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-24	29 July 2026	23 July 2026	Mary Burnett on behalf of NEL Save Our NHS	A series of supplementary questions regarding Health Navigator were submitted following the response to the questions outlined in ICB-23.	Due to the length of the responses, the full questions and responses can be found at the following link https://northeastlondon.icb.nhs.uk/wp-content/uploads/2026/09/Questions-from-the-public_supplementary-questions-regarding-Health-Navigator.pdf
ICB-23	11 June 2026	7 June 2026	Mary Burnett on behalf of NEL Save Our NHS	**Q1:** The Introductory Letter from the ICB to patients about the Clinical Coaching Programme is signed off by the ICB's Chief Medical Officer. It invites patients who have questions, or who do not wish to be contacted, to "contact us". Yet the contact information given is that of the provider, Health Navigator, not the ICB. What is the Board's response to this misrepresentation and how will it address this? **Q2:** As we understand it, Health Navigator developed a prediction model that it uses to initially identify those who might benefit from coaching. Its coaches then manually screen these patients against EPR data to check suitability for the coaching programme. What limits are there on the data that HN – and its coaches - can access and how is personal information protected? Please supply a copy of the Data	**A1:** The Board recognises the importance of clarity and transparency in patient communications, particularly where roles and responsibilities between organisations are concerned. The invitation letter was intentionally issued under the ICB's name, as the service is commissioned within the NHS and patients are more likely to recognise and trust communication originating from their local NHS organisation. Health Navigator, as the delivery partner, is responsible for operational delivery and day-to-day patient engagement. Contact details for Health Navigator were therefore included to ensure that patients could quickly access timely support, ask questions about the coaching service, or opt out without delay. Where queries relate more appropriately to the ICB, these are redirected and managed in collaboration with the ICB. We recognise that the current wording could be clearer in distinguishing between the roles of the ICB and Health Navigator. We will work together

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				Sharing Agreement between Health Navigator and the ICB. **Q3:** HN states that patients can opt out of their data being combined or shared by letting HN know, and they will then inform the NHS not to share patient data with them. However, this is after patients' data has already been shared with HN. On what basis does the Board believe it is appropriate to provide HN with patients' names and details before notifying patients themselves that their data may be shared with a private company and before providing patients with the opportunity and information to opt out? **Q4:** Most patients will not be aware that a privacy notice is legally required under the GDPR when personal data is collected or used. HN's invitation for coaching makes no mention of its privacy notice - the notice can only be found by those specifically searching for it on the HN website. This means that invited patients will not be fully informed of their rights. Given the Board's responsibility for ensuring the privacy and confidentiality of patient data, how does the Board intend to address this omission? **Q5:** HN's privacy notice says that the de-identified data it holds for coaching and reporting purposes may be shared outside HN-company. Please confirm that HN will only be sharing patients'	to review and refine the wording of the letter so that it more explicitly reflects this partnership and ensures patients can easily understand who to contact for different types of queries. Oversight of communications and service delivery is supported through regular joint governance forum, the delivery group, ensuring that materials remain accurate, transparent, and patient-centred. **A2:** This stage of the process was reviewed and approved as part of the CAG Section 251 application, and has been carried out with ICB oversight. Health Navigator Clinical Coaches access patient information via the London Shared Care Record for the purpose of screening patients for eligibility and suitability for the coaching programme. Coaches only access records for patients identified through EMIS and search for patients using their NHS number. They review only the information necessary to determine eligibility and support safe participation in the service. All Clinical Coaches are registered healthcare professionals and are bound by professional, legal and contractual duties of confidentiality. They have a responsibility to ensure that access to patient records is limited to legitimate, authorised purposes. **A3:** Since the inception of health navigator programme there has been the ability for patients to opt out has been promoted in GP practice at least 6 weeks in advance of the programme. So, a patient can opt out before any data is shared. Patients can opt out at any stage of the process and this was a requirement stipulated in the Health Navigator Section 251.

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				de-identified NHS data with the ICB and no other party.	The data shared with health navigator, is de-identified, this means there are no names, addresses are present in the data. Indeed, the ICB does not retain any identifiable data. The de-identified is processed under section 251 approval and the level of risk determined through the development of algorithms. It is only at the point when a patient's risk is deemed actionable that health navigator will request the reidentification of a patient record. This request is made with patient direct care in mind for the purposes of inviting a patient to a coaching session. The identified data is then used to search the patients EPR record to assess a patient's suitability for coaching at this stage, for example a patient may be pregnant, receiving palliative care, this means patient are not considered amenable to the coaching service. At any point in the process the patient can opt out of health navigator data sharing, a patient opting out will initiate a deletion process and will prevent any further contact. **A4:** We recognise the importance of ensuring patients are appropriately informed about how their data is used and their rights under GDPR. Health Navigator has implemented a number of measures to support transparency. A patient data leaflet is included with the initial invitation letter, clearly explaining how personal data will be used before any contact is made. This material was reviewed through PPIE processes and approved as part of the CAG Section 251 application prior to implementation. In addition, a full privacy notice is provided directly to patients as part of the onboarding documentation, and is also available via the

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					Health Navigator website (hnclinical.com) in a patient-friendly format. All materials have been developed to ensure accessibility and clarity. We welcome the opportunity to strengthen this further and are happy to make the reference to the privacy notice more explicit within the invitation letter and/or supporting leaflet, ensuring patients can more easily access this information at the earliest stage. We will also continue to work with GP practices and clinical coaches to ensure that any patient queries about data use and privacy are appropriately addressed during interactions. **A5:** Health Navigator can confirm that patient data is only shared in a de-identified form and solely for purposes directly related to the delivery, evaluation, and oversight of the programme. As part of the agreed programme of work, de-identified data is shared with the ICB and with appointed evaluation partners, including Lane Clark & Peacock (LCP) and The Healthcare Improvement Studies Institute. These organisations are supporting an independent evaluation to assess whether patients receiving coaching experience improved outcomes compared to similar cohorts. All data sharing arrangements are governed by formal data sharing agreements and are conducted in compliance with the CAG Section 251 approval, GDPR requirements, and the agreed Information Governance frameworks. No data is shared for purposes outside of programme delivery, evaluation, and contractual oversight. Patients are informed of how their data may be used through the programme's patient materials,

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					and all processing is undertaken in line with these commitments.
ICB-22	31 March 2026	18 March 2026	Bren McInerney	**Q1:** In light of the series of community-led conversations held across multiple areas aimed at enabling NHS leaders to listen directly to what matters most to local communities, how will the Board use the learning gathered from these conversations, what actions will follow, and how will the board communicate outcomes and accountability back to the residents and communities who had given their time and trust to participate?	**A1:** Ensuring that our end-of-life strategy focuses on providing care in people's homes rather than care homes: Our focus is on offering choice to local residents and enabling people to die in their place of choice, which may be their home. For some people, we need to acknowledge that their home is a care home. For some other people, their choice is to die in a hospice or in a hospital. This may be to do with the impact they feel their passing may have on other family members, whether care can be appropriately provided at home and whether there is space available. A major strand of our end of life work is improving access to community based end of life care across north east London. We have worked closely with a community advisory group to build in their perspective to our approach which is now being tested in Waltham Forest and we have also worked on the delivery of bereavement services, information about the progress of illnesses and conditions and joined up carers' work with local authorities for example. We are also working to promote use of the Universal Care Plan which ensures people's wishes are identified, captured and respected at all ages and stages. Clarity on our strategy for involving local community groups and residents in strategic commissioning, how we will work with them to respond and account to them on progress: Involving local community groups and residents is an integral part of our commissioning cycle and

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					our ambition is set out in our Strategic Commissioning Framework. In summary, we recognise we need to maintain a range of ways to involve local people. We look for demonstration of engagement with users, residents and community groups through the services we commission. We have established community advisory groups to gather input to identified pathway development, have ensured dedicated capacity in our new structure despite the 50% reduction in headcount and have continued to support provider collaboratives which are close to users of their services. We continue to invest in the Voluntary, Community, Faith and Social Enterprise Sector (VCFSE) collaborative, recognising the wide reach and expertise in engagement held by the sector. We are working on a refresh of our Working with People and Communities Strategy in light of our enhanced strategic commissioning role, having made significant progress in strengthening community leadership, building awareness of health literacy, implementing a reward and recognition scheme, growing our People's Panel and investing in the Community Insights System to ensure parity with other data insights. <u>Improved communication with residents, particularly with changes to Healthwatch:</u> Maintaining strong communication with residents remains a core area of focus, particularly important in light of the many changes being delivered across the health and care landscape. We are working closely with our 8 local HealthWatches and keeping a close eye on any

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					information about next steps. We have retained a communications function and an engagement function in our new structure and are committed to clear communications with local residents on the issues which matter most to them. Sustainable funding to engage diverse communities in consultation and longer term funding to deliver health and wellness services: In light of the NHS 10 year health plan, we are growing a transformation fund, which for the financial year 2026 – 2027 comes to £42m. Through this pot, we have for example made funding available to develop neighbourhood health, to deliver earlier intervention in long term conditions and to enable care closer to home, all of which have a facet of community engagement and shifting funding over time to community and to prevention. In addition, we have retained our commitment to Health Inequalities Funding – the evaluation of our current allocation approach, by a partnership of two academic institutions will report in due course with recommendations for how we best allocate funding in the future for optimal benefit in addressing health inequalities. We have also retained our commitment to funding the VCFSE Collaborative and to investment in the Community Insights System. Involvement of the community sector and residents in innovation, research and development: We are aware of some strong models for involvement of the community sector and residents in innovation, research and development both nationally and more locally, for

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					example in Tower Hamlets, on which we are keen to build. We have good and developing relationships with a range of academic institutions which are increasingly recognising the huge diversity of north east London and the opportunity this poses for research and innovation, working collaboratively with local communities to build on their insight and experience. We see community-based research as vitally important in making further progress with priority areas such as neighbourhood health. Building on the work of the Voluntary, Community, Faith and Social Enterprise Collaborative, through an agreement to improve joint work with the community sector and residents at neighbourhood and place level: We have committed to continued funding of the VCFSE Collaborative which we believe is a critical vehicle for joint working across the sector and the NHS. Work on a strategic approach for joint working, including a focus on the ICB's model for commissioning the sector is well advanced and being refined. Consideration on how the ICB can be an advocate of residents in its commissioning decisions: We believe that in our strategic commissioning role we need to ensure the voice of residents is heard and responded to through the commissioning cycle. We recognise the specific role of advocacy and believe that whilst it may be appropriate to fund advocacy services it is not our role to act as the advocate of residents in our commissioning decisions.

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
ICB-21	29 January 2026	26 January 2026	Sana Yusuf on behalf of East London Healthcare Workers for a Free Palestine.	**Q1:** Over 500 people local to the area covered by the ICB signed a letter sent to the executive team urging them not to implement the Federated Data Platform (FDP) locally and to pause any future rollout. The FDP is supplied by Palantir. Palantir is an American company that has a long history of using its technology to facilitate human rights abuses across the world, and multiple groups have come out in opposition to the company being deemed a suitable partner for the NHS. Many medical and data ethics experts have also voiced alarm at the supposed safeguards put in place to protect patient data within the FDP. Despite this and despite its adoption not being mandated by NHS England the interim chief exec's response to the letter signed by NHS workers, patients and social care workers was simply to ensure that the FDP would be implemented safely and appropriately with no response to the ethical concerns raised. With this in mind, East London Healthcare Workers for a Free Palestine would like to ask how the ICB intends to evaluate the ethical considerations of inclusion of the FDP within local health data infrastructure in	**A1:** The NHS uses data every day to manage patient care and plan services, and the NHS Federated Data Platform (FDP) is intended by NHS England (NHSE) to create a common data infrastructure that can securely bring together information from hospital health records, waiting lists, and theatre and staff rosters, to better manage patient care. While implementation of the FDP is not formally mandated, ICBs are being asked and encouraged to use it; it is worth noting that in issued planning guidance for 2026/2027 and the recently published Strategic Commissioning Framework (in late October/ early November respectively), the guidance indicates that FDP will be the location of tools such as segmentation and a strategic commissioning tool. Equally, several NHS England dashboards are hosted on using the FDP to monitor and manage ICB performance and the FDP is the only official source of immunisation and vaccination uptake monitoring. NHSE ran an independent and transparent procurement exercise in line with public contract regulations. A consortium, led by Palantir, was awarded the contract to deliver the NHS Federated Data Platform in November 2023. NHSE is confident that its procurement process did not enable any supplier that does not meet the strict standard selection criteria (which includes mandatory and discretionary exclusions relating to illegal activity, social and environmental breaches) and robust Information Governance requirements to continue through the process. Access to NHS health and social care data within the NHS Federated Data Platforms will be

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
				a way that's actually responsive to patient & staff concerns? We note that at the last board meeting board members set out a commitment to principals which were about co-production and including the community in decisions, how does proceeding with FDP in the face of these significant community concerns fit into these principles?	carefully controlled. Only authorised users will be granted access to data for approved purposes. The contract has strict stipulations about confidentiality, and there is governance in place to monitor delivery and usage of the NHS FDP. Palantir only operate under the instruction of the NHS when processing data on the platform. Palantir do not control the data in the platform, nor are they permitted to access, use or share it for their own purposes. NHSE has made a clear statement on privacy and data protection which is available on its website. Within north east London we are committed as a system to work together on the safe and appropriate implementation of the FDP.
ICB-20	25 September 2025	22 September 2025	Raminta Diliso on behalf of GamCare	**Q1:** Given the well-established links between gambling harms and mental health issues such as anxiety, depression and suicidality, could the Board outline how they will use the funds from the new statutory gambling levy to ensure that people experiencing gambling harms can access gambling support and treatment?	**A1:** Thank you for the question raising the important issue of the links between gambling and harms such as anxiety, depression and suicidal ideation. Whilst guidance is available from the Gambling Commission on the calculation and collection of the levy, we – and local government public health colleagues with whom we have discussed this – have had limited information of the distribution of the levy across the three domains identified for funding: research, prevention and treatment. Our understanding is that the Commission will manage the distribution of the statutory levy throughout Great Britain. This will be managed under the strategic guidance of the government to support research, prevention and treatment of gambling-related harm.

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
					Research 20% of the funding will be allocated to research and innovation for the establishment of a bespoke Research Programme on Gambling. Also, the Commission will direct further research in line with its licensing objectives, taking into account its current Evidence Gap and Priorities. Prevention 30% of the funding will be allocated to developing a comprehensive prevention strategy across Great Britain. The government will appoint a lead commissioning body based on a thorough review of the available evidence. Treatment 50% of the funding will go to NHS England and appropriate bodies in Scotland and Wales to commission treatment and support services for gambling-related harms, including those in the third sector. We in the ICB have not had notification of how funding for treatment for gambling harms will be distributed by NHS England. It is worth noting that operators are required to make their first statutory levy payments by 1 October 2025.
ICB-19	14 May 2025	24 April 2025	Steve Meadows	**Q1:** The NHS 2025/2026 Priorities & Operational Planning Guidance states Integrated Care Boards and providers must make full use of the consolidated supplier frameworks agreed through NHS Supply Chain optimising medicines value and improving the adoption of and compliance with best value frameworks in medicine and procurement. Which NHS Supply Chain	**A1:** NHS Supply Chain is primarily used to procure products such as equipment, consumables, food and office solutions offering access to hundreds of frameworks. NHS providers typically choose a framework based on the product category, specific requirements, value for money, and other relevant considerations. In the same way, the ICB adopts a similar approach—selecting the most appropriate framework to meet

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
				Frameworks will the ICB and its providers be prioritising to show projected savings in implementing the planning guidance?	procurement needs, ensure compliance, and achieve value for money.
ICB-18	29 January 2025	27 January 2025	Paul	**Q1:** Patients have been advised that the Upminster Medical Centre will close in August and patients moved to Rainham Health Centre. This will be too far for many patients to travel so are there any other plans to ensure all patients have ease of access to GP services?	**A1:** Upminster Medical Practice in St. Marys Lane, Upminster is a branch site of Rainham Medical Centre. A number of safety concerns were reported to the owner of the building who has now advised us that due to the significant cost of bringing the building up to standard, they will not be undertaking any repairs. To ensure the safety of both patients and staff, we are now working to move services out of this building as of 29 August 2025 and will be consolidating the practice at the main practice site at Rainham Health Centre site in Upminster Road South, Rainham. Registered patients will continue to receive care and support from this site. We recognise that any changes to GP provision can be unsettling and assure you that this decision has been taken with the practice in the best interests of patients, staff and the practices ability to ensure patient safety and quality care. The ICB will be working closely with PPG members and the practice team to make sure that registered patients are informed about any changes and understand the options available to them if they wish to register with another practice that is closer to home. The ICB have sent direct letters to all registered patients with information about the closure and details of several practices that are accepting new

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
					patients within one mile of Upminster Medical Centre. If patients require support with registering, they can speak to the practice team at the practice they wish to register with.
ICB-17	29 January 2025	24 January 2025	Paul	**Q1:** Why do north east London patients have to wait a long time in emergency departments, when brought in via ambulance, and cannot go to Essex hospitals when Essex patients can come into north east London hospitals via ambulance? Is there any investment going into Queens Hospital to accommodate the out-of-area patients and to improve A&E waiting times?	**A1:** In North East London we, as do a number of trusts in London and across the country, have long waits in our emergency departments for patients which relate to both ambulance and non-ambulance attendances. Our longest waits have seen reduction since November 2024 from 25 to 5 patients (80%) in early January 2025. We continue to work with system partners each day to pro-actively manage and optimise patient flow support pathways and reduce waits across ED. This is against a background of increased activity, with our hospitals seeing 6.7% (or 6235) more patients than December 2023, and continued to see 75.10% of patients within 4 hours, which includes 3.7% more patients within 4 hours despite the pressure. We do see activity into our NEL hospitals from Essex and other areas via ambulance, which may be related to designated pathways, or from where the ambulance picked up the patient. We have strong partnership working across our systems through our system coordination centres and providers, and work to repatriate patients back into their home areas as soon as possible.

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
					Our hospital services are funded through the NHS North East London, and we continue to work with Places and the ICB to support improvement and a partnership approach to meet the needs of our populations and timely care.
ICB-16	29 January 2025	23 January 2025	David Lee	**Q1:** How does the Board assure itself that (a) it is compliant with its legal obligations in relation to continuing healthcare[1], (b) its CHC arrangements are robust and (c) whether there is any performance monitoring in place to provide such assurance. **Background** • The ICB still has no CHC policy in place and has issued no timescale for the publication of the policy. • In addition, no CHC appeals disputes policy is in place. This leaves people seeking CHC in a wholly invidious and unfair position. • In the absence of a policy ICB officers appear to be operating outside of the National Framework. Page 143 of the National Framework	A1: **How does the Board assure itself that (a) it is compliant with its legal obligations in relation to continuing healthcare[1],** The ICB holds regular internal CHC review meetings to review its CHC performance. The Quality Safety and Improvement Committee (QSIC), a subcommittee of the Board, oversees quality issues and strategic risks, receiving regular reports on CHC. QSIC provides an exception report to the ICB board. Additionally, CHC services are included in our 2024/2025 internal audit programme, with assurance provided through the audit and risk committee, which is also a subcommittee of the ICB board. **(b) its CHC arrangements are robust and** Through the processes described above **(c) whether there is any performance monitoring in place to provide such assurance.** CHC performance data is collected monthly, with corrective actions implemented as required under the oversight of the directorate of nursing and quality. A comprehensive quarterly report is reviewed with the ICB executive lead and NHS England to monitor performance, identify

[1] The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, Part 6 : Standing Rules NHS Continuing Healthcare
[1]

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
				guidelines para 32.3 states: "If practitioners are unable to reach agreement, the higher level should be accepted." The Decision Support Tool also makes this clear (page 8 paragraph 25): *"If… it proves difficult to decide or agree on the level,* the MDT should choose the higher of the levels." Despite this ICB officers are issuing CHC decisions based on the lowest level of scoring at the MDT rather than the highest, cynically downgrading scores that they had agreed at the DST without offering any rationale or justification. **Timescales:** Para 182 of the National Framework states "It is expected that ICBs will normally respond to MDT recommendations within 48 hours (two working days), and that the overall assessment and eligibility decision-making process should, in most cases, not exceed 28 calendar days from the date that the ICB receives the positive Checklist." Case example: • DST meeting early July 2024;	mitigations, and implement necessary improvements. All CHC performance monitoring since 2017, is accessible to the public on the NHS England website. https://www.england.nhs.uk/statistics/statistical-work-areas/nhs-chc-fnc/ Statistics » Continuing Healthcare and NHS-funded Nursing Care **The ICB still has no CHC policy in place and has issued no timescale for the publication of the policy.** The ICB Continuing Healthcare service currently follows the revised 2022 National Framework which sets out the principles and processes of NHS Continuing Healthcare and NHS-funded Nursing Care. This document operationalises the NHS Continuing Healthcare legislation; The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, Part 6: Standing Rules NHS Continuing Healthcare. We acknowledge that on occasion, the CHC Assessment process does exceed 28 days. When this occurs, a plan of recovery is put in place. **In addition, no CHC appeals disputes policy is in place. This leaves people seeking CHC in a wholly invidious and unfair position**. The appeals policy and the dispute policy serve different purposes within the context of Continuing Healthcare (CHC) decisions. The appeals policy applies when a patient or their family disagrees with a CHC eligibility decision.

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
				• MDT meeting mid-September 2024; • decision letter issued early December 2024, without details of scoring; • scoring details shared in January 2025, with date of local resolution meeting offered in May 2025. At the same time the appellant is given 10 days to review the details in the 60-page DST document and submit their appeal. Are Board members content that this is being done in their name?	The ICB has an internal appeals policy, ratified by the Quality, Safety, and Improvement Committee in November 2023, which ensures that staff follow the correct process. If a patient or their nominated representative is not satisfied with the CHC decision the CHC team arrange a Local Resolution Meeting (LRM) with them to address the concerns raised. If the matter is not resolved at this stage, the family is advised of their right to escalate the appeal to NHS England for an Independent Review Panel. They must notify the ICB of their intention to appeal within six months of the eligibility decision date stated in their outcome letter. The dispute policy, in contrast, refers to disagreements between organisations, most commonly between the Local Authority and the ICB. This process is separate from the appeals process and follows a different resolution pathway designed to manage disputes between agencies rather than individual patient appeals. While we cannot comment on individual cases, we acknowledge that the case referenced in the correspondence does not meet the expected timeline standards. We are committed to ensuring that all patients receive timely responses and outcomes. Should the individual wish to request a detailed review of their case, we will facilitate this with their consent.
ICB-15	29 January 2025	17 January 2025	Bianca Linhares-Huang and Syed Abrar	**Q1:** As the adoption of AI continues to shape the delivery of mental healthcare, what is the ICB's approach to leveraging these tools to enhance outcomes, improve efficiency, and	**A1:** Artificial intelligence (AI) is at a critical point of being adopted by the NHS. Its use is being extensively piloted in healthcare for tasks such as: • faster and more accurate diagnosis

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
				ensure equitable access to services? Additionally, if you are a third-party that is able to support the ICB's strategy and priorities, who would be the best person to contact regarding this matter in the first instance?	• reduction of errors caused by human fatigue • to assist with or automate repetitive tasks • decrease costs • reduce mortality rates In other industries AI is already used widely, e.g. in facial recognition software on consumer devices, virtual assistants, and algorithms that provide results used in search engines and social media platforms. It promises many benefits to healthcare, such as helping with the complex decision-making and analysing the huge amounts of data being generated by digital health devices (DHTs). Artificial Intelligence (AI) has the potential to give health and social care practitioners back "time to care" by removing time consuming repetitive tasks that could easily be automated. This also has the potential for further democratisation of healthcare to patients themselves by providing them with information directly. To achieve its potential, AI must be developed in a regulated way, and as a collaboration between clinicians, software engineers, data scientists and product designers. The early challenges include gathering enough good-quality data to build models, understanding the information governance surrounding this and developing proof of concept of AI tools. As these initial challenges are overcome other factors will grow in importance such as workflow integration,

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
					demonstrating evidence of real-world clinical effectiveness and providing ongoing safety. This technology presents a need to change the way health and social care practitioners are trained and educated to make best use of it to capitalise on the opportunities presented. Questions from third parties can be directed to our Chief Information Officer, Niall Canavan.
ICB-14	25 September 2024	23 September 2024	John Ollett	Q1: Obesity is one of the largest problems facing the NHS. As a patient that is obese and now has type II diabetes as a result, I am a prime candidate for the new Semaglutide (and upcoming Tirzepatide) drugs to aid weight loss. But my GP will not prescribe them for either weight loss or diabetes because they have not been approved by the Board. Why have these not been approved despite the NICE guidelines and what is the timescale?	A1: Thank you for your question asking about the availability of Semaglutide and Tirzepatide in north east London. Semaglutide is recommended by NICE as a treatment option for weight management, where it is offered alongside a reduced calorie diet and increased physical activity in adults as part of a dedicated service, under the management of specialist weight management teams only. These specialist weight management services are not currently available in North East London, therefore this medication is not yet available to be prescribed locally. NEL ICB is actively exploring ways of providing specialist weight management services for the residents of north east London and when these become available, we will be in a position to provide an update about Semaglutide availability. Tirzepatide is available as a treatment option for people with type 2 diabetes who meet certain criteria, as recommended by NICE. Evidence for its place in weight management therapy is currently being reviewed by NICE. They have not yet said when to expect their final decision. Therefore, currently Tirzepatide is not

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
					recommended as part of weight management therapy. Please discuss the options available to you with your GP Practice. This could include referral to a dietician, health coach, social prescriber, a community weight management service or a combination of these services depending on your specific clinical situation.
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.

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
					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.
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:	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

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
				• 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 • 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.	https://northeastlondon.icb.nhs.uk/our-organisation/our-board/questions-from-members-of-the-public/. 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	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

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
				ensuring that individuals are given privacy information (such as why their data is being collected and who it will be 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	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 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
				processes are in place across the ICS for the proper collection and processing 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

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
					Selection Regime, which was only introduced in January 24, gives commissioners greater flexibility 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	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

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
				processes and thus the integrity of the data that the ICB uses. 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	ensure that data is recorded appropriately stored and managed safely and only used for appropriate 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
				processing/privacy notices and that these notices are comprehensible to the 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*

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
					of Inflammatory Bowel Disease (IBD) or non-IBD (including Irritable Bowel Syndrome) in children 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,	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

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
				following its decision to stop publishing primary care commissioning decisions 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	that we adapt and develop our governance to ensure things are working well in line with our 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
				healthcare has, but I am concerned that in the few enquiries that I have made 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

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
					about the 'Big Conversation' plans which are going to provide a great opportunity this spring to 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

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
					have shorter waiting times for some types of surgery.
				Q4. If patients are directed down this pathway, is there an audit of how many patients are being offered surgery?	A4. The ICB has data that enables it to see how many patients are referred to independent sector providers and NHS providers.
				Q5. How are patient satisfaction and outcomes of surgery being monitored for NHS patients who are having consultation and surgery in the private sector?	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.
				Q6. How is the provision of consultation and surgery by private providers being funded? For example, is this separately funded?	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?	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.
				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?	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

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
					their Information Governance Steering Group (IGSG) and Audit and Risk Committees, although 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

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
					include contact details for each controller to allow challenge and scrutiny of that processing.
				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

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
					improvements in terms of administrative processes to meet quality and efficiency standards. The efficiency targets applied to CHC 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

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
					best, can build on insights from their existing Joint Strategic Needs Assessments, to understand and improve health equity within their communities. 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

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
					the population and not only those groups experiencing the most extreme exclusion and vulnerability experience poorer health than they 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

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
					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 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.

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
					People experiencing homelessness – Housing is a key determinant of health, and homelessness and inadequate housing are significant and increasing problems across NEL. Mortality among 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

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
					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 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.

Reference	Meeting date	Submitted date	Submitted by	Question	Answer
					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.
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

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					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 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.

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					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 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

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					• 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. • 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.	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.

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				b) Which of these have been arranged through the Health Systems Support Framework?	