ICBs remain absolutely committed to a continued Healthwatch presence at our future Board meetings, in place for as long as Healthwatch organisations remain in place themselves. It is a matter for the public record that both Boards have strongly re-emphasised their</p>

			total commitment to public engagement and involvement, as one of our highest priority responses to core ICB Statutory Duties. This has also been the subject of offline engagements held between the ICB's Comms & Engagement Team directly with the four Staffordshire & Shropshire Healthwatch organisations. In order to agree future attendance at all Board meetings for the foreseeable future. Healthwatch will continue to hold "Participant Member" status per ICB Constitutions, and to act in that capacity. However owing to the physical and logistical constraints we face from bringing two systems into one, it was also agreed at those offline sessions that one Healthwatch representative from the NHS STW patch and one from the NHS SSOT patch each would hold this status. With the 4 Healthwatch's between them agreeing to rotate attendance for the 6 bi-monthly Boards in public sessions between themselves, to allow all 4 to remain engaged in that way: e.g. Stoke-on-Trent & Telford & Wrekin at the April meeting, Staffordshire & Shropshire at the June meeting, etc
Q7	Gill George	In the interests of transparency and accountability, will the Board cluster take urgent steps to ensure that meetings are <b>audible</b> both to members of the public who attend in person and those who view the meeting online? Will the Chair encourage Board members to speak clearly, to use microphones as applicable, and to give their name and job role before making a verbal contribution to the meeting? Will the Chair acknowledge and take remedial steps if a member of the public present at the meeting says something such as, "Sorry, Chair, but it's impossible to hear"? Can consideration be given to a camera system that shows the face of the speaker rather than an indistinct blur of many unidentifiable faces?	<u>Executive Lead – Mish Irvine/Paul Winter</u> We recognise how important it is that Board meetings are fully audible and accessible for everyone attending in person or online. Our Corporate Affairs and Communication Teams carry out sound and connectivity checks before each meeting and monitor audio quality throughout, taking immediate action if issues arise. The Chair already reminds Board members to speak clearly, use microphones properly, and introduce themselves by name and role when contributing. If anyone attending indicates they cannot hear, the Chair will pause the meeting, acknowledge the concern, and ensure the issue is resolved—such as adjusting equipment or asking speakers to repeat their comments. We are also reviewing our camera setup so that online viewers have a clearer view of the person speaking rather than a wide, indistinct image. We remain committed to improving the experience for all attendees and will continue to make enhancements based on public feedback.
Q8	Gill George	The last Board meeting very effectively excluded members of the public who tried to view it online. A journey from rural Shropshire to the meeting venue was a considerable distance, and expensive and awkward by public transport. There is	<u>Executive Lead – Mish Irvine/Paul Winter</u> Thank you for sharing your experience and for your perseverance in trying to join our last Board meeting, the first ever held on an "In Common" basis. We are sorry that some were unable to view the

		<p>surely a need for NHS leaders to make a positive commitment to public involvement at this time of rapid change.</p>	<p>meeting online and that the physical journey from rural Shropshire proved so difficult and costly. We recognise that for many in our rural communities, digital access is not just a convenience but a necessity for involvement. It is clear that on this occasion, we failed to meet the standard of accessibility our residents deserve. Both ICBs are fully committed to a culture of inclusion where every voice can be heard, especially during this period of rapid change. To ensure this is addressed, we are:-</p> <p>(1) Actively reviewing our digital streaming setup to prevent technical exclusions in future meetings (the session held in Telford last week was more in our control as to the venue and the IT interoperability). (2) Evaluating meeting locations to better balance accessibility across our diverse geography. (3) Strengthening our Public Involvement Strategy to ensure that 'digital-first' does not mean 'digital-only' or 'digital-exclusive'. We value your input and would welcome the opportunity to discuss how we can make our future meetings more accessible for our public. There is however no dilution planned now or in the future to the historically positive commitment to public involvement shown by both ICBs. Meetings held in public will need to rotate for the six sessions per annum that are agreed between the NHS STW patch, and then the NHS SSOT patch, so as to keep things equitable for both populations that the Cluster serves. We are working hard to achieve sufficient in-person and virtual representation and attendance at these meetings, per provisions made in our ICB Constitutions' Standing Orders sections, for meetings held in public.</p>
Q9	Ian Syme	<p><u>Looked After Children Initial/Review Health Assessment Compliance.</u></p> <p>Looked After Children are a particularly extremely vulnerable group.</p> <p>The ICB have a very specific duty to ensure that Looked After Children have an Initial Health Assessment and a Reviewed Health assessment within very specific designated time frames.</p>	<p><u>Lead – Heather Johnstone</u></p> <p>The ICB and MPFT are working collaboratively to address performance in review health assessments, which has been partially driven by increased demand. Throughout 2025/26, progress has been made, leading to a reduction in the length of time assessments remain overdue. Additional funding, along with an updated service specification and strengthened reporting arrangements, has been agreed from April 2026. Work is now underway to finalise the timelines for the service redesign and for meeting statutory requirements.</p>

	<p>The inability to comply with those duties has been a standing item on SSOT ICB Board reporting for way over a year now.</p> <p>On January 16th 2025 contained within 'enclosure 15: SBAF Update' of SSOT ICB Board papers was the paragraph as per screen grab Ive attached to this question. In fact quote.. 'Additional resources have been allocated and a recovery plan agreed with Q3 data predicting recovery by end of the financial year 2024/25.' That 'recovery' if it came to exist was extremely 'short lived'.</p> <p>Contained within this months ICB Cluster Board Papers file or 26th March 2026 minutes of the SSOT ICB Quality and Safety Committee (meeting held 18/2/26) the situation regarding Looked After Children's Initial/Review Health Assessment Compliance is quote " ...not showing ANY consistent improvement or clear direction of a reduction in trajectory."</p> <p>When will there be FULL sustainable compliance so that a very vulnerable cohort namely Looked After Children receive their Initial/Review Health Assessments as required within stipulated time frames because at present its brutally obvious that this 'service' is way too often sub optimal?</p>	
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