NHS
North East London
Integrated Care Board

North East London ICB board questions from the public - log

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
ICB-13	29 May 2024	22 May 2024	Shirley Islam	Q1: During the summer of 2023, there was a series of 'Big Conversation' events across the eight boroughs. Unfortunately, a year later eg the NELHCP website states updates will be coming https://www.northeastlondonhcp.nhs.uk/getinvolved/what-is-the-big-conversation/. How can we find out what happened as a result? In particular interested in the actual views and data captured from the residents in the City of London. In future may I suggest feedback within a few months, especially to those who took part for the first time, to increase and not decrease engagement going forward.	A1: Thank you for your question and your interest in the Big Conversation. As we heard during the Board meeting, there has been work underway since last summer to ensure that we build on the Big Conversation in each Place. Working with the local HealthWatch in each area, we are in the last stages of the process of bringing a summary paper through each Place Partnership with detail of responses from local people and communities as well as the more thematic views which were expressed. In the next period, we are also going to test out with local people the draft success measures of the Integrated Care Strategy which were shaped through the Big Conversation, as set out in the Board paper. As the Board paper also states, we want to test the draft success measures back with local people as part of the process of adopting them to make sure that we have appropriately interpreted what is of most important to local people. I do apologise that it has taken several months to collate all the responses and to ensure that we correctly pick up the most important points. I do agree that feedback sooner would have been advantageous and I apologise that we haven't been able to update you before now. Taking forward ongoing dialogue in each Place remains a priority for us as we continue to engage with local people and to build and embed co-production.

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
ICB-12	29 May 2024	16 May 2024	Jan Savage (on behalf of NELSON)	Q1: NEL ICB says it wants to know what its local communities think about their local NHS and care services. Yet its website's links to information on how residents in the different boroughs might become involved do not work. Among these links is one about how to ask a question at NHS North East London Board meetings. While this looks like a technical problem, we suggest there is an underlying and more substantial issue of democratic deficiency. Members of the public can attend NEL Board meetings but these (previously once a month) are now only open the public every other month. In addition, questions from the public are edited, with the risk that the Board's responses avoid key points or make little sense. To make matters worse its usually hard for those attending meetings virtually to see all Board members present, and sound quality is poor. And although Board members may be asked by the Chair to introduce themselves when they speak, they rarely do, and nothing is said to clarify their role. To address these issues, will the Board ensure: • Questions from the public can be of varying length but those under a specified word limit (a limit allowing sufficient words to explain context) will not be edited	A1: The ICB engages with its north east London communities in a variety of ways, including the Big Conversation, holding meetings in public, and through the People's Panel which is made up of more than 2,200 residents living in north east London and was created as a way to listen to our diverse communities. Details on how local people can get involved can be found on our dedicated webpage https://northeastlondon.icb.nhs.uk/get-involved/opportunities-to-get-involved/. We encourage people to contact us if they notice any technical errors on our website and we aim to rectify any issues as soon as possible. Thank you for bringing the broken website link to our attention as this has enabled us to rectify the issue. Since the ICB was established in July 2022 our ICB Board has met on a bi-monthly basis and each of these meetings have been held in public. The meetings are also recorded and can be viewed on our website https://northeastlondon.icb.nhs.uk/our-organisation/our-board/board-meetings-and-papers/. Due to the length of some questions received from the public there may be occasions where these are shortened for the meeting's minutes, however the minutes are transparent and stipulate when the question has been shortened and they include a link to our questions log which has all questions and answers written in full https://northeastlondon.icb.nhs.uk/our-organisation/our-board/questions-from-members-of-the-public/.

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
				• All broken website links will be fixed within 24hrs of being reported • All Board discussions will be fully available to the public (apart from those that fall under genuine and legally valid exclusion criteria) • Names, roles and responsibilities of all those contributing to Board meetings will be easily available to all in attendance.	We rotate venues for each ICB Board meeting to a different north east London borough, in order to provide local people with the opportunity to attend a Board meeting in person. The venues we attend have varying layouts and technology, which we appreciate can have a varying sound quality for those viewing online. We will continue to work with partner colleagues to source meeting venues appropriate for streaming online, recognising the priority of a physical presence for the Board in venues across north east London. Board members are asked by the Chair to introduce themselves when speaking and we have nameplates on desks to illustrate who each member is. We appreciate that this may be difficult to read for those viewing the meeting online, so going forward we will include an attendance list at the start of each pack of papers. We also have a page on our website that highlights who our members are https://northeastlondon.icb.nhs.uk/our-organisation/our-board/.
ICB-11	27 March 2024	22 March 2024	Jan Savage (on behalf of NELSON)	Q1: We understand that it is the responsibility of the data controllers of individual organisations within the ICS (such as GP practices or Trusts) to ensure that any processing of the data they generate complies with the UK GDPR. This responsibility includes ensuring that individuals are given privacy information (such as why their data is being collected and who it will be	A1: The ICB takes the security of patient data very seriously and takes steps to ensure that providers who hold personal data both do so in a way that is secure, and that they communicate effectively with the individuals in question. For assurance, a Data Access Group has been established which is system-wide ICB-led forum where partners are required to submit requests in order to access data. We have a Strategic Information Governance Network (SIGN) which is another forum where system partners come together and

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
				shared with) at the time that their data is collected. However, anecdotal evidence consistently indicates that individuals are not receiving this information at any point in their patient journey. We therefore sent a series of FOI requests to the ICB to enquire how it saw its responsibility for ensuring that this information is received. Responses focused on the responsibility of individual data controllers to provide this information, while also suggesting that the onus for finding the information rested with patients. This represents a failure to meet a key transparency requirement under the UK GDPR that clearly needs to be addressed. At the same time, the ICB is dependent on the integrity of the data it receives from the ICS provider organisations for service planning, population health etc. and so needs to ensure its proper collection and use. Finally North East London is not a collection of individual organisations but an integrated system with collective responsibilities. We therefore ask what steps will the ICB take to work with data controllers and others to ensure that robust processes are in place across the ICS for the proper collection and processing	collaborate on information governance issues. However, the ICB cannot take responsibility for the data that provider organisations hold as it does not have the legal authority to do so; this is the responsibility of each individual partner organisation. The Information Commission also has a legal duty to oversee and regulate data protection.

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
				of patient data, including that this is done with the full knowledge of patients.	
ICB-10	27 March 2024	22 March 2024	Terilla Bernard – Chair of Aldersbrook Medical Centre Patient Participation Group	Q1**:** Is the board aware that the ICB states that to provide stability for Aldersbrook Medical Centre (AMC) patients, they are moving away from APMS contracts; if this is the case why is there currently a programme across NEL to agree six new APMS contracts and a Barking and Dagenham practice has had its five-year extension recently agreed? Are we at AMC to assume that we are being singled out, because this does not appear to be equitable.	A1: Services at Aldersbrook Medical Centre (AMC) are provided under a time-limited APMS contract. Following the 5 year review point, the current provider has decided not to extend the contract for a further 5 years. The London Directive is to equalise APMS contracts so that the terms of these contracts fall in line with GMS and PMS contracts which are the national GP contracts. The ICB has been equalising all APMS contracts when these contracts reach their review point and all new APMS contracts are procured on an equalised basis, including the recent six practice procurement that has just concluded. The current provider did not agree to the ICB proposal for transitioning their APMS contract to equalisation with GMS / PMS contracts. AMC has a small list (4,700). The average list in Redbridge is about 8,740; the national average is 9,369. Therefore, there is a high risk that a procurement would not be successful. As AMC is too small to procure as a practice and the ICB has assessed that a GP practice should continue at Aldersbrook, with the financial and list size restraints, the move for AMC becoming part of an existing GMS / PMS practice under a dual site arrangement, appears to be the most suitable option. This would give longevity and stability to the practice and its patients. The Provider Selection Regime, which was only introduced in January 24, gives commissioners greater flexibility

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
					in the range of options available to securing patient care, that didn't exist when the previous APMS procurement was undertaken.
ICB-9	31 January 2024	18 January 2024	Jan Savage (on behalf of NELSON)	Q1: Members of NELSON (North East London Save Our NHS) submitted a series of Freedom of Information (FOI) requests to NHS North East London about how it processed patients' personal data. One strand of questioning asked about the measures in place to ensure that the public can have confidence in the way their personal information is being used by the ICB, particularly for purposes other than patients' direct care. An initial response was that, as established by the UK GDPR, the responsibilities of data controllers always rest with the individual organisations within the ICS (i.e. care providers such as GP practices or hospital Trusts) that generate the data. The ICB said it could not overrule this. However, while this is true at one level, it seems that the ICB takes a surprisingly relaxed approach: the ICB is dependent on the data generated by the organisations within it to carry out activities such as planning services or Population Health Management, and yet it does not seem to take steps to ensure the integrity of these organisations' data collection processes and thus the integrity of the data that the ICB uses.	A1: The NHS uses data every day to manage patient care and plan services. Better use of existing data brings benefits for patients by ensuring more joined up care, improving health outcomes and ultimately helping to save lives. We take data privacy incredibly seriously. The ICB supports providers by investing in appropriate clinical systems which the ICB, where appropriate, supports moving providers to common systems, such as a number of shared or consistent systems being used across Barts Health, BHRUT and the Homerton. While the ICB has an overarching convening role in the management of the NEL healthcare system, the legal responsibility for keeping data safe rests with each individual NHS organisation (which includes hospital trusts and GP Practices). All independent organisations have responsibilities as controllers for that data under UK GDPR and UK Data Protection Act (2018). This legislation specifically identifies responsibility for collection and data integrity upon the controller for those records. This is an important principle as each organisation records information about treatment of patients as they go about the work of provision of healthcare services, so as processors they need to be directly accountable by law for how that data is stored and managed. In turn, the ICB seeks assurance from each provider Trust to ensure that data is recorded appropriately stored and managed safely and only used for appropriate

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
				Similarly, when asked what was in place to ensure that the public understands the proposed use of their data for purposes beyond their direct care, the response was that “We have fair processing and privacy notices to document and inform on all uses of patient data”. However when asked at what point in their care journey could patients have sight of such notices, or what was done to ensure that patients could see these notices before their data was collected, the only answer was that “Patients can access privacy notices at any point of their journey”. Asked where these privacy notices could be found, we were referred to the websites of the ICB and ICS, which would give details of the care providers across the ICS who generated the data and were responsible for issuing privacy notices. Expecting patients to scour the ICS website for providers and then the websites of those providers to find a privacy notice that patients are anyway unlikely to be aware of, and to do so before their data is collected, is hardly an inclusive approach to informing patients about the use of their data. Questioned whether the ICB issued guidance to care providers to ensure that patients/citizens have been involved in drawing up fair processing/privacy notices and that these notices are comprehensible to the	and legal purposes. The ICB also conducts automated de-identified reviews of commissioning data sets, where we are legitimately involved in the data flow. This includes data quality and data completeness queries, with the results shared with partners. All NHS organisations are also required to complete an annual mandated NHS England Data Security and Protection Toolkit that assesses data quality and integrity processes, which when these are published provide the ICB with appropriate assurances. In addition to this, the UK data protection legislation provides a route of complaint and escalation where a data subject (a living person or patient in this context) feels that issues like data collection and / or integrity and other data matters are not being implemented in line with UK data protection legislation and that is via the role of the Information Commissioners Office (ICO) which overseas implementation of the UK data protection legislation in the UK. Furthermore, UK data protection legislation implements a number of data rights for data subjects which include having incorrect data corrected (data integrity) and transparency (publication of privacy notices by data controllers) and any challenge or complaints about how organisations (controllers) implement or uphold those rights should again be made to the ICO and not the ICB. Each organisation will use their data in different ways and therefore will publish their own privacy notices. Patients will be aware of which organisations are providing their care.

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
				public, the response again was that "each care provider is responsible for its own data management". Given that NHS North East London is an integrated system, do members of the ICB agree that it should take responsibility for establishing comprehensive, patient-centred guidance for all organisations across the ICS to ensure that the data generated across the system (and that the ICB relies on) has been collected appropriately, including with the full knowledge of patients?	The ICB carries out work with its ICS partners to promote and publicise how the NHS works across North East London and the ICB engages with patients at ICB and Place (borough) level. We are currently working through the North East London Citizens' Panel to test how easy the existing guidance on use of patient level data is to understand for local people. We are collating existing guidance with a view to promoting plain English guidance. NHS England has provided all providers with guidance here.
ICB-8	29 November 2023	1 November 2023	Jess	Q1: Can the ICB please provide its rationale for not funding faecal calprotectin testing in children under the age of 16 in primary care?	A1: The faecal calprotectin test is not directly available in primary care settings for children under 16. This is because faecal calprotectin levels are raised in children and does not signify disease. GP practices in north east London follow the patient pathway by seeking advice and guidance from secondary care providers (for example Barts Health, BHRUT, Homerton Healthcare) who would make a recommendation for treatment. If this did not solve the patient's issues, then a referral to a specialist would be made and then the test would be offered; which is in alignment with NICE guidance: NICE guidance recommends faecal calprotectin to be measured mainly in secondary care and with the following recommendations: *Faecal calprotectin is recommended as an option to support clinicians with the differential diagnosis of Inflammatory Bowel Disease (IBD) or non-IBD (including Irritable Bowel Syndrome) in children*

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
					with suspected IBD who have been referred for specialist assessment, if appropriate quality assurance processes and locally agreed pathways are in place for testing.
ICB-7	31 May 2023	20 May 2023	Karen Smallwood, Forest Farm Peace Garden (charity)	Q1. As a small charity providing support for those with moderate mental health issues, how can we work in partnership with the NHS?	A1: The ICB recognises the crucial role small charities play in the health and wellbeing of local residents. The local place based partnership director has connected with Karen to discuss this in more detail and will provide details of the local Council for and Voluntary Service (CVS) who promote, support and develop the voluntary and community sector as well as the Voluntary, Community and Social Enterprise (VCSE) Collaborative which is being developed.
			Josh Mellor - Local Democracy Reporter - Waltham Forest, Redbridge, Havering	Q.2 In a number of recent enquiries I have made, which are dealt with by a member of communications staff at something called the CSU, the responses have been limited in scope and avoided acknowledging or responding to key questions in the enquiry. In some cases, the CSU staff member declines to pass on my follow up questions to their "primary care colleagues", who the CSU colleague appears to have become a gatekeeper to rather than a medium. An example of limited transparency is a request to know what commissioning decisions are being made by NHS NEL, following its decision to stop publishing primary care commissioning decisions	A2: We are committed to openness, accountability and transparency for the ICB, hence these board meetings are circulating around the seven place-based partnership bases. Being open, transparent and accountable are really important. The ICB and the integrated care partnership, established on 1 July last year, are not the same as the CCGs that went before. There are different responsibilities and accountabilities, and I am confident that we are meeting our legal and statutory responsibilities in this regard. We are not quite a year in yet, with more responsibilities and guidance coming through from our regulator. As part of our annual review we will be reflecting on a range of feedback to ensure that we adapt and develop our governance to ensure things are working well in line with our

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
				when it transformed from a CCG to an ICB in July 2022. The reason for not providing details of primary care commissioning decisions? "We are no longer required to by law". After several slightly vague responses to requests to release this uncontentious information, regardless of NHS NEL's legal obligations, I attempted to ask through FOI. The response that came back last week did not even acknowledge two of the four (clearly numbered) questions about decisions that have been made. The first time I submitted a list of questions to ask at a public board meeting last year it was suggested I communicate via the communications team instead. But following that first meeting, in attempting to obtain the statistics behind one of the board's responses (on ratios of GP to patient in each borough), I had to go through several more exchanges with the communications team and later FOI, before the source of the figures was clarified (and even then only partially). I am optimistic about the NHS NEL's potential in the face of some very serious challenges East London healthcare has, but I am concerned that in the few enquiries that I have made	principles. This goes for all of the processes we have in place for people to contact us with their questions and feedback.

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
				the responses appear to be to spin, delay or evade rather than acknowledge and answer directly. Is this approach appropriate for an NHS body? Does this display the commitment to transparency and accountability that the NHS pledges in its constitution?	
ICB-6	25 Jan 2023	20 Jan 2023	Patrick Morgan – Chair – Patient Participation Groups	Q1. Now that the CCG no longer exists, how does the ICB intend to include the patient voice, as represented by PPGs, at its meetings and decision making.'	A1. Since the ICB was set up in July 2022 we have been working on establishing our new arrangements and governance – this includes at a north east London level and through our seven place based partnerships and sub-committees. What is different to the CCGs before is that we are far more integrated between health and care – with Healthwatch and the voluntary and community sector very much embedded at a north east London level and within places. Patient Participation Groups (PPGs) have a really important role to play in improving local practice arrangements, but also within local neighbourhoods/primary care networks (PCNs) and there is lots more work underway to develop these. We can see real value in PPG leads coming together to share and discuss issues and ideas with neighbourhood staff/ leads/ colleagues. Waltham Forest colleagues across health, the local authority, voluntary and community sector (VCS) are working with Healthwatch and others to develop our local participation arrangements – with an ambition of far more co-production. You may have heard about the 'Big Conversation' plans which are going to provide a great opportunity this spring to

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
					discuss this in much more detail – including how residents, including PPG groups, get involved in local, borough and broader NEL wide issues. We understand you are in touch with our local engagement managers and will ensure we keep you informed as we develop our plans, informed by local people.
ICB-5	25 Jan 2023	13 Jan 2023	Sybil Ritten	Q1. Is this an official or unintended pathway? Is this a decision made by a clinician, an administrator or an algorithm?	A1. The ICB commissions services from NHS providers as well as independent sector providers for some diagnostic and treatment services. GPs should be able to discuss a choice of options with patients based on their condition and available provider. Many NHS providers continue to deal with the backlog caused by Covid-19 and consequently have long waits for appointments. This may mean the options available to patients on the electronic referral system (e-RS) to book appointments with any local provider are not always visible. There are a number of independent sector providers offering surgery in North East London, generally to people who are less complex in terms of procedures or other underlying health conditions.
				Q2. Shouldn't patients be made aware of being on this pathway and offered an NHS provider alternative?	A2. Patients should be able to discuss alternative providers with their GP and make an informed choice, this may include a discussion on how long the expected wait for appointment and surgery is at each provider.
				Q3. What is the waiting time for a patient who is directed to this pathway compared to an NHS pathway?	A3. Waiting times for surgery across NHS and independent sector providers vary across North East London. Independent sector providers often have shorter waiting times for some types of surgery.

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
				Q4. If patients are directed down this pathway, is there an audit of how many patients are being offered surgery? Q5. How are patient satisfaction and outcomes of surgery being monitored for NHS patients who are having consultation and surgery in the private sector? Q6. How is the provision of consultation and surgery by private providers being funded? For example, is this separately funded?	A4. The ICB has data that enables it to see how many patients are referred to independent sector providers and NHS providers. A5. The NEL ICB and its predecessors (the CCG) have contracts with independent sector providers that set out expectations on quality including patient satisfaction and outcomes. A6. This is funded from the NHS budget for services in NEL. The Independent Sector providers continue to be funded on a cost and volume basis.
ICB-4	25 Jan 2023	4 Jan 2023	Jan Savage - North East London Save Our NHS	Q1. How is access to patients' confidential data being governed so that the public can have confidence in how their personal data is being used? Q2. What committees, sub-committees and working groups concerned with the use and management of patients' data are in place or planned and what are their terms of reference?	A1. The question asks about the ICS but it is important to note that data controller responsibilities always rest with individual controller organisations and neither the ICB (this organisation) nor ICS (made up of partner organisations) can overrule this which is established in UK (General Data Protection Regulation (GDPR). Therefore, any intended purpose and lawful purpose for processing by the ICB or the ICS must be agreed by all relevant data controllers which will include undertaking a Data Protection Impact Assessment (DPIA) and this being scrutinised and agreed by all relevant controllers. A2. All healthcare organisations that provide direct care will have in place a Senior Information Risk Owner, a Caldicott Guardian and a Data Protection Officer. Typically, each organisation will manage intended use of patient's data via their Information Governance Steering Group (IGSG) and Audit and Risk Committees, although

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
					each organisation may manage these slightly differently. NEL ICB maintains an IGSG which meets monthly and this reviews DPIAs undertaken by the NEL Data Access Group (DAG) which is an ICS-wide group for reviewing NEL commissioned data processing across the region. The NEL IGSG reports to the NEL Audit and Risk Committee.
				Q3. What is the nature of patients' data that is made available to the Population Health programme? For example, does the use of personal data rely on implied consent?	A3. Our Population Health Plans do not intend to include the use of confidential personal data and only plans to utilise anonymised data and are therefore not subject to UK GDPR / Data Protection Act and do not intend to rely on consent or implied consent as a lawful basis. Confidential personal data would only ever be used for population health where there is a clear lawful basis to do so as described by UK GDPR.
				Q4. Who can access patients' data currently, and for what purpose?	A4. Each data controller (organisation) within the NEL ICS geography would need to respond to this question individually and NEL ICB would not be able to undertake this for them. Patient data may be available under national direction such as Secondary Uses Service for commissioning but these are under the direction of NHS Digital and are not set locally. Each data controller is required by law to publish privacy notices under UK GDPR which will define the purposes and lawful basis for processing confidential personal data and who that data is shared with and for what purpose and must include contact details for each controller to allow challenge and scrutiny of that processing.

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
				Q5. What action is NEL HCP taking to ensure that patient data security is in line with the recommendations made by the National Data Guardian and Chair of the UK Caldicott Guardian Council?	A5. North East London Health Care Partnership (ICS) is made up of various health and care organisations across the NEL geography and they are all nationally mandated to evidence a set of data processing requirements described in the NHSD Data Security and Protection Toolkit (DSPT). The DSPT incorporates the recommendations of the National Data Guardian in her 2016 report *"Review of Data Security, Consent and Opt-Outs"* which includes the use of the Cyber Essentials Plus accreditation.
ICB-3	25 Jan 2023	7 Dec 2022	Mary Burnett - Waltham Forest Save our NHS	Continuing Healthcare – Q1. How much is expected to be saved on operational efficiencies in Continuing Healthcare in 2022/23 and 2023/24 and what percentage of the overall Continuing Healthcare budget this is?	A1. For 2022/23 a -3% deduction was made for efficiency – which across an overall Adult continuing healthcare (CHC) Budget £112m amounted to £3.4m. For 2023/24 – we have had the planning guidance and the financial plans are still being worked on. Given this, we are not able to share further detail on this question at the moment in terms of CHC efficiencies expected, however, all NHS ICB budgets including CHC are being asked to achieve some QIPP/efficiency savings in 2023/24.
				Q2. What impact will those operational efficiencies have on patients who need Continuing Healthcare?	A2. Continuing Health Care (CHC) is a framework-based service where it is a statutory duty of the ICB to ensure that all assessed care needs of the patient are met. As there is no material change to the framework, we do not envisage any impact on the care provided to the fully eligible CHC patients. The operational efficiencies are part of ICB's commitment towards continuous improvement and are aimed at service improvements in terms of administrative processes to meet quality and efficiency standards. The efficiency targets applied to CHC

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
					are aimed at timely review of assessments and ensuring prices paid for care are managed effectively.
				Q3. What the combined (across all the previous 7 CCGs) budget for continuing healthcare was in 2021/22 and how many individual patients were supported from continuing healthcare?	A3. (1) The NEL CCG's Adult CHC Outturn for 2021/22 was £103.1m (2) The average number of patients per month was 1,240 patients (using the total closing number of patients each month/12months).
				Q4. What is the projected budget for NEL ICB for continuing healthcare for 2022/23 and for 2023/24 and how many individual patients is that budget projected to support in each year?	A4. (1) The NEL ICB Adult CHC Forecast for 2022/23 as at Month 8 is £144.1m (2) The average number of patients per month was 1228 patients (using the total closing number of patients each month/8 months) (3) As noted above, given the current planning timeline for this year we are unable to share the budget for CHC and the projected numbers of patients supported at this time.
				Health Inequalities – Q5. Which specific health inequalities does the ICB consider key for NE London?	A5. Health equity underpinning everything we do is a fundamental principle underpinning our work as an ICS and this was agreed by system stakeholders through a series of workshops led by our Chair, Marie Gabriel. Action to reduce health inequalities within NEL ICS is primarily led locally at place and neighbourhood level close to local communities, through partnership working across the NHS, local authorities, and the voluntary and community sector. Place based partnerships bring together key partners who know their communities best, can build on insights from their existing Joint Strategic Needs Assessments, to understand and improve health equity within their communities.

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
					For example, the recent work in Waltham Forest with Professor Sir Michael Marmot and the UCL Institute of Health Equity provides rich insights and recommendations, many of which are relevant for action across other parts of NEL. We are keen to learn from this more broadly across the ICS and we are discussing this within our NEL Population Health and Integration Committee. In NE London, our communities experience poorer than average health outcomes when compared to the rest of the country across many key indicators, including premature deaths from cardiovascular disease, healthy life expectancy for women, child obesity, low birth weight, children with dental decay and most vaccination and screening rates. Further, there exist significant health inequalities between our communities within NE London: between geographic areas, by deprivation, by protected characteristics such as ethnicity or living with a disability, or among people whose situation means they experience greater exclusion or vulnerability, for example refugees and people seeking asylum. Health inequalities are linked to wider social and economic inequalities. We tend to see poorer health outcomes among lower socioeconomic groups, and in areas with higher levels of deprivation – and this varies across NE London and intersects with other dimensions such as ethnicity and gender. There is a gradient in health outcomes by deprivation, meaning that most of the population and not only those groups experiencing the most extreme exclusion and vulnerability experience poorer health than they

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
					might otherwise do because of their life circumstances. This means that we cannot limit our approach to singling out particular groups – though this is necessarily part of the approach to ensure we address the health needs of the most vulnerable – but rather we need to take systematic action at every opportunity to reduce health inequalities across our entire population. The Core20Plus5 (national framework for ICSs to reduce healthcare inequalities) asks ICSs to focus on the most deprived 20% of areas nationally, as well as ICS-chosen 'plus' groups experiencing poorer-than-average healthcare access, experience and outcomes. Every part of the system has a part to play in reducing health inequalities. In general, places are better able to prioritise which groups experience health inequalities locally and action needed to best address these inequalities. Service providers should be considering the full range of potential health inequalities dimensions when planning and delivering services. However, there is an opportunity for us to set some system priorities for NEL to focus activity within a defined period across the system. Within the interim ICP strategy, based on data and insight and engagement, we have identified two priority dimensions for tackling health inequalities across NEL, and three priority underserved groups in NEL: Two priority dimensions Poverty – Nearly a quarter of our residents live in one of the most deprived 20% areas of England and more than 1 in 5 children in some boroughs

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
					live in poverty, with rates rising in nearly all places. People living in poverty experience poorer mental health, live in poorer quality housing and are less able to afford products and services that underpin good health. The recent pandemic and cost of living pressures bring additional challenges for our poorest residents and exacerbate existing health inequalities. Ethnicity – More than half of our population in NEL are from a minority ethnic background. The pandemic highlighted and widened inequalities between ethnic groups and evidence is clear that collecting ethnicity data, measuring and addressing ethnic disparities in healthcare access, experience and outcomes, and addressing racism and discrimination, are crucial to efforts to reduce health inequalities. Three priority groups People with learning disabilities and autistic people – We estimate that there are nearly 52,000 people in NEL with a learning disability. People with learning disabilities and autistic people have greater and more complex health needs and experience higher levels of unmet health need than the general population, and are more likely to face multiple barriers to accessing services. People with learning disabilities were 4.8 times more likely to die than those without during the first phase of the Covid-19 pandemic, in areas of NEL for which data were available. People experiencing homelessness – Housing is a key determinant of health, and homelessness and inadequate housing are significant and increasing problems across NEL. Mortality among

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
					people experiencing homelessness is around ten times higher than the rest of the population, yet many of these deaths are preventable. The homeless population face barriers to accessing health and social care services including stigma and discrimination and rigid eligibility criteria for services. Carers – A recent GLA survey estimated that 17% of our population in NEL provide informal care. Informal carers make a significant contribution to supporting the health of vulnerable people, yet evidence suggests that carers themselves are at risk of poor physical, mental and financial health outcomes. Whilst these are included in the interim ICP strategy, we will continue to consult on these and welcome feedback as we develop the full strategy over the coming months.
				Q6. What are the baseline KPIs for health inequalities from which the NEL ICB will measure its success in this area?	A6. We are currently developing a set of success measures for the system as part of the ICP strategy, which align with the Core20Plus5 national frameworks (adults and children and young people), key population health needs as identified by our NEL population health profile, and the four ICS priorities. This will support the system to collaborate around high impact actions to improve population health and reduce health inequalities, and enable the development of outcomes frameworks that can be used to measure success. There are a series of success measures in development for the four system priorities, and many of these are focused on reducing health

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
					inequalities within that priority area – for example, 'reduce prevalence of obesity and we will be smoke free by 2030' is a success measure within long term conditions. In addition to the specific health inequalities measures set out in relation to the four priorities, the draft success measures for reducing health inequalities are as follows: Across NE London we are reducing the difference in access, outcomes and experience with a focus on people from minority ethnic backgrounds, people with learning disabilities and autism, people who are homeless, people living in poverty or deprivation and for carers. Healthy life expectancy is improved across NE London and the gap between our most and least deprived areas/ those living in poverty and the wealthiest is reduced. We have improved ethnicity data collection and recording across health and care services and deliver inclusive, culturally competent and trusted health and care services to our population. Our staff have access to training on health inequalities and we routinely measure and address equity in NHS waiting lists. We are mitigating against digital exclusion. Tackle racism and increase cultural competence and cultural awareness in services. We acknowledge that there is more work to do to develop these into measurable KPIs, and we continue to welcome feedback in developing the full strategy and our work on health inequalities.

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
ICB-2	30 Nov 2022	25 Nov 2022	Josh Mellor - Local Democracy Reporter - Waltham Forest, Redbridge, Havering	Q1. In layman's terms, what exactly is ICB's role in healthcare in east London?	A1. Please see the information here on our website. There is also a helpful summary from the King's Fund about the new health and care system arrangements, including the role of an ICB here.
				Q2. North east London (particularly the outer boroughs) suffer from a disproportionately low ratio of GPs and nurses compared to other parts of London, does the ICB see this as an urgent issue and what actions have the ICB's previous bodies taken and what does the ICB plan to take to address this in the short to medium term?	A2. The data provided shows the ratio of GPs per 100,000 population for London is 51 which compares to an average of 59 for north east London. There is a variation between our boroughs across the system and the ICB recognises the ratio of GPs is an issue that needs to be addressed collectively as a system. In regard to the London ratio of nurses, the data shows the ratio is 15 per 100,000 population which is the same for north east London. The ICB is committed to increasing the number of GPs in north east London and the target that has been agreed is at least a ratio of 44 per 100,000 in all of our neighbourhoods by 2025.
				Q3. Access to face-to-face appointments and the "telephone triage" of patients by receptionists who appear not to have any medical qualifications is a widespread concern for residents, what is the ICB's policy on access to face-to-face appointments and what oversight does it have on the policy region-wide?	A3. Face to face appointments can be delivered in a variety of ways depending on the need, including phone, video and face-to-face. Across north east London approximately 65% of appointments are face to face and appointments are provided in the most appropriate way, depending on need. The role of the receptionist is not a clinical role; however, they will try to get the patient to see the most appropriate healthcare professional within the multi-disciplinary team in the practice. There isn't a universal approach to the role of receptionist, as it will depend on each individual practice. Practices are focusing upon the multi-disciplinary role of their team but if patients are unhappy with the response they

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
					receive from the receptionist they can complain to the practice manager in the first instance. The ICB does not have an explicit role in the oversight of the role of receptionists, it is determined by GPs as independent providers and employers. The north east London training hub has developed various training support programmes which are offered to practice staff and we are keen to continue working with residents and Healthwatch to address any future concerns.
				Q4. CAMHS (child and adolescent mental health services) and AMHS patients are waiting a year or more for treatment in east London, a number of inquests have and will touch on this issue and BHRUT's chief executive has raised this concern as affecting his hospitals, is this issue viewed as urgent and how is it being addressed in the short term?	A4. NELFT closely monitors all waiting times for services as part of our monitoring of patient experience and ensuring patients are safe. In regard to access to adult mental health (MH) services we have access points via our talking therapy services and access teams where we have a 2 targets routine (access in 6 weeks) and urgent (access in 48 hours). Breaches of this are monitored monthly and there is no current evidence of breaches. Once accessing these entry points there may be secondary waits where patients have been assessed for planned care secondary care specialist psychological pathways but should there be any urgent / crisis issues these will be supported. Each patient will have a crisis plan and access to crisis support via MHS Direct. Any crisis contact will precipitate crisis pathway services if they are required. Regarding CAMHS services - we monitor the access and assessment to treatment for all services. This monitoring does not show that we are breaching our access and assessment targets which are based on presenting clinical need. The

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
					data does support increasing demand but does not indicate delays in access and assessment. We are also working with partners to deliver more mental health services in schools.
				Q5. The accounts deficit at the start of NEL ICB's life is significant and there appears to be a savings and efficiency plan, what services are facing savings and efficiencies and what are the consequences of failing to close the budget gap by the end of the financial year?	A5. The ICB is looking to find efficiencies across all areas of its variable expenditure. This includes tighter recruitment controls on agency expenditure, and operational efficiencies in areas including continuing health care (CHC) and prescribing. It is not looking at reductions in service, but focusing on the most effective ways to use its resources and additional winter funds for the remainder of the year. In addition, it will look to find any additional non-recurrent savings. NHS England has published its protocol on how any variations to ICB and Trust plans will be managed.
				Q6. Is the limited amount of access to NHS dentistry a concern for the ICB and what measures will it be taking to ensure all eligible residents are able to sign up for and receive dentistry services as soon as needed?	A6. NHS Dentistry is currently commissioned by NHS England, but will be delegated to the ICB from 1 April 23. This will give greater opportunities for NEL to build on work currently being undertaken to address access to dental services. Areas of work being undertaken to improve access to dental services are outlined below: • 3-year road map for recovery of Dental Services, following disruption caused by the Pandemic • Dental Access sessions commissioned from 2023 – 2025 to stabilise as many patients as possible to prevent inappropriate A&E and GP. • Ensuring priority for high-risk patients and those in pain to be seen as soon as possible within NHS Dental Services.

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
					• Re-procurement of contracts that have been handed back to NHSE during the last 12 months. • Supporting pilot programmes to deliver access and prevention to priority and inclusion health groups in support of the reduction of health inequalities.
ICB-1	28 Sep 2022	23 Sep 2022	Mary Burnett -Waltham Forest Save our NHS	Q1. ICB's Financial Plans a) Has the ICB sought advice from a Consultancy when formulating its Financial Plans, either for 2022/23 or for the longer term? b) If so, which Consultancy? c) How were they appointed? d) What was the specification for their work for the ICB? e) What reduction on total forecast expenditure by NHS Providers did they suggest? Q2. Management Consultancy Contracts a) Please list all Management Consultancy contracts concerning NHS provision in the ICB area that have been active during the last 12 months or are set to take place over the next 12 months. b) Which of these have been arranged through the Health Systems Support Framework?	A1. a) The ICB has not engaged consultants to help formulate the 2022/23 financial plans, and will use its internal resources in developing its longer-term plans. b) N/A as per answer given under a) c) N/A. Generally, where consultants are commissioned, they are framework providers invited to respond to specific tendered pieces of work. d) N/A as per answer given under a) e) N/A as per answer given under a) A2. a)The ICB publishes information here on the public facing website which shows the details of all signed contracts, including management consultancy contracts, and invoices paid. b) The ICB has not yet used the new national Health Systems Support Framework that has been introduced but does use a similar national framework.