NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Primary Care Commissioning & Assurance Committee - Meeting held in Public

The focus of this committee is to seek assurance on the commissioning of primary medical services for the people of Bedfordshire, Luton and Milton Keynes. It has oversight of the decision-making processes and will challenge and assess and ensure that any risks are appropriately managed with the controls and mitigations in place to do so.

Date: 17 March 2023
Time: 1445-1700
Venue: MSTeams

Agenda

No.	Agenda Item	Lead	Purpose	Time
	Opening Actions			
1.	Welcome, Introductions and Apologies	Alison Borrett Chair		1445-1455
2.	Core Purposes of Integrated Care Systems: • **improve outcomes** in population health and healthcare • **tackle inequalities** in outcomes, experience and access • **enhance productivity** and value for money • help the NHS support broader **social economic development** •	Chair		
3.	Relevant Persons Disclosure of Interests • Register of Interests	Chair	Note changes and approve	
4. 4.1 4.2	Approval of Minutes and Matters Arising Minutes 9th December 2022 Minutes Extraordinary Meeting 11th January 2023		 Approve Approve	
5.	Review of Action Tracker		Note changes and approve	
6.	Questions from the Public	Chair		
	Strategy & Integration - Assurance			
7.	Transition of Delegated Community Pharmacy, Optometry and Dental (POD) contracts to the ICB	Liz Eckert Programme Lead POD Transition	Approve / Note	1455-1520

No.	Agenda Item	Lead	Purpose	Time
	BLMK Fuller Programme			
8.	BLMK Fuller Programme - progress update	Amanda Flower Associate Director of Primary Care Commissioning and Transformation	Note	1520-1530
8.1	Primary Care Workforce Programme • Highlight report	Susi Clarke Primary Care Workforce Programme Lead Primary Care Training Hub Lead	Note	1530-1540
	Operational - Assurance			
9.	Primary Care (Medical Services) Contracting Assurance Update	Lauren Sibbons Senior Contract Manager	Note	1540-1555
9.1	Ivel Medical Centre contract resignation	Lynn Dalton Associate Director of Primary Care Development	Note	
10.	Winter Resilience for Primary Care Acute Respiratory Infection Hubs 2022/23	Amanda Flower Associate Director of Primary Care Commissioning and Transformation	Note	1555-1600
11.	Universal Offer Update Personal Medical Services (PMS) reinvestment proposal and principles for 2022-2024/2025	Amanda Flower Associate Director of Primary Care Commissioning and Transformation Lynn Dalton Associate Director of Primary Care Development	Note / Agreement	1600-1610
12.	Primary Care Directorate Risk Register Primary Care Digital Risk Register	Jill White Senior Primary Care Contracting & Development Manager	Note	1610-1620
13.	Primary Care Estates Report from Estates Working Group	Nikki Barnes Head of System & ICB Estates	Note	1620-1635
14.	Primary Medical Services Delegated Primary Care Financial Report (January 2023)	Roger Hammond Associate Director of Finance	Note	1635-1645

No.	Agenda Item	Lead	Purpose	Time
	Governance			
15.	Communications from the meeting	Chair	Discuss	1645-1650
16.	Review of meeting effectiveness	Chair	Discuss	
	Closing Actions			
17.	Any Other Business	Chair	-	1650-1700
18.	Date and time of next meeting: 16 June 2023 ▪ at 1030-1230 ▪ MSTeams	Chair	-	-

Members are asked to:
> Review the Register of Interests and confirm their entry is accurate and up to date.

All in attendance are asked to:
> Declare any relevant interests relating to matters on the agenda.
> Confirm that all offers of Gifts and Hospitality received in the last 28 days have been registered with the Governance & Compliance team via blmkicb.corporatesec@nhs.net

Extract from Register of Conflicts of Interest
Primary Care & Commissioning Assurance Committee
as at 8.3.23

Surname	Forename	Position within, or relationship with the ICB	Interests to Declare	Financial Interest	Non-Financial Professional	Non-Financial Personal	Indirect	Description of Interest	Date From	Date To	Actions to be taken to mitigate risk	Date Declared
Blackmun	Diana	CEO, Healthwatch Central Bedfordshire	No									05/12/2022
Borrett	Alison	Non Executive Member	No									21/06/2022
Carr	Marimba	Deputy Director of Public Health at Milton Keynes Council, representing the Director of Public Health for MK, Central Bedfordshire and Bedford Borough at the PCC&A committee	No									05/12/2022
Cartwright	Sally	Director of Public Health, Luton Council	No									22/06/2022
Cox	Felicity	Chief Executive, BLMK ICB	Yes		Y			I am a registered pharmacist with the General Pharmaceutical Council (GPC) and a member of the Royal Pharmaceutical Society	17/08/1987	Ongoing	I will excuse myself should an interest arise	14/06/2022
Dalton	Lynn	Associate Director Primary Care Development	No									06/12/2022

Flower	Amanda	AD PC Commissioning & Transformation	Yes		Y			I am a lifetime (unpaid) Trustee for Sophie's Moonbeams Trust who provide support grants to families who have children that would benefit from accessing therapeutic interventions. The grants allow families/children to access that support. Sophie's Moonbeams Trust Registered charity number 1182086	19/09/2018	Ongoing	Declare the interest / exclusion from meetings/decision making where applicable	09/12/2022
Garnett	Fiona	Associate Director and Head of Medicines Optimisation	No									02/11/2022
Gill	Manjeet	Non Executive Member	Yes		Y			Non Executive Director, Sherwood Forest NHS Hospitals Foundation Trust	11/11/2019	Ongoing	Would flag any conflict in agendas	27/09/2022
Gill	Manjeet	Non Executive Member	Yes		Y			Managing Director, Chameleon Commercial Services Ltd, 12 St Johns Rd, LE2 2BL	09/09/2017	Ongoing	Regular 1-1s flag any issue and agenda items	27/09/2022
Harrison	Michael	Co-CEO of Beds & Herts Local Medical Committee	Yes		Y			Beds & Herts LMC Ltd, Astonbury Farm, Astonbury Lane, Aston, Stevenage SG2 7EG	03/07/2017	Ongoing	Declare in line with conflicts of interest policy	06/12/2022
Head	Vicky	Director of Public Health, Bedford Borough, Central Bedfordshire and Milton Keynes.	No									27/06/2022
Keech	Tracy	Healthwatch MK	Yes			Y		Member of procurement panel for Brooklands, Neath Hill, and Kingfisher GP Practices	Dec-22	25/01/2023	Declare in line with conflicts of interest policy	15/12/2022
Kufeji	Omotayo	Primary Services Partner Member	Yes		Y			The Bridge Primary Care Network Clinical Director	01/04/2021	Ongoing	May need to be excluded from decisions regarding Primary care Networks	11/05/2022
Kufeji	Omotayo	Primary Services Partner Member	Yes		Y			Member, NHS Confederation Primary Care Network	07/07/2019	Ongoing	Declare conflict during discussions	08/09/2022
Kufeji	Omotayo	Primary Services Partner Member	Yes		Y			Member, National Association of Primary Care (NAPC) Council	01/10/2020	Ongoing	Declare conflict during discussions	08/09/2022
Kufeji	Omotayo	Primary Services Partner Member	Yes		Y			Trustee, Arts for Health Milton Keynes	01/04/2020	Ongoing	Declare conflict during discussions	08/12/2022

Kufeji	Omotayo	Primary Services Partner Member	Yes		Y			Trustee, Milton Keynes Christian Centre	01/10/2019	Ongoing	Declare conflict during discussions	08/12/2022
Kufeji	Omotayo	Primary Services Partner Member	Yes		Y			GP partner, Newport Pagnell Medical Centre	01/02/2004	Ongoing	May need to be excluded from decisions regarding Primary Care Networks	08/12/2022
Learoyd	Elizabeth	Chief Executive, Healthwatch, Bedford Borough										
Mayer	Matthew	Chief Executive Officer, Berkshire, Buckinghamshire & Oxfordshire LMCs										
Poulain	Nicky	Chief Primary Care Officer	Yes		Y			Registered nurse and midwife and a member of trhe RCN			Declare in line with conflicts of interest policy, exclusion from involvement in related meetings or discussions and/or decision making as guided by Governance Lead	17/02/2023
Shah	Mahesh	Partner Member	Yes	Y				AP Sampson Ltd t/a The Mall Pharmacy, Unit 3, 46-48 George Street, Luton LU1 2AZ, co no 00435961, community pharmacy	Nov-88	Ongoing	Declare in line with conflicts of interest policy, exclusion from involvement in related meetings or discussions and/or decision making as guided by Governance Lead	20/05/2011

Shah	Mahesh	Partner Member	Yes				Y	RightPharm Ltd, 60a Station Road, North Harrow, HA2 7SL, co no 08552235, community pharcy, son & sisters	28/03/2014	Ongoing	Declare in line with conflicts of interest policy, exclusion from involvement in related meetings or discussions and/or decision making as guided by Governance Lead	20/05/2022
Shah	Mahesh	Partner Member	Yes				Y	Calverton Pharmacy Ltd, Ashleigh Mann 60a, Station Road, North Harrow HA2 7SL, co no 07203442, community pharmacy, son & sisters	03/04/2018	Ongoing	Declare in line with conflicts of interest policy, exclusion from involvement in related meetings or discussions and/or decision making as guided by Governance Lead	20/05/2022
Shah	Mahesh	Partner Member	Yes				Y	Gamlingay Pharmacy Ltd, 60a Sation road, North Harrow, HA2 7SL, no no 05467439, son & sisters	01/04/2021	Ongoing	Declare in line with conflicts of interest policy, exclusion from involvement in related meetings or discussions and/or decision making as guided by Governance Lead	20/05/2022

Shah	Mahesh	Partner Member	Yes		Y			Committee Member, Bedfordshire Local Pharmaceutical Committee	1984	Ongoing	Declare in line with conflicts of interest policy, exclusion from involvement in related meetings or discussions and/or decision making as guided by Governance Lead	20/05/2022
Shah	Mahesh	Partner Member	Yes		Y			Community Pharmacy PCN Lead, Oasis Primary Care Network, Luton	06/02/2020	Ongoing	Declare in line with conflicts of interest policy, exclusion from involvement in related meetings or discussions and/or decision making as guided by Governance Lead	20/05/2022
Sibbons	Lauren	NHSE aligned staff - Senior Contract Mgr, Primary Care	No									08/12/2022
Stanley	Sarah	Chief Nurse Director	No									08/09/2022
Stenning	Alexia	AD PC Commissioning & Transformation	Yes		Y			I am a Registered Nurse with the NMC (Nursing and Midwifery Council) and belong to the RCN (Royal College of Nursing). I am interested in clinical issues	Sep-90	Ongoing	As appropriate	08/12/2022
Turner	Philip	Chair, Healthwatch Luton	No									06/12/2022
Westcott	Dean	Chief Financial Officer	Yes		Y			Board Advisor, London School of Commerce	01/12/2022	Ongoing	Declare in line with conflicts of interest policy	13/12/2022
Westcott	Dean	Chief Financial Officer	Yes				Y	Wife is Senior Mental Health Transformation Manager at West Essex CCB	01/06/2021	Ongoing	Declare in line with conflicts of interest policy	14/06/2022
Westcott	Dean	Chief Financial Officer	Yes					Chair of Board of Trustees - Association of Chartered Certified Accountants Pension Scheme	01/06/2021	15/11/2022	Completely outside of the NHS	14/06/2022
Whiteman	Sarah	Chief Medical Director	Yes			Y		Civil partner, Advanced Nurse Practitioner (Walnut Tree Health Centre, Milton Keynes)	2013	Ongoing	No involvement in relation to decision making	14/06/2022

Whiteman	Sarah	Chief Medical Director	Yes		Y			Stonedean, Practice - Sessional GP/former partner	01/06/2007	Ongoing	No involvement in relation to decision making	14/06/2022
Whiteman	Sarah	Chief Medical Director	Yes		Y			General Medical Council Associate	2012	Ongoing	Exclusion of self from involvement in related meetings, projects or decision-making	14/06/2022

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 09.12.22.

Time: 1515-1700

Venue: MST

Minutes of the: **Primary Care Commissioning & Assurance Committee (PCC&AC)**

Meeting held in Public

Members:		
Name	Role	Initial
Alison Borrett	Chair / Non-Executive Member BLMK ICB	AB
Alexia Stenning	Associate Director of Primary Care Commissioning &Transformation BLMK ICB	AS
Amanda Flower	Associate Director of Primary Care Commissioning &Transformation BLMK ICB	AF
Dean Westcott	Chief Finance Officer BLMK ICB	DW
Lauren Sibbons	Senior Contract Manager NHSE	LS
Lynn Dalton	Associate Director of Primary Care Development BLMK ICB	LD
Manjeet Gill	Non-Executive Member BLMK ICB	MG
Marimba Carr	Deputy Director of Public Health at Milton Keynes Council, representing the Director of Public Health for MK, Central Bedfordshire and Bedford Borough	MC
Mike Harrison	Co-Chief Executive, Bedfordshire & Hertfordshire LMC Ltd	MH
Nicky Poulain	Chief Primary Care Officer BLMK ICB	NP
Sarah Stanley	Chief Nursing Director BLMK ICB	SS
Tracy Keech	Deputy CEO, Healthwatch Milton Keynes	TK

Apologies:		
Cartwright, Sally	Director of Public Health, Luton Council	SC
Diana Blackmun	Chief Executive Officer, Healthwatch Central Bedfordshire	DB
Felicity Cox	Chief Executive Officer, BLMK ICB	FC
Fiona Garnett	Associate Director of Medicines Optimisation BLMK ICB	FG
Helen Terry	Chief Executive, Healthwatch Bedford Borough	HT
Mahesh Shah	Primary Medical Services Providers Partner Member BLMK ICB	MS
Matt Mayer	Chief Executive Officer, Berkshire, Buckinghamshire & Oxfordshire LMCs	MM
Phil Turner	Chair, Healthwatch Luton	PT
Sarah Whiteman (Dr)	Chief Medical Director BLMK ICB	SW
Tayo Kufeji (Dr)	Primary Medical Services Providers Partner Member, BLMK ICB	TKU

In attendance:		
Nikki Barnes	Head of System & ICB Estates BLMK ICB	NB
Roger Hammond	Associate Director of Finance BLMK ICB	RH
Susi Clarke	Primary Care Workforce Programme Lead, Training Hub Lead, BLMK ICS	SC

No.	Agenda Item	Action
1.	**Welcome, Introductions and Apologies (Chair)** Chair welcomed everyone to the meeting. Apologies were received and noted. Chair informed the committee that this was a meeting held in public and not a public meeting and therefore	

	any questions were requested beforehand. No questions had been received. Members of the public attending could ask questions via chat in relation to the item being presented or under item 13. The meeting would be recorded for the purpose of the minutes. Members of the public were advised to mute speakers and as the meeting was being recorded they may wish to turn cameras off. The meeting was confirmed as quorate.	
2.	**Core Purposes of Integrated Care Systems (Chair)** Committee reminded of the core purposes of ICSs to improve outcomes in population health and healthcare, tackle inequalities in outcomes, experience and access, enhance productivity and value for money and help the NHS support broader social economic development. These principles needed to be considered during discussions and when making decisions alongside the core principles of trust, respect, integrity, accountability, care and compassion.	
3.	**Relevant Persons Disclosure of Interests – Register of Interests (Chair)** Register of interest declarations for each member of the committee were shared with the papers and confirmed as accurate and up to date. Several members to be added which will be completed by the next meeting. No declarations were made prior to or at the meeting for any offers of Gifts and Hospitality received in the last 28 days that had not been registered with the Governance & Compliance team, or to relevant interests relating to matters on the agenda.	
4.	**Approval of Minutes and Matters Arising (Chair)** Committee confirmed the minutes were an accurate record of the meeting held on 27.09.22.	
5.	**Review of Action Tracker (Chair)** Actions closed: 9, 10, 11 & 12. Committee advised that Action 9 'Focus on digital developments and the wider digital offer' remained a standing item as part of the BLMK Fuller Programme for the Primary Care Delivery Group and this Committee.	
6.	**BLMK Fuller Programme** **– Progress Update (Amanda Flower, Alexia Stenning and Nicky Poulain)** BLMK Fuller Programme is a system programme with the aim of anchoring transformation around our neighbourhoods utilising Place Boards to implement the recommendations of the Fuller stocktake at place. Programme is built around four key pillars: 1. development of neighbourhood teams aligned to local communities 2. streamlined and flexible access for people who require same day urgent care 3. provision of proactive personalised care and support for people with complex needs and co-morbidities, (who benefit most from continuity of care) 4. ambitious and joined up approach to embedded and integrated prevention. Key milestones highlighted in the report for each pillar and the work in progress to complete the overall programme plan to support delivery at place. Programme accountable to this Committee with two groups established to support delivery: ▪ ICB Fuller Programme Working Group: has oversight of processes and progress to ensure escalation issues and challenges are resolved and to facilitate system connectivity; ▪ BLMK Fuller Stakeholder Collaborative Group: intention to continue to build, develop and deliver the programme in a collaborative way and ensure we are supporting and enabling place-based delivery and implementation.	

	Positive feedback on the programme approach received from all system partners. Programme supports and allows further development of work already undertaken in BLMK, particularly around access. Programme is a standing item at Central Bedfordshire and Luton Place Boards and in discussion within Bedford and Milton Keynes structures. Place Boards are pivotal in terms of developing neighbourhood teams and how the programme is delivered. The approach taken is a framework which embeds and supports delivery at place ensuring the voice of residents and patients is central. Committee to receive terms of reference for the working and collaborative groups and a highlight report for assurance on progress. Prevention agenda works across all stakeholders and ICB working very closely with colleagues in public health, voluntary and all acute sectors. Further opportunity for crucial prevention work with the delegation of pharmacy, optometry and dentistry to the ICB from April 2023. Members discussed and raised the following points / questions: - MG noted the welcome, systematic and positive report focusing on development areas. - AF confirmed to MG that the government publication of access data to GP practices was beneficial/empowering for population/patients but could also present challenges for practices at a time of unprecedented demand where some of that demand is difficult for primary care teams to respond to. Data is a starting point for discussion and ICB to work with population on communications to describe how general practice and wider offer of primary care is working, how we can support the population, general practice and the wider primary care teams. - BLMK were already undertaking a significant amount of work across the four pillars; important to use opportunity to map what exists, best value on how resources used, take stock and build on best practice (learn and share/development approach) and review evidence from other areas. - AF confirmed public health representation at Place Boards and welcomed MC's offer of involvement in the collaboration group. - Programme is to be owned and delivered by everyone including sharing consistent messaging from all domains and connectivity e.g., with the BLMK People & Communities Committee (MG) - AF confirmed to TK that communications were focused on the availability of wider health professionals in primary care teams rather than definition of 'Additional Role Reimbursement Schemes' positions. Chair endorsed communications that supported change and provided reassurance to patients **Committee noted the proposed BLMK Fuller Programme approach and progress.** **ACTION13: Discuss and agree public health representation at the BLMK Fuller Stakeholder Collaborative Group** **ACTION14: Discuss prevention priorities/programmes further and embedding of place driven prevention.**	**AF, AS & MC** **AS, MC**
7.	**Winter Resilience for Primary Care (Amanda Flower)** NHS England (NHSE) letter published 26.09.22. set out how support intended to be provided to primary care (General Practice, Primary Care Networks (PCNs) and teams) throughout the winter period with three key areas of focus: - *identify rapid mobilisation of support to primary care*: in response ICB submitted high level estates initiatives (x16) and transformation schemes (x12) on 21.10.22. to mobilise rapidly to provide resilience. No confirmation of funding available at this stage but potentially	

NHSE have requested further information by 12.12.22. on 7 estates and 6 transformation schemes that would fit criteria for winter funding for stage two of the process. Any funding made available would expect to be realised in January 2023.

- *immediate changes to the Network Contract Directed Enhanced Service (DES)*: Committee provided with assurance in relation to recycling of funding from DES and Investment and Impact Fund (IIF). PCNs have outlined plans on how they would utilise funding to bolster winter capacity. The impact and additionality provided will be evaluated.

- *reduced bureaucracy and improvements between primary and secondary care interface*: key areas of focus for improvements to support patients and general practice. BLMK Consensus Statement drafted and championed by the Bedfordshire Clinical Interface Forum which sets out principles on how primary and secondary care will work together in the system. Expected to be adopted and implemented from January 2023.

Paper sets out the transformation schemes being further developed/implemented and those fully implemented to ensure winter resilience plus the Estates projects for additional capacity.

Standard operational procedure for Acute Respiratory Infection Hubs being developed with clinical leaders and PCN Clinical Directors for mobilisation and delivery from now to end of March 2023 to take advantage of non-recurrent funding made available. This will introduce additional capacity to manage episodic respiratory infections during the winter period and the suggestion is for four Hubs (one per place).

Members discussed and raised the following points/questions:

- AF confirmed that the winter plan and preparation were intended to be a dynamic process and part of the task in submitting next stage of the plan on 12.12.22. was to test if the schemes put forward were the right ones or needed amending to reflect change which included the proposed industrial action. Martha Roberts, BLMK ICB Chief People Officer, is working closely with NHSE Regional Team on the impact of industrial action.
- Consensus Statement is a huge opportunity to empower patients in terms of communications to support their experience as they move through the health system. TK praised the document recognising communication between primary and secondary care were key.
- MH confirmed that the British Medical Association (BMA) had officially written to NHSE on 08.12.22. asking for suspension of all Quality and Outcomes Framework (QOF) and Investment and Impact Fund (IIF) to free up capacity to support appointments in winter.

Committee noted the current Primary Care specific winter preparation and resilience approach and the Primary Care schemes as part of the system winter resilience plans.

8.
8.1

Primary Care Workforce Programme
Highlight Report (Susi Clarke)

Progress update on all schemes within the workforce programmes strategic workstreams.

Key areas and exciting developments highlighted:

- Additional funding allocated (over £500k) in October 2022 from Health Education England (HEE) to support 50% of PCNs to establish individual training teams; provides networks with additional capacity to support their educator capacity and embed proper systems of induction and supervision for all roles (under Additional Role Reimbursement Scheme or students coming into the networks). Thirteen expressions of interest submitted (over 50%) Approach taken was to ensure equitable access to funding for all PCNs recognising they are at different stages of maturity. Package of wrap around support to be put in place for

	each individual PCN to include review of baselines, learning and training capacity and organisational development. ▪ Additional funding received to establish integrated working project with two Community Pharmacies. ▪ Quality & Expansion programme recognised regionally as performing to a high standard. ▪ Shine Project has been shortlisted for a Health Business Award (provides the Shiny Mind App to staff and for them to prescribe to patients via a prescription portal App). ▪ Training and Development Manager, ACP Strategic Lead and Personalised Care Lead appointed to support the work programme. **Members noted the progress outlined in the primary care workforce highlight report.**	
8.2	**Primary Care Network (PCN) Workforce Plans** Update on the final PCN indicative workforce plans (2022-23) submitted to NHSE on 31.10.22. Report provided a breakdown of the plans by PCN and place, outlined the forecast spend of the Additional Role Reimbursement Scheme allocation and the planned growth in workforce 2022-2023. Strategic view taken of plans at a place level in terms of financial implications and recruiting to planned numbers which will prove challenging particularly for clinical roles due to lack of adequate supply. Two new non-clinical roles added to the scheme - Digital & Transformation Lead and GP Assistant. PCNs plan to recruit an additional 29 GP Assistants this financial year. Campaign to raise local community awareness of non-clinical opportunities including targeted piece of work to engage with reservists who have been working within the vaccination centres via a Career Fair. Plan to recruit Paramedics, Clinical Pharmacists and Pharmacy Technicians and to ensure mitigations of any risks for partner organisations. Oversight of the plans enables the Training Hub to strategically target and support PCNs planning to recruit specific roles. Clinical Leadership team will support with clinical recruitment, induction and supervisory levels and for First Contact Practitioners to understand the requirements to complete the roadmap. SC explained to MG that funding was confirmed and allocated to PCNs by NHSE at the beginning of the year to draw down on with a two-part submission. Workforce plans submitted at beginning of financial year with a six-month period to review and amend; October submission is an indication of spend and underspend. **Committee noted the financial implications and recruitment and workforce growth implications of the PCN workforce plans.**	
9.	**Primary Medical Services Delegated Primary Care Financial Report (September 2022) (Roger Hammond)** Report for assurance provided a high-level summary of September 2022 delegated primary care financial position which had been reviewed by the Committee's subgroup the Primary Care Delivery Group on 08.11.22. It is the role of the subgroup to scrutinise finances, discuss risks and make informed decisions in overseeing the delegated budget to promote increased quality, efficiency, productivity and value for money across primary care services. Delegated primary care shows improvement year to date from last report with underspend at Month 6 primarily driven by the Investment and Innovation Fund (2021-22) which has now been validated and paid to practices; not all targets achieved and benefit released against the year-to-date position. Forecast effectively breakeven despite pressures (particularly from backdated rent reviews), with sufficient contingency and prior year benefit available to manage any unexpected expenditure.	

	Other primary care services expenditure was summarised including Local Enhanced Service position being lower than anticipated for Q1 & Q2 and current levels rolled through to year end. GP Investments underspent due to extended hours being lower than allocation received; scheme has now ceased and funding rolled over into PCNs providing additional hours/services (fixed funding being spent at PCN level). Prescribing information runs two months behind the reporting month. Seeing upward trend with May/June actual costs higher than originally estimated; detailed work shown that Category M drug prices have increased 25% in unit price since April to Sept/October 2022. Pressures continue to build with potential £2-3m overspend at year end. RH confirmed to the Chair that this was a national pressure and not specific to BLMK. **Committee noted the September 2022 delegated primary care financial position.**	
10.	**Communications from the meeting to all partner organisations (Chair)** Committee discussed the need for clear consistent messaging about capacity in Primary Care and use of language across the health and care system as it is important to manage and support the expectations of the public and also of healthcare professionals. NP and four place PCN representatives to provide a presentation at the BLMK Health & Care Partnership Board on 14.12.22. MG offered support. MG to link in these messages / communications and patient empowerment with the BLMK People & Communities Committee and its work programme.	
11.	**Review of meeting effectiveness (Chair)** Members were asked whether the quality of the papers was sufficient to allow them to discharge their duties and the expectations of each paper? **Chair stated that the papers were very clear, well laid out and presented to the Committee. Members invited to provide any additional feedback to the secretariat.**	
12.	**Annual cycle of business (Chair)** **Members noted the cycle of business. Chair believed the Committee were covering items at frequency required. Members invited on an ongoing basis to advise the Chair of any future agenda items they wished to be added/removed.**	
13. 13.1	**Any other Business (Chair)** **Questions from the Public** No questions received from the Public prior to or at the meeting. No other business was raised.	
14.	**Date and time of next meeting**: 17.03.23. Meeting held in Public 1415-1615 via Teams.	

Approval of Minutes:		
Name	Role	Date
Alison Borrett	Chair	10.01.23.

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 11 January 2023

Time: 1400-1530

Venue: MST

Minutes of the: **Extraordinary Primary Care Commissioning & Assurance Committee (PCC&AC)**

Meeting held in Public

Members:		
Name	Role	Initial
Alison Borrett	Chair / Non-Executive Member BLMK ICB	AB
Alexia Stenning	Associate Director of Primary Care Commissioning &Transformation BLMK ICB	AS
Amanda Flower	Associate Director of Primary Care Commissioning &Transformation BLMK ICB	AF
Dean Westcott	Chief Finance Officer BLMK ICB	DW
Felicity Cox	Chief Executive Officer, BLMK ICB	FC
Elizabeth Learoyd	Chief Executive, Healthwatch Bedford Borough	EL
Lynn Dalton	Associate Director of Primary Care Development BLMK ICB	LD
Mahesh Shah	Primary Medical Services Providers Partner Member BLMK ICB	MS
Manjeet Gill	Non-Executive Member BLMK ICB	MG
Marimba Carr	Deputy Director of Public Health at Milton Keynes Council, representing the Director of Public Health for MK, Central Bedfordshire and Bedford Borough	MC
Matt Mayer (Dr)	Chief Executive Officer, Berkshire, Buckinghamshire & Oxfordshire LMCs	MM
Mike Harrison	Co-Chief Executive, Bedfordshire & Hertfordshire LMC Ltd	MH
Nicky Poulain	Chief Primary Care Officer BLMK ICB	NP
Sarah Stanley	Chief Nursing Director BLMK ICB	SS
Sarah Whiteman (Dr)	Chief Medical Director BLMK ICB	SW
Tayo Kufeji (Dr)	Primary Medical Services Providers Partner Member, BLMK ICB	TKU

Apologies:		
Diana Blackmun	Chief Executive Officer, Healthwatch Central Bedfordshire	DB
Fiona Garnett	Associate Director of Medicines Optimisation BLMK ICB	FG
Lauren Sibbons	Senior Contract Manager NHSE	LS
Phil Turner	Chair, Healthwatch Luton	PT
Sally Cartwright	Director of Public Health, Luton Council	SC
Tracy Keech	Deputy CEO, Healthwatch Milton Keynes	TK

In attendance:		
Andrew Selous	Member of Parliament for South West Bedfordshire	AS
Anne Brierley	Chief Transformation Officer BLMK ICB	ABR
Dave Hodgson	Mayor of Bedford Borough	DH
Geoff Stokes	Interim Programme Director, Governance BLMK ICB	GS
Jackie Bowry	Engagement Manager, BLMK ICB	JB
Maria Wogan	Chief of System Assurance and Corporate Services BLMK ICB	MW
Michelle Summers	Associate Director Communications and Engagement BLMK ICB	MS
Nikki Barnes	Head of System & ICB Estates BLMK ICB	NB

No.	Agenda Item	Action
1.	**Welcome, Introductions and Apologies (Chair)** The Chair welcomed Committee members, colleagues and members of the public and outlined the format and purpose of the meeting. The apologies were noted. The Primary Care Commissioning and Assurance Committee is a committee of the Integrated Care Board (ICB) and is responsible for the ICB's functions in relation to primary care across Bedfordshire, Luton and Milton Keynes (BLMK). The extraordinary meeting had been called to review the outcome of the primary care estates prioritisation process that commenced in November 2022 in relation to the ICB's statutory function to the use of its delegated primary care budget for GP premises, and for the Committee to decide how best to progress this work. The ICB had complied with its standing orders in giving the minimum notice period for the meeting to enable practices to proceed with improvements where possible for the benefit of residents, primary care practices and their staff. The Chair acknowledged that partner colleagues wished to raise wider and more strategic issues such as the approach to enabling the integration of health and care as part of Fuller Neighbourhoods, but these would not be discussed, or any decisions made on that topic today. The Committee had been notified of non-Committee member colleagues who requested to ask questions of the Committee and it was agreed that they would be invited to do so. The Chief Primary Care Officer (NP) would introduce the report supported by the Chief Finance Officer (DW) and the Head of System & ICB Estates (NB) for the Committee to discuss and make decisions on the recommendations. A report of the meeting would be made to the Board of the ICB on 27.01.23. The Chair reminded colleagues and attendees that the meeting was held in public and was not a public meeting. It would be recorded for the purposes of minute taking. The meeting was confirmed as quorate. Committee Members introduced themselves and their roles within the organisation.	
2.	**Relevant Persons Disclosure of Interests – Register of Interests (Chair)** The register of interest declarations for members had been shared with the papers and confirmed as accurate and up to date. The register included all declarations received from members and participants at the date of preparing the extract. Members confirmed that no offers of Gifts and Hospitality had been received in the last 28 days that had not been registered with the Governance and Compliance team. Interests in relation to agenda item 3 were declared by two members of the Committee - Dr Sarah Whiteman (as a GP in Milton Keynes and Bedfordshire) and Dr Tayo Kufeji (as a GP Partner in Milton Keynes). The Chair and the Governance and Compliance Team had discussed and agreed that the individuals were not conflicted, could remain in the meeting and take part in the decision-making process.	

3.	**Primary Care Estate – Prioritisation of Revenue Consequences** **Questions to the Committee** The Chair invited Dave Hodgson, Mayor of Bedford Borough (DH) and Andrew Selous, Member of Parliament for South West Bedfordshire (AS) to present their questions to the Committee and confirmed that Committee Members would respond to those questions through the presentation and discussion of the report. The Mayor of Bedford Borough (DH) referred to a presentation on primary care estates to the Bedford Borough Health and Wellbeing Board in September 2021 where information and commitment to deliver services were shared by the former CCG. He requested that the analysis of existing primary care space was shared including how this compared to the national average per 10,000 patients and the recommended position for each one. He believed that Bedford Borough were underprovided by more than 40% in jointly commissioned work which was not reflected in the report. The MP for South West Bedfordshire (AS) conveyed the concerns of constituents and Central Bedfordshire Council (CBC) at the proposals in the report and outlined the increase in housing growth in the area. He questioned the ICB's inability to find £2.915m from a budget of £1.7bn to support all the proposed schemes for primary care developments to proceed. He explained the anger of Leighton Buzzard residents who had purchased homes on the basis that there would be a health hub and a surgery in the vicinity. AS requested that the recommendations were not signed off at the meeting today and for the ICB to pause, at least until the ICB Board meeting on 27.01.23., to reconsider and review housing numbers to ensure fairness and equity for the area and every part of BLMK. The Chair acknowledged the importance of the issues raised. The ICB recognised, appreciated and supported the vital importance of primary care in improving the health of its residents. **Strategic context** The Chief Executive Officer (FC) explained that the ICB does not have sufficient monies to deliver everything it would like to deliver for primary care. She confirmed that the ICB continues to hold strategic conversations with NHS England Regional and National teams and the Minister for Primary Care and Public Health to demonstrate the importance of primary care and the issues on primary care estates, not just to general practitioners or in the context of people wanting to access a general practice, but in its impact across the system. For example, the difficulty of recruitment and retention of GPs and additional roles can eventually lead to an increase in urgent and emergency care as people cannot get same day appointments; that in turn impacts on the ability to deliver elective care with the move into escalation areas which disrupts the opportunity for other work to take place including urgent and planned surgery. The focus could sometimes be on acute hospitals at times of pressure without understanding the interdependencies of primary care services, (both general practices and pharmacies in particular), and the impact of not having sufficient space for workforce has on the ability to deliver across the health system. The ICB requested support from colleagues both political and non-political in raising the issue of primary care estates as a fundamental building block of the NHS and its services, and a fundamental way of how to keep the population safe and healthy.	

Prioritisation of Revenue Consequence

The Chair asked NP to present the report and to explain the different elements of the work completed including how the prioritisation process was undertaken and why, who was involved and referencing the questions raised.

NP explained that the purpose of the meeting was to discuss how the ICB had fulfilled its statutory duties to allocate its Primary Care Delegated Budget; in particular how the available funding would be used to support primary care estates in line with nationally agreed criteria and how the ICB fulfilled its internal governance processes to prioritise a budget it had statutory responsibility for.

The former BLMK Clinical Commissioning Group (CCG) developed and approved a Primary Care Estates Strategy in 2020 which recognised and highlighted premises challenges. The need to establish an up-to-date picture of the schemes in the pipeline was agreed via this Committee, and to transparently prioritise how any available funds were invested.

The report had recommendations to support investment in primary care estates, including the schemes which should be prioritised with two key areas for discussion:

- the source and level of funding to be made available and
- how the prioritisation process had been applied, and the recommendations for which schemes should be progressed.

A significant proportion of the spend against the Primary Care Delegated Budget is dictated by the national General Medical Services (GMS) contract. The ICB currently spends just under £9m per annum of this budget on primary care estates (revenue funding). There is an annual growth allocation, but this is generally required to cover the increase in premises costs as a result of standard rent reviews.

The report made recommendations for how further revenue funding to support investment in primary care estate could be made available. However, further discussions around this had been held over the last few days, and the report circulated had some areas now out of date, which DW would update the Committee on.

The Estates, Technology & Transformation Fund (ETTF) finished last year with no successor programme and the only NHS capital funding stream which can support primary care estates is the business as usual (BAU) Capital Allocation that the ICB receives annually. For 2022/23 this was £1.66m, and funds GP IT costs, corporate IT and estates costs, as well as primary care estates. The ICB's Finance & Investment Committee has agreed an indicative budget of circa £500k for primary care estates, with the majority of the remainder being required for GP IT to support the effective running of GP practices for the benefit of patients.

The report made recommendations for prioritisation of the £1.95m revenue funding within the scope of the Primary Care Delegated Budget, aligned to prioritisation of the available £500k capital funding for this year and next.

DW described the current proposal for a budget of £1.95m for investment in primary care estates and provided context to address the question raised by AS before explaining a potential way forward. The ICB has a budget of circa £1.7b but in terms of the financial settlement it receives as a system next year it will also have a £90m efficiency savings target to meet.

The majority of expenditure in terms of core ICB budgets is already allocated and the level of discretionary spend out of the £1.7b is circa £300-350m. The ICB faces the challenge of an efficiency target of circa £30m on its core activities (8.5% of budget) as part of the system's

£90m target. The ICB only has £1.66m capital funding for all primary care estates and the report described how the ICB had been looking at finding the money to fund the revenue investment also required.

The ICB had worked with and listened to primary care partners, and it was clear that partners did not want the Universal Offer to fund part of the solution. The ICB gave a commitment to review other sources of funding but DW reiterated that all budgets were under considerable pressure. Potential alternative solutions would include a non-recurrent solution in the coming year with a view to finding a sustainable solution going forward, not just for the shortfall faced but for the other primary care investments needed for estates going forward. The ICB committed to find a solution and that primary care money would be spent on primary care budgets.

The purpose of the meeting and report are to demonstrate that the ICB are trying to find a pragmatic way forward to identify solutions to the challenges faced with primary care estates. The aim of the ICB had been, and always would be, to be transparent in decision making against a tight public sector financial settlement and increasing demand on all its services.

The ICB looked forward to primary care being a strategic partner in helping to find some of the answers to the efficiency challenges it would face as a system going forward.

NP explained how the estates prioritisation process was applied, the recommendations for which schemes should be progressed and that Primary Care colleagues and Local Medical Committees (LMCs) were part of the process. The criteria were co-designed and panel membership agreed by this Committee and drew on the national prioritisation criteria. Primary Medical Services is delegated and the ICB is dictated by the national contract.

The ICB recognised the estates criteria were new and untested locally and agreed that the panel would have authority to make recommendations outside the order of final scoring where robust rationale could be provided.

The panel reported to the Committee in December 2022 that the scoring and risk assessment of all schemes had been completed during four panel meetings in November with next steps to work with ICB Executive and Finance teams to prioritise an affordable pipeline.

The Committee had previously noted that four schemes had already received commitment prior to commencement of the prioritisation process. The commitment was made to fund the revenue consequences of those four schemes (£1.54m per annum).

The outcome of risk ratings was reported to the Committee with three schemes identified as particularly high risk to patient care if not progressed. The panel made these the highest priority for any additional available revenue funding.

During 2021-22 the Committee took pragmatic decisions to fund four Primary Care Network (PCN) estates schemes non-recurrently to meet operational pressures and enable recruitment. The termination of any of these schemes would prove detrimental to patient care and the recommendation of the panel was that the eleven schemes be supported at this stage (total net recurrent commitment of £1.87m per annum). There were a further twelve schemes included on the list for prioritisation which had no material impact on revenue due to recycling void costs or a result of S106 funding.

In summary, the panel had recommended twenty-three schemes to be supported at this stage. Thirty schemes could not be supported at this stage from the primary care delegated budget with the risks outlined in the report. The ICB recognised that all the schemes had value, and

that the process was about deciding which schemes should be supported in which order within the scope of available budget.

The ICB confirmed that any additional monies that became available would be allocated in line with the prioritised list. It was committed to exploring any opportunities and to work with partners to consider how to continue to address the important issue of primary care estates.

The Chair asked Committee members for any questions or comments.

TKU stated that primary care estates not only supported day to day primary care for patients but helped address ICB priorities including health inequalities. He welcomed and supported the ICB seeking alternative revenue sources to progress the schemes prioritised.

MG had received assurance from the financial context provided by DW and that the process had been in collaboration and partnership with different stakeholders. She suggested working as a collective partnership to raise a dialogue about potential devolution-based deals with the government as infrastructure funding for new housing growth was a national issue.

NP and the Chair agreed it was about working collectively to optimise finite resources.

Recommendations

The Chair noted comments from Members on the following recommendations:

Recommendation 2: MG requested that it be noted that the ICB had heard questions from the public, there was a limited budget and for the ICB to explore how to do more strategic work with partners to address that issue.

Recommendation 5: DW and NB confirmed that that the current year's capital had to be spent by 31.03.23. and decisions endorsed by the Committee would ensure this was achieved.

Recommendation 6: MS approved subject to further discussions and findings around Fuller Neighbourhood Teams and obligations.

The Chair invited Committee members to make a decision on the information provided at the meeting. Members confirmed each individual recommendation:

1. **Received** the outcome of the primary care estates prioritisation process.

2. **Approved** the recommended indicative budget of £1.95m to invest recurrently in primary care estates. £1.54m of this cost relates to schemes already committed / operational.

3. **Supported** the alternative funding approach for the £1m revenue shortfall for the schemes as outlined by the Chief Finance Officer in the meeting and that primary care budget will be spent on primary care.

4. **Approved** the recommended list of schemes to be supported in principle, including the schemes with marginal revenue impact, even though the scores for some of these were lower than others, noting that individual business cases are required for final approval to be given and should the revenue impact become higher than expected it may not be possible to ultimately approve the business case for these schemes.

5. **Noted** that these proposals enable circa £468k and £472.5k of the BAU capital to be directed towards primary care estates in 2022/23 and 2023/24 respectively, (but note the risk that

delays to concluding the prioritisation process may cause some slippage with capital spend between years).

6. **Requested** the Board and Finance and Investment Committee of the ICB to consider making additional revenue available for primary care estates as part of the 23/24 resource allocation process, noting that a Board seminar on primary care and the development of Fuller neighbourhoods will include discussion of primary care estates as an enabler of neighbourhood working and is planned for 24.02.23.

7. **Recognised** that there are other primary care providers with estates needs who are not within the twenty-three and we are committed to working with them and system partners on their needs. Welcome the support and interest from all our partners in this issue and commit to working with all partners at a system and place level and we will continue to escalate the need for additional funding for primary care nationally.

In agreeing the recommendations, it was acknowledged that the views of representatives had been heard at the meeting but that there was limited funding available. Alternative funding streams are being sought but the decisions today will ensure that available funding can be spent before the end of the financial year. The ICB Board will discuss primary care and the outcomes of the Fuller review at a Board seminar in February 2023.

The Chair invited any outstanding questions or comments from DH and AS.

DH stated that the ICB was making a decision based on criteria not shared with the public/himself. He reminded the Committee of his question about sharing the analysis of existing primary care space and that some of the proposals were not as originally presented to the Bedford Borough Health and Wellbeing Board and the public in September 2021 which had not progressed and now it appeared that they would not happen. He explained the range of estates issues for Wixams, Sharnbrook and Wootton, the loss of space the NHS could have got for free and the impact of a lack of facilities for residents.

DH was disappointed by the decision and the apparent lack of engagement with stakeholders before a decision was taken. He wanted to work together to try and get government funding for primary care estates to ensure the right outcomes that all partners wanted for BLMK residents.

The ICB had been open, transparent and worked with partners but NP acknowledged DH's view and stressed its commitment to learn and improve its working as a partner in the system.

The Primary Care Commissioning and Assurance Committee meetings are held in public with reports and minutes available on the website and the membership of the committee includes representatives from each Health and Wellbeing Board. The ICB would continue to work with the local authorities to identify their nominated members to address and support transparency.

The primary care commissioning delegated budget is dictated by the national GMS contract and this is its business as usual for the 93 practices across the 23 PCNs.

ACTION15: Health and Wellbeing Board representatives for the Committee to be confirmed by local authorities. **NP**

AS confirmed he was unhappy with the decision. The ICB had confirmed it had no discretion on £1.35b of the £1.7b budget, but he did not believe it could not find the £2.915m required to enable the vital schemes to proceed. He cited the massive unfairness for Houghton Regis

(which will be larger in population than Dunstable or Leighton Buzzard), yet this was not reflected in the proposals except for one request for a meeting room for Toddington (Titan PCN) which had been turned down.

A fourth GP surgery planned for Leighton Buzzard had been identified in a planning application and S106 agreement in 2015. This had not progressed despite the increase in the number of residents with the only support provided being two additional consulting rooms. He stated that there was a danger of S106 money not being utilised, land earmarked for health being handed back and a lack of joined up working with local authorities. He recognised it was a complicated system with many areas of the country struggling but questioned if the ICB took learning from areas where partners were working together successfully on future strategic planning.

He did not believe it was a good meeting or process and asked that the ICB revisit the budget and reprioritise, and for conversations to be held with the acute sector, national government and local authorities to make progress together.

AS confirmed that FC had agreed to attend a public meeting in Leighton Buzzard to hear residents' views.

FC confirmed that resource allocation would be part of the ICB Board meeting held in public. DW emphasised that the decision endorsed by the Committee was to review the rest of the budgets but noted the challenges of the £90m efficiency savings and stressed that there were no easy decisions. The ICB and partners are aware of the huge demand on acute hospital services but as an ICB had committed to work with partners to transform services for the benefit of patients to enable it to look at how resources are allocated between the various sectors.

The ICB expects to balance the efficiency savings target of £55m for 2022-23 which means not having to cut services in future years, but it does that by taking responsible and sometimes difficult decisions.

DW responded to AS' point about finding the revenue funding. There is £1.66m capital funding for the whole of primary care in BLMK and whilst recognising revenue being a constraint it could equally, (if revenue solutions were found this year), be a capital issue next year. The key is working in partnership with partners across the geography to find sustainable solutions going forward.

NP assured AS that the ICB had looked at working with and learning from ICBs with similar populations noting the areas of high deprivation in BLMK which the ICB has worked closely with the practices and PCNs on. She thanked the practices and PCNs for their work on addressing inequalities.

Learning taken from the covid vaccination programme included that those with the greatest need do not always go to 'buildings' and the ICB also needed to work innovatively with all four places, key partners and primary care (Fuller Neighbourhood Teams) to address that divide. The ICB recognised the importance of buildings and facilities and it had taken non-recurrent budget risks to PCNs to ensure they could recruit to additional roles which included social prescribers to support inequalities.

The Chair stated the importance for the Committee to note the comments from DH and AS and that any other issues discussed or raised around comments today would be discussed further outside of the meeting.

	The Committee had heard the need for the ICB to work with providers and local authorities to look at revenue schemes available and to ensure that revenue is used to best serve BLMK residents.	
4.	**Communications from the meeting to all partner organisations (Chair)** The Chair asked GS, Interim Programme Director, Governance, to confirm that the decisions had been taken correctly and he confirmed that they had. Following the Committee meeting, practices and PCN leads who have put forward schemes for consideration would be contacted with the outcome. Briefing documents would be shared with key stakeholders in each of the four local authority areas detailing the outcome of the meeting and the offer to meet with the ICB Chief Primary Care Officer (NP) to discuss provision of primary care by place. MW confirmed that 'Questions & Answers' would be published in response to questions and comments from residents in the meeting chat facility. The Chair requested that this was published promptly.	
5.	**Review of meeting effectiveness (Chair)** The Chair confirmed that the ICB would undertake a lessons learned review in terms of process and engagement for the decision making on this matter with partners invited to participate. The review to be shared with the ICB Board and fed into a review of ICB governance and its approach to working with partners, members of parliament and the public. The Chair invited feedback on the effectiveness of the meeting, but no further comments received.	
6.	The Chair thanked members of the public and the Committee for attending the meeting and DH and AS for their questions and comments for the ICB to consider. The Chair confirmed that future meeting dates and minutes were on the BLMK ICB website. **Date and time of next meeting**: 17.03.23. Meeting held in Public 1415-1615 via MS Teams.	

Approval of Minutes:		
Name	Role	Date
Alison Borrett	Chair	30.01.23.

ITEM 5

Primary Care Commissioning & Assurance Committee (PCC&AC) meeting held in Public - Action Tracker

Key

Escalated	**Escalated** - items flagged RED for 3 subsequent meetings - BLACK
Outstanding	**Outstanding** - no actions made to progress OR actions made but not on track to deliver due date - RED
In Progress	**In Progress.** Outstanding - actions made to progress & on track to deliver due date - AMBER
Not Yet Due	Not Yet Due - BLUE
COMPLETE: Propose closure at next meeting (insert date of meeting)	**COMPLETE** - GREEN
CLOSED	Actions to be marked closed and moved to "Closed Actions" Tab once approved for closure at meeting.

Action No.	Meeting Date	Agenda Item	Action	Action Owner	Past deadlines (Since Revised)	Current Deadline	Current Position (Latest Update)	RAG
13	09.12.22.	BLMK Fuller Programme - progress update	Discuss and agree public health representation at the BLMK Fuller Stakeholder Collaborative Group	Amanda Flower, Alexia Stenning & Marimba Carr			**Terms of References being reviewed and updated. Healthwatch and Public Health to be represented at the Group.**	**In Progress**
14	09.12.22.	BLMK Fuller Programme - progress update	Discuss prevention priorities/programmes further and embedding of place driven prevention.	Alexia Stenning & Marimba Carr			**Priorities discussed and agreed but will continually be reviewed – Digital Weight Management Programme, Stop Smoking and Tobacco Control, Imms and Vacs (all ages and includes flu and covid), Healthchecks (NHS Health Check Programme, SMI and LD), National Screening Programmes, secondary prevention.**	**COMPLETE: Propose closure at next meeting (17.03.23.)**

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Primary Care Commissioning & Assurance Committee – 17 March 2023
7. Transition of Delegated Community Pharmacy, Optometry and Dental (POD) contracts to the ICB

Vision: "For everyone in our towns, villages and communities to live a longer, healthier life"	
Please state which strategic priority and / or enabler this report relates to	
Strategic priorities	
☒	**Start Well:** Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
☒	**Live Well:** People are supported to engage with and manage their health and wellbeing.
☒	**Age Well:** People age well, with proactive interventions to stay healthy, independent and active as long as possible.
☐	**Growth:** We work together to help build the economy and support sustainable growth.
☒	**Reducing Inequalities:** In everything we do we promote equalities in the health and wellbeing of our population.

Enablers			
Data and Digital ☒	Workforce ☒	Ways of working ☒	Estates ☐
Communications ☒	Finance ☒	Operational and Clinical Excellence ☒	Governance and Compliance ☒
Other ☐(please advise):			

Report Author	Liz Eckert Interim Programme Lead POD Transition
Date to which the information this report is based on was accurate	Friday 03 March 2023
Senior Responsible Owner	Nicky Poulain Chief Primary Care Officer

The following individuals were consulted and involved in the development of this report:
Liz Eckert, POD Programme Lead Lynn Dalton, Associate Director of Primary Care
This report has been presented to the following board/committee/group:
N/A

Purpose of this report - what are members being asked to do?

The members are asked to:

A) **Note** the work ongoing to progress the safe delegation of Community Pharmacy, Optometry and Dental contracting from NHS England to the ICB from 01 April 2023
B) **Approve** a recommendation to the ICB Board to accept delegation from 01 April 2023
C) **Note** the outstanding risks and view of internal audit, and support a recommendation of a side letter to the Delegation Agreement which sets out the ICB concerns and limitations in relation to the readiness for delegation
D) **Note** the new governance arrangements for POD from 01 April 2023
E) **Approve** a recommendation to delegate pharmacy regulatory decisions to Pharmaceutical Services Regulatory Committee (PSRC), which is a designated statutory committee for decisions in relation to the pharmaceutical regulations
F) **Approve** the Memorandum of Understanding (MOU) and associated Standard Operating Procedure (SOP) with Hertfordshire and West Essex ICB for the management of Pharmacy and Optometry contracts and hosting the staff that will continue to support the six ICBs.

Executive Summary Report

1. Brief background / introduction:

This paper is to provide the PCCAC with an update on the ongoing programme of work to transition Primary Care Pharmacy, Optometry and Dental services to the ICB from 01 April 2023.

2. Summary of key points:

2.1 Services will transition from NHS England to the ICB on 01 April 2023 subject to a safe delegation approval process.
2.2. Work has been progressed with key functions across the ICB to ensure that the preparatory work required has taken place.
2.3. An NHSE team will be transferred to the ICB to facilitate the Dental contracting, with Pharmacy and Optometry teams being hosted by Hertfordshire and West Essex ICB to work across the region. It should also be noted that NHSE GP contracting team will also transfer to the ICB to support GP contracts delegated to the ICB in July 2022.
2.4. Readiness has been tracked and monitored through a safe delegation checklist process which provides two-way assurance between the ICB and NHS England.
2.5. Whilst there are still some actions outstanding to be completed in March 2023 and some risks remain, they are not substantive enough to delay delegation.
2.6. Internal Audit have completed a review of the preparation process and their draft report has been received.
2.7. The governance arrangements have been reviewed, and the proposed way of working from April 2023 are set out in this paper. The PSRC is responsible for all pharmacy regulatory decisions, so we need to formally delegate this function.
2.8. A Memorandum of Understanding (MOU) has now been finalised between Hertfordshire and West Essex ICB as hosts of the Pharmacy and Optometry contracting team, included in appendix 1 for approval.
2.9 Subject to PCCAC recommendation to the Board to approve the delegation of these services the ICB will enter into a national delegation agreement taking responsibility for the contracting or POD this is consistent with the process applied for commissioning of primary medical services.

3. Are there any options?		
N/A		
4. Key Risks and Issues		
The risks in relation to the transition of the delegated functions include: - Financial risks (funding and transactions) - Complaints function and workload - Staffing resource in order to deliver contracting function to ICB's standards - Knock on resource implications in finance, quality, contracting and corporate functions.		
Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☒	No ☐
Risks are being recorded on directorate Risk Registers. The transfer-specific risks are recorded on the Primary Care Risk Register and are subject to monthly review.		
5. Are there any financial implications or other resourcing implications, including workforce?		
Financial and staffing resources.		
6. How will / does this work help to address the Green Plan Commitments? Click to view Green Plan		
N/A		
7. How will / does this work help to address inequalities?		
The transition of POD functions to the ICB will support transformation of services, enable the ICB to work with POD contracts ensuring they have placed based representation to support delivery of the ICB health inequalities this will include exploring the opportunities offered through the contracts/pharmacy framework to support public health initiatives and other local enhanced commissioned services.		
8. Next steps:		
As outlined in the report.		
9. Appendices		
Appendix 1 – Letter of comfort, NHS England Appendix 2 – MOU with Hertfordshire and West Essex ICB Appendix 3 – Delegation Agreement between NHSE and ICB		
10. Background reading		
None.		

1. Progress made since last report to the Committee

Since the last paper presented to the committee on 09 December 2022, we have continued to work with NHS England (NHSE) to progress the areas of readiness set out in the Safe Delegation Checklist (SDC). The ICB teams have been linking in with regional and national colleagues to understand the requirements and get processes in place. A number of masterclasses have taken place, with more planned during March, to understand some of the details around the way that the contracts and payments work for POD as they are different to other contracts that we currently manage. We have continued to track delivery against the SDC

at weekly meetings with NHSE and fortnightly meetings with ICB colleagues, ensuring that areas of risk are captured and mitigated. Section 3 sets out the current risks.

We have begun our engagement with POD contractors through meetings with the representative committees. Through this we are getting a better understanding of the local and national issues that are facing the contractors and determining how best to engage with providers at place level. This engagement will continue, and we will be looking at ways to broaden the primary care agenda to include POD contractors in discussions around place neighbourhood team development, prevention and maximising their contribution to the local population. It will be important and valuable to include all providers in co-production of local models.

We have been familiarising ourselves with the limitations and opportunities of the national contracts for these providers and how we might as an ICB influence the services that are on offer for patients. It is clear that the contracts, particularly Dental and Optometry, have significant limitations in that they are not attractive to providers due to the level of payments made for NHS services and the increased costs relating to workforce and overheads. We will continue to develop our understanding and monitor the market risks closely. However, we have identified opportunities to maximise the existing contractual responsibilities around prevention and public health, so we will work with providers to explore what more can be done in respect of this.

2. Current position

2.1 Staff consultation and transfer

The consultation period for staff transferring from NHSE closed on Friday 03 March 2023. Over the next week or two we will be linking with the staff on a 1:1 and team basis to ensure that they are supported through the transition to the ICB. Once the individuals are confirmed to be transferring, we will look at roles and responsibilities, ensuring that there is clarity including how the team links in to the wider Primary Care team. The Pharmacy and Optometry team will transfer to Hertfordshire and West Essex ICB and their induction will include an introduction to BLMK and key individuals to link with.

2.2 Final SDC actions

The SDC will continue to be updated through March and following transition where actions need to be concluded. There are no outstanding actions that preclude the delegation taking place as planned on 01 April 2023. Alongside the SDC actions we will be asking the Dental team, once transferred to the ICB to set out their processes in a Standard Operating Procedure (SOP) as part of business continuity arrangements.

2.3 Indicative priority timeline

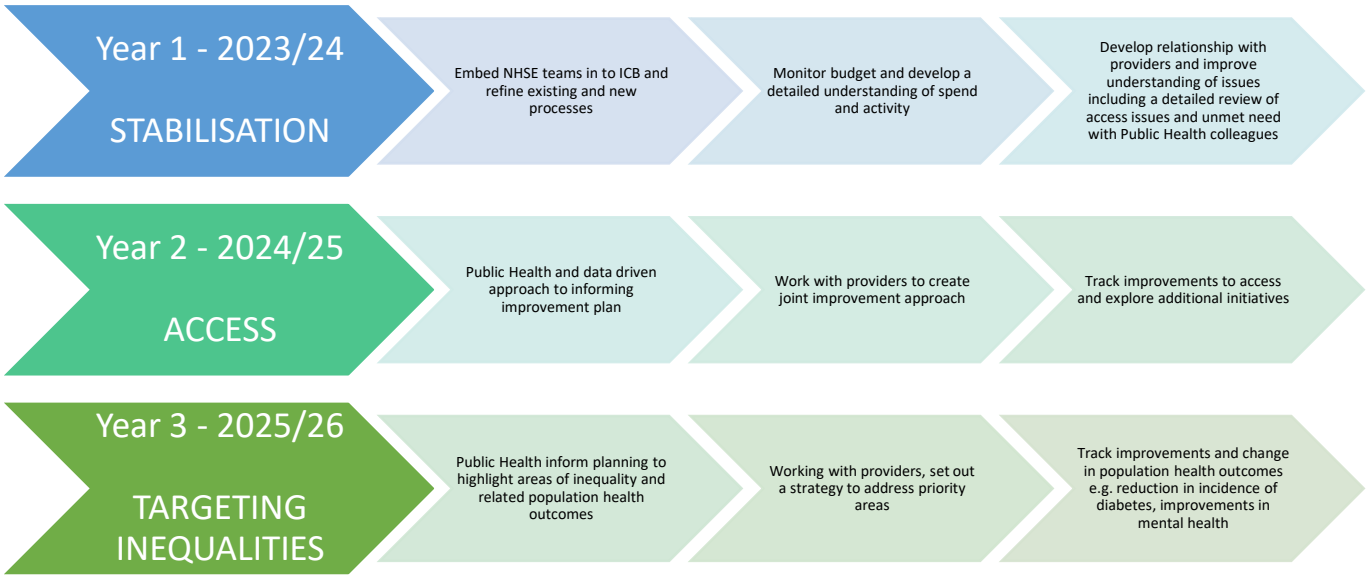
Having established a number of risks in relation to the contracts, provider landscape and patient access, it is important that we develop a thorough understanding of the issues, drivers, budgets and opportunities before we make any significant changes to approach. We therefore propose to use the first year of delegation to embed the teams in to the ICBs and ensure that existing and new processes are established and robust. The 2022/23 contract year-end finalisation will take place by August 2023 including provider level reconciliation, and this will help us to understand the budgetary impact and the options available to us in terms of under or overspends and activity levels. It takes some time as there are:

- 162 Community Pharmacy contracts
- 86 Optometry contracts
- 148 Dental contracts (including 2 acute hospitals and 2 community services)

This is in addition to 93 GP contracts that also transferred in July 2022, so the Primary Care team will be responsible for an additional 489 contracts in total. The challenge of this should not be underestimated and therefore we should plan for 2023/24 to be about learning, developing relationships and understanding local issues and risks.

We also need to use this first year to work in partnership with Public Health colleagues to develop a clear picture of population need including unmet need. We need to develop a clear picture of the population health impact of dental health, eye health, and the determinants of health that can be helped through Community Pharmacy interactions. This information will be needed to inform our decision making as we move forward, and also provide a place-based picture on which we can prioritise how we co-design neighbourhood level initiatives.

Once we have a clear understanding of the local issues we will use the second year to develop a plan to address access and develop a joint improvement approach. Year three onwards will be focussed on targeting inequalities and making sure that we are maximising the impact we can have on improving population health outcomes. It is important that we manage expectations around our ability to make rapid improvement, as we are limited by both national contracts and a lack of agreed local priorities. There is a reputational risk of not being able to resolve long standing, regional and national issues.



3. Outstanding risks and Internal Audit view

The risks relating to delegation have been identified and presented to the Executive Team and the ICB Board in its private session on 17 January 2023 to ensure visibility and enable a discussion around further mitigating actions that the Board would like the team to take pre-delegation.

They were also discussed with NHSE in January 2023, and this resulted in a letter of comfort which set out the NHSE response to some of the risks identified. The letter is in Appendix 1. This position has been taken in to account in a review of the risks that remain in place and they have been included on relevant risk registers for ongoing management.

The ICB Board also asked that the remaining risks be captured in a side letter to NHSE which will accompany the signed Delegation Agreement. Further information on this is set out in section 7.

The remaining high and medium risks are set out in the table below and are also reflected in relevant risk registers:

Gap Identified	Mitigation	Possible Financial Impact	Likelihood of risk materialising (H/M/L)
Quality Workforce			
Limited resource to cover across quality and safeguarding structure with no additional resource from region to support. Additional assurance will be needed across quality and safety to bring in line with other ICB	Letter of Comfort from NHSE setting out limited requirement for quality intervention.	£85,343 incl. 25% on costs [Recurrent issue]	H

contracted services or, where this isn't appropriate, develop light-touch oversight. HWE ICB will not be fulfilling this function for P&O, so consideration needs to be given across all POD contracts.	Consideration for 8a Quality Assurance role to review and implement an effective system.		
Complaints Workforce			
The current EoE primary care complaints team is staffed by 6 x band 5 WTE and 3 x band 6 WTE. We have received confirmation that they will be shared across the ICBs in the region, but they will not split the band 6 posts between ICBs as there are individuals in the roles. Therefore, we can expect to either receive 1 x band 5 WTE OR 1 x band 5 and 1 x band 6 WTE and no additional funding to address any shortfall. This decision will be based on the preferences of the team with some thought to the volumes of complaints. BLMK has a relatively high level of complaints compared to other areas in the region (145 received between April and October 2022, the majority of which [108] relating to GP services). There will also be an impact from the national contact centre no longer being available as the initial point of contact for complainants, but the impact of this on the ICB is yet to be clearly understood.	If we only receive 1 x band 5, consideration will need to be given as to whether we need additional resource, either 0.5 or 1 x WTE at band 6, but this needs to be looked at within the context of the whole team as this level of complaints will significantly increase the current level that the team deal with. New Complaints Manager to review current and future workload once in post.	1 x band 6 WTE £50,735 incl. 25% on costs 0.5 x band 6 WTE £25,367 incl. 25% on costs [Recurrent issue]	H
Management cost reductions			
On 02 March 2023, NHSE confirmed a requirement for ICB baseline running costs to be reduced by a real terms 30% reduction by 2025/26 with at least 20% to be delivered in 2024/25 with no anticipated increases for inflation. Adjustments for staff transferring to deliver the POD contracting functions will be made separately, but details of this are yet to be shared. With nearly 500 more contracts to manage, this could further exacerbate the risks around quality and complaints workforce and introduce additional risks to the primary care team capacity and other related ICB functions.	Look at the detail of the future years running cost allowance, once published, and ensure the increased workload in primary care commissioning and contract management is considered in planning.	TBC	H
Secondary Care Dental Backlog			
As with other secondary care services, we anticipate that a significant secondary care backlog will have built-up through the pandemic – this will have been exacerbated by poor primary care dental access and lack of onward referral. It is likely that the severity of dental disease will have increased, with increased requirement for expensive restorative and periodontic treatments. The extent and cost of clearing the backlog is unknown. However, will not be supported by the current budgets which are based upon pre-covid secondary care dental contractual values.	Clarity regarding extent of secondary care dental backlog. NHSE have provided information re: elective recovery monies for 2023/24 to support backlog reduction	Unknown will need waiting list information to cost. [Non-Recurrent Issue]	H

Community Pharmacy Underlying Financial Deficit			
Community Pharmacy services is forecast to over spend in 2022/23. ICBs will have minimal ability to influence the financial position of this service, which is mainly determined by national negotiations with the industry.	Further information in respect of community pharmacy underlying financial issues has been provided with some mitigation in recurrent allocations. The ICB will need to review the impact of national negotiations with the industry.	Up to £2m [Recurrent Issue]	M
Primary Care Dental Access			
The national contract has disincentivised dentists from taking on NHS work, and has been deemed not fit for purpose by national bodies. There are significant issues with Primary Care Dental access which have been exacerbated through the pandemic with contractors not delivering contractual UDA values, reducing NHS hours or handing back NHS dental contracts. There is undoubtedly significant unmet demand, but it is unclear the scale and extent of the issue is and why the issue has arisen. Some patients have been turned away if their case is not complex enough to cover the costs of delivery. This has had a disproportionate impact on people on benefits / those unable to pay for private care. Ethnic populations have a higher incidence of bad oral health, and there is clear evidence to link this to the incidence of diabetes and other key indicators of health. As an indicator, 25% of 5-year-olds in BLMK already have some level of tooth decay.	Understand baseline demand (data requested). Dental public health advisor within NHSE. An increase to specialised dental activity undertaken within the ICB. Targeted use of the dental underspend.	The scale of the financial risk here is likely to be significant (£2m+) but unable to be quantified. [Recurrent Issue]	H
Financial Operational Processes			
There are technical financial aspects of this programme where engagement from NHSE Central Team has been missing and therefore it is unclear how some key financial processes will be undertaken including supplier set-up, financial feeder processes from the Business Services Authority etc.	A technical task and finish group has been set-up across the Region to oversee the technical aspects of the programme; this is supported by a BLMK workgroup.	N/A	M

Whilst workforce remains an area of concern, none of the outstanding risks are substantive enough that the ICB should not proceed with delegation as planned from 01 April 2023.

In December 2022 our internal auditors were asked to review both the process that the ICB had taken in preparing for delegation, and the risks that had been identified with a view to exploring whether there were additional risks, and whether there were further actions that the ICB could take in mitigating what has been identified. The internal auditors were undertaking a similar process for other ICB clients, so this was also a useful exercise to see whether the ICB process and risks were broadly in line with others. The draft report has been received and comments are being collated in response. The draft report findings were:

- We consider that NHS Bedfordshire, Luton & Milton Keynes ICB has applied a thorough approach, with the resources it had to work through all the tasks and functions in the SDC. It has raised questions throughout the process, made requests for information to gain an understanding of functions and obtain assurances, so that it is in the best possible position to provide a recommendation to the Board.

- It is a concern, that as at mid-February 2023, that there are areas that have not been concluded or actions known to mitigate the risks. The ICB has been raising these throughout the process, impressing their concerns. However, the financial, workforce and reputational quantification of these are not yet clear. The ICB Board is being made aware of the benefits and issues for taking on full delegation of POD.

- An experienced team that will be hosted by HWE ICB (from 1st April) has been established to continue to provide the current level of service provision for contracting arrangements for Pharmacy and Optometry. Dental staff are being transferred to the ICB to undertake the dental remit.

- The ICB has identified risks which the teams are working through the potential mitigations and actions. The top areas are explained under 'Observations'. These need to be assessed, monitored and incorporated into the ICB risk management processes.

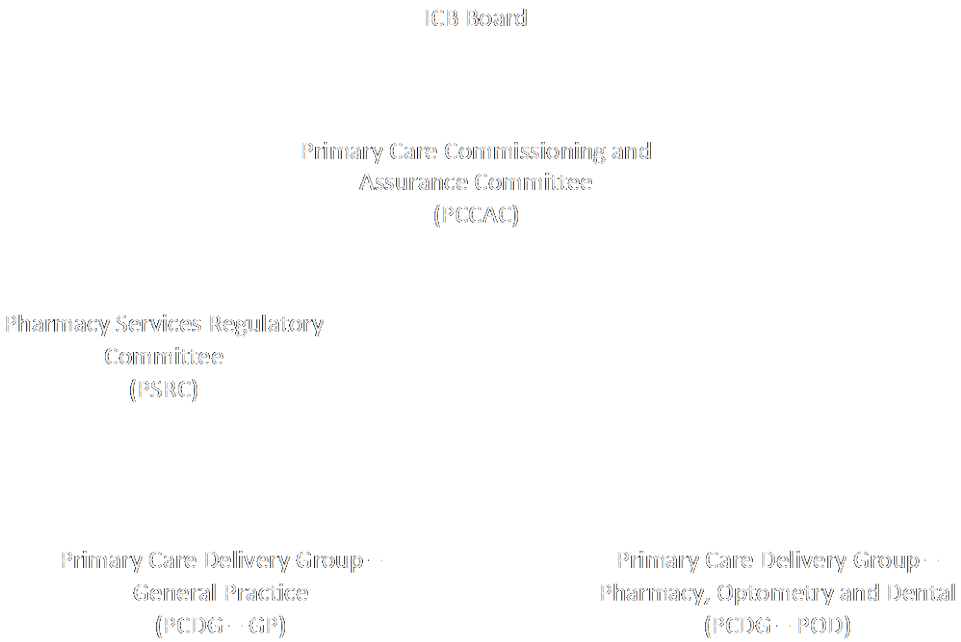
- There has been collaboration between the ICBs and East Region NHE E, with regular meetings and specific workshops by 'function'.

- We consider that the current RAG risk ratings that have been identified for each 'function' at this point in time, are a fair reflection of the position.

This was shared with the Audit and Risk Committee on 03 March 2023, and the full report along with management responses and the current position on outstanding risks will be presented to their next meeting.

4. Governance structure

As previously shared with the Committee, the Primary Care governance structure has been amended to include POD, and the Terms of Reference for relevant committees are being updated. Due to the volume of business associated with Primary Medical Services that currently takes place at the Primary Care Delivery Group (PCDG) and PCCAC, it has been suggested that, rather than add POD business in to the existing PCDG and expand the membership, an aligned PCDG will be put in place during the transition period for at least twelve months. The Terms of Reference and membership for the PCDG – POD is currently being worked on. Both of the PCDG's will report in to PCCAC, and then to the ICB Board.



The Terms of Reference for the PCDG – POD will be shared with this Committee at its next meeting for approval.

Pharmacy regulatory decisions will be delegated from PCCAC to the Pharmacy Services Regulatory Committee which covers the Eastern region. This Committee has held this function for some time, and it is a requirement of the delegation agreement that this remains in place. The Committee is asked to agree to this delegation.

5. Memorandum of Understanding with Hertfordshire and West Essex ICB

The Memorandum of Understanding (MOU) and supporting Standard Operating Procedure (SOP) documents have been set out to detail how the hosting of the Pharmacy and Optometry contracting team by Hertfordshire and West Essex ICB will work with the other five ICBs across the region. The finalised version of the MOU is in Appendix 2 and requires approval. The SOP will continue to develop as working practices embed to ensure that it is reflective of roles and responsibilities and provides increased clarity as we go forward.

6. Delegation agreement

The delegation agreement is in Appendix 3. It is the formal agreement between NHS England and the ICB and sets out the responsibilities for each. It will be signed by Felicity Cox on behalf of the ICB. It will be accompanied by a side letter which will set out the current risks at the point of delegation.

7. Next steps:

In summary, whilst some risks and actions remain outstanding relating to the delegation of POD, there is nothing substantive enough that would preclude the ICB proceeding with delegation as planned from 01 April 2023.

As a result, members are asked to:

A) **Note** the work ongoing to progress the safe delegation of Community Pharmacy, Optometry and Dental contracting from NHS England to the ICB from 01 April 2023
B) **Approve** a recommendation to the ICB Board to accept delegation from 01 April 2023
C) **Note** the outstanding risks and view of internal audit, and support a recommendation of a side letter to the Delegation Agreement which sets out the ICB concerns and limitations in relation to the readiness for delegation
D) **Note** the new governance arrangements for POD from 01 April 2023
E) **Approve** a recommendation to delegate pharmacy regulatory decisions to Pharmaceutical Services Regulatory Committee (PSRC), which is a designated statutory committee for decisions in relation to the pharmaceutical regulations
F) **Approve** the Memorandum of Understanding (MOU) and associated Standard Operating Procedure (SOP) with Hertfordshire and West Essex ICB for the management of Pharmacy and Optometry contracts and hosting the staff that will continue to support the six ICBs.

NHS England
East of England

To: **Felicity Cox**
Chief Executive
Bedfordshire, Luton and Milton Keynes ICB

Via Email

NHS England – East of England
2-4 Victoria House
Capital Park
Fulbourn
Cambridge
CB21 5XB

7 March 2023

Dear Felicity

Delegation of Primary Care Commissioning and Contracting Functions – Letter of Comfort

We have worked closely for many months to prepare for the delegation of responsibility for primary care commissioning functions on 1 April 2023. As we finalise the preparations for delegation, I wanted to assure you that our commitment to partnership working will continue beyond delegation as we strive to drive the opportunities presented through integration of these important functions. Whilst we as NHSE will have some formal duties beyond the delegation within our retained accountability, I am summarising the continued working relationship below.

- The NHS England Operating Framework sets out that we will continue to act in a supportive and collaborative way to transition to delegated arrangements.
- As ICBs continue to evolve, it is in all of our shared interests to ensure that delegation is a success.
- NHS England is preparing a delegation toolkit to provide helpful information such as:
  1. how we expect we will work together with ICBs to achieve our joint aim of successful delegation;
  2. the expected roles and responsibilities that each party will have;
  3. the types of support that NHS England will provide to ICBs;
  4. how data will be used;
  5. the assurance responsibilities that ICBs must fulfil in relation to delegated functions.

- We expect to launch the toolkit in the coming months when the New NHS England programme has provided more information about final structures of the organisation.
- We confirm that the important roles of the NHS Business Standards Authority and Primary Care Support England will continue as per current arrangements that can be adapted to meet delegated structures for regions. Any changes to these arrangements in future would be consulted on with ICBs.

There will undoubtedly be challenges in the future and we will work through these together. The template that we have developed for the delegation of care functions is a strong model and will support future delegations as they arise.

I would like to thank you and your team for the considerable work that you have undertaken to work with us to develop a model that will ensure the future provision of primary care drives improved outcomes and reduced inequities for our populations.

Yours sincerely,

Ruth Ashmore
Regional Director of Commissioning (East of England)
SRO Flu and Covid
NHS England

CC: **Jatinder Garcha**, Regional Director of Primary Care and Public Health Commissioning, NHS England and **Nicky Poulain,** Director of Primary Care, BLMK ICB

Memorandum of Understanding (MOU) for the Hosting Arrangement of Community Pharmacy and Optometry

Section one: MOU terms and conditions

1. Purpose of the MOU

Subject to approval, from 1st April 2023, NHS England will delegate responsibility for the contractual management of community Pharmacy and Optometry (P&O) to Integrated Care Boards (ICBs). As part of this transition, the teams that are responsible for this area of work also transfer to ICBs. As a relatively small function, the ICBs across the East of England have agreed that, rather than assign part of individuals time to each ICB, the team should continue to work as one, hosted by one ICB. Hertfordshire and West Essex ICB (HWE ICB) has agreed to host the team that fulfils this function, and this MOU sets out how the responsibilities will be split between the host ICB, the other ICBs and the interdependent functions that will be retained by NHS England and how they will work together to provide an effective hosted contract management function.

2. Legal Basis of this MOU

It is acknowledged that this MoU is not a legally binding agreement, and it does not change the statutory roles and responsibilities or functions of either Party. NHS England will continue to exercise its statutory powers where necessary to address organisational issues and support system delivery in line with the principles set out in this document. The accountabilities of individual NHS organisations also remain unchanged.

3. Parties to the MOU

The following organisations are party to this agreement and will confirm its application through appropriate internal governance mechanisms:

- NHS Herts and West Essex (HWE) Integrated Care Board (ICB) – the host
- NHS Bedfordshire, Luton and Milton Keynes (BLMK) ICB
- NHS Cambridgeshire and Peterborough (C&P) ICB
- NHS Mid and South Essex (MSE) ICB
- NHS Norfolk and Waveney (N&W) ICB
- NHS Suffolk and North East Essex (SNEE) ICB

NHS England, whilst not a party to this MOU remain a key partner through their retained responsibilities as set out in section 7.

Signatures for each party can be found at Appendix 1 to this document.

4. Core principles

This MOU has been drafted around the following core principles:

- The national Delegation Agreement is the primary agreement and the primary point of definition of the responsibilities of organisations in relation to this function. This MOU sets out how the ICBs in the East of England will fulfil the responsibilities and is not designed to replace the requirements set out in the national Delegation Agreement.
- Whilst HWE ICB is hosting the P&O Contracting Team, all ICBs signing up to this agreement have equal responsibility for ensuring the effective commissioning and contracting of P&O services which meets the needs of their local population.

5. Responsibilities of the host ICB

HWE ICB as host ICB will be responsible for the employment and day to day management of the P&O Contracting Team. HWE will ensure a single point of entry to the P&O Team, and provide management oversight to enable planning, prioritisation and communication.

More details on the responsibilities of the P&O Contracting Team are included within the Standard Operating Procedure (SOP).

6. Responsibilities of each ICB

This MOU supports the national requirements as set out in the Delegation Agreement and each ICB will be responsible for compliance to the requirements as set out in it. Each ICB will identify a lead to work with the P&O Contracting Team to act as point of contact for local issues and represent the ICB at key meetings. In addition, the specific points below are noted:

a. Financial management

Each ICB will receive their agreed delegated funds direct from NHSE and will retain financial responsibility for the management, monitoring and payment process relating to these. This includes compliance with their ICB's financial requirements, processes and systems and audit requirements. HWE ICB is not responsible for any overspends or cost pressures relating to these services.

b. Oversight

Each ICB will ensure that there is adequate oversight and monitoring of the commissioning and contracting of the performance of P&O contracts through their local Primary Care Commissioning Committee or relevant ICB Assurance Committees. Where there are contractual issues, this will be raised with the P&O Contracting Team for addressing through contractual routes.

c. Commissioning, transformation, and innovation

Each ICB is responsible for the commissioning of and transformation and innovation relating to local pharmacy and optometry. Where services are locally commissioned in addition to the core specification, the monitoring of performance and payment in relation to this will be the responsibility of the local ICB.

d. Controlled drugs

The current arrangement for controlled drugs continues to apply in line with the policy and procedure of the individual ICB and responsibilities set out by the Controlled Drugs Accountable Officer / Function. They will continue to link with the regional Controlled Drugs Accountable Officer on matters of assurance.

e. Data Protection and Information Governance

Data Protection and Information Governance will be the responsibility of each ICB and will provide information and advice to the P&O function as required in relation to their data and processes. HWE ICB is not responsible for specialist advice to the team in relation to these matters.

f. Quality

The responsibilities around quality stays ‘as is’, with the P&O contracting team signposting of contractors as required and follow up of contractual actions.

g. Locally Commissioned Services

Locally Commissioned Services are the responsibility of each ICB. Liaison with the relevant local professional committee will sit with the respective ICB. The P&O Team will work with the ICB to share any relevant intelligence on contractors from which new services will be commissioned.

7. Responsibilities that are retained by NHS England

Directly supporting the delivery of the P&O function are a number of (reserved) functions retained by NHSE East region and third-party suppliers as set out in the National Delegation Agreement. This includes the Professional Standards Team and Counter fraud, provision of these services by NHSE will continue. NHSE will set out how they deliver these services as part of Standard Operating Procedure to be shared with ICBs (Appendix 6).

8. Governance and decision making

The formal governance of matters relating to pharmaceutical services contracting will be through the Pharmaceutical Services Regulations Committee (PSRC) which will have delegated powers from a relevant committee (through the Terms of Reference) of each of the six ICB Boards (equivalent to the Primary Care Commissioning Committee). PSRC will provide standard quarterly reports to the local PCCC or equivalent on decisions made at PSRC. The P&O Contracting Team will provide updates as necessary to respective systems as issues arise.

General Optometry Services matters will be reported to PCCC or equivalent including information to support decision making as and when matters arise, and this will be supported by the P&O Contracting Team.

9. Risk management and risk sharing

a. Risk Management

Each ICB will maintain a risk register. The P&O Team will maintain a log of contract issues such as those arising from CPAF visits. This will be shared annually with ICB leads and formally with the PCCC or equivalent within each ICB. This may be a nil return for some ICBs as number of visits are limited. It will be each ICBs responsibility to include P&O risk and issues in their directorate risk register presented to the equivalent of the Primary Care Commissioning Committee. The P&O Contracting Team will be responsible for escalating or recommending contractual action to PSRC.

Corporate risks such as team resilience, would be recorded as part of the HWE Primary Care Risk Register and shared with all ICBs to include in their risk registers as necessary.

b. Staffing resource risk sharing

HWE ICB will seek to maintain the current level of staff resource to undertake the P&O Contracting Function. Where there is a cost pressure arising such as reliance on agency staff to cover vacancy or absence, HWE will take steps to mitigate this.

Any additional costs arising will be shared equally between the six ICBs. Wherever possible, this will be agreed in advance. If there is a significant underspend against the budget e.g., due to prolonged, unfilled vacancies this will be shared equally by the six ICBs.

c. Financial Risk

Each ICB will receive their agreed delegated funds direct from NHSE and will retain financial responsibility for the management, monitoring and payment process relating to these. This includes compliance with their ICB's financial requirements, processes and systems and audit requirements. HWE ICB is not responsible for any overspends or cost pressures relating to these services.

10. Data sharing

An interim data sharing agreement is in place across the ICBs covered by this MOU and NHS England as a key partner to enable relevant information to be shared. From April 2023 there will be a new national data sharing agreement for POD will be subject to review when available to enable data to flow from hosted function to individual ICBs. Responsibility for the safe sharing of this information sits with HWE as host ICB.

11. Agreement and updating of the SOP

The MOU stands on its own in terms of the agreement to host the P&O Contracting Team by HWE ICB on behalf of the other parties. However, as the transition takes place and the working arrangements embed, we would expect the SOP to continue to be refined. This MOU should therefore be read in conjunction with the latest version of the SOP. Changes will be agreed by ICB nominated leads. As a minimum the SOP should be reviewed **six-monthly** to ensure that it is reflective of current working practices.

12. Termination of this agreement

This MOU shall take effect on the commencement date (1st April 2023) and shall continue in force until the date that the parties jointly determine that this MOU shall terminate.

The ICB Parties, acting collectively or individually, may terminate this MOU for convenience at any time by giving the other Parties not less than twelve months' notice in writing. The Parties shall comply with clause consequences of termination of this MOU.

The termination of this MoU for any reason shall be without prejudice to any rights or obligations which shall have accrued or become due between the Parties prior to the date of termination. Nor shall it affect the coming into force or the continuation in force of any provision of this MOU which is expressly or by implication intended to come into or continue in force on or after such termination.

On termination of this MOU howsoever arising:

- the Parties shall provide all reasonable assistance to each other to ensure an orderly handover of the management services of the contracts undertaken by the P&O Contracting Team under the terms of this MOU;
- the Parties shall use reasonable endeavors to ensure that the handover is carried out with the minimum inconvenience and disruption to the Commissioner Parties and the service users; and
- each Party shall comply with any additional obligations on such Party relating to termination of this MOU as are agreed by the Parties.

On termination of this MOU, each Party shall immediately return to the other Parties (as

relevant), all confidential information of the Parties in its possession, which was obtained pursuant to this MOU.

In the event the hosting arrangement is dissolved, the resource will be reallocated in accordance with the new arrangements in line with TUPE or other relevant policy.

Section two: Standard operating procedures (SOP)

1. The purpose of the SOP

The SOP sets out the way that the hosted team will work and interact with the other ICBs to ensure effective commissioning and contracting of services in line with the national contract and the local requirements of ICBs. This element will be reviewed and updated on a regular basis to reflect changes to business processes as the changes are embedded.

2. The duties of the P&O Contracting Team

The P&O contracting team will continue to undertake the same duties performed within NHSE. These duties are set out in detail in Appendix 2. In summary they include:

- Contractual management and regulation of the market (noting that these services are not procured)
- Contract and Regulatory framework management
- Community pharmacy services delivery
- Clinical waste for community pharmacy
- Rota changes including bank holiday opening

The P&O team is fully integrated with staff members undertaking roles relating to both contractor groups. This single operating model and one team approach has facilitated economies of scale that will continue under the hosting arrangement with HWE ICB.

Under a hosted arrangement, the P&O contracting team will transfer to HWE ICB. The resource to transfer is attached with this MOU. *(Appendix 5).*

The P&O team will not undertake any new duties without explicit agreement between all six parties and due consideration given to the resourcing impact.

The current and established contact routes between contractors and their local representative committees (i.e. LPC, LOC) regarding contracting issues will remain in place and are not altered by the delegation. ICBs may set their own forums for discussion with their local representative committees. Contractors are responsible for notifying the representative committee on contractual issues if they wish. National contracts are negotiated the Pharmaceutical Service Negotiating Committee or via the national team and they are responsible for engaging with representative committees. Local service developments are the responsibility of each ICB.

3. Line management, HR and OD

HWE ICB will be responsible for line management of the team as the employer and HWE HR policies will apply.

a. Host policies

The P&O Contracting Team will work to HWE ICB employment policies and procedures and HWE ICB will ensure that the team receives an effective induction, including to the other five ICBs. The other ICBs will ensure that there is effective material to facilitate the induction of new staff, and that new members of the team are introduced to their key contacts across the systems.

b. Recruitment

HWE ICB will be responsible for the recruitment to vacancies with input from partner ICB where the post to be replaced has a named interface role. Where there is a change that requires either a reduction or increase in resources, this will be agreed with the parties of the MOU and the cost or benefit will be shared equally.

c. Access to training and development

HWE ICB will ensure that all staff in the P&O Contracting Team receive an effective induction and all applicable mandatory training, and the team should be able to access other training as per organisational policy.

d. Employment terms

The P&O Contracting Team will be employed in line with other ICB staff including CoSoP/TUPE for staff transfers (subject to a national decision). No reductions in the team will be made without express agreement of all six ICB parties.

4. The handling of queries and feedback

a. Freedom of information (FOI) and Subject Access requests (SAR)

Regional FOI requests will continue to be coordinated by NHS England. Each ICB remains responsible for FOI and SAR requests about their contracts. FOI and SAR requests received by HWE pertaining to the other ICBs will be directed to apply to the relevant team within each ICB. The P&O Contracting Team will work with each ICB FOI team to provide information if available and will work to agreed timetables as set out in the request from the ICB. (Once a process is agreed with IG leads, this will be added to the MOU as an Appendix).

b. MP letters

MP letters will come to the relevant ICB and the ICB complaints team work collaboratively with P&O to provide a response. Signing off the responses will be the role of the ICB in line with their internal policy.

c. Complaints

The first point of contact for complaints will continue to be the national contact centre. Complaints will be the responsibility of each ICB. The P&O Contracting Team will work with each ICB complaints team to provide information if available and will work to agreed timetables as set out in the request from the ICB.

d. Incidents and serious incidents

Contractors are responsible for logging and investigation of incidents. Each ICB will be responsible for managing incidents, serious incidents, issues, and concerns as raised by the Contractor in line with ICB policies and processes.

The P&O team will undertake any contractual action arising the incident. Where the P&O Team become aware of an incident it will encourage the contractor to report the incident appropriately using NRLS. Incidents related to Controlled Drugs will be reported to the Professional Standards Team. The P&O Team will report any incidents to the relevant ICB.

e. Data Security Breaches

i) By Contractors - Data Security Breaches should be reported by the contractor within 24-48 hours (working week). Where the P&O Team are aware of the breach, the Team will follow up with the contractor to ensure reporting.

ii) By P&O Team – will follow HWE local policy and inform the relevant ICB IG lead.

iii) ICB IG lead will be responsible for working with the P&O team to manage any incidents reported.

5. Assurance function support

a. New contractors

Market Entry is managed by the P&O team in collaboration with PCSE. PCSE will notify the P&O team when there is an application for a contractor to open, close or a contractual change and the first referral process starts. First referrals require a response to a number of set questions. PCSE undertakes a review of information the applicant provides, and P&O undertake a further review and approves.

Checklist for each application and information that is required is completed. Information sent by PCSE to Interested Parties (45 days). 14-day consultation period.

Committee reports then drafted by P&O team. Change of Ownership do not go to PSRC and can be determined under delegated authority. Other reports presented at PSRC where decisions are made on applications. Decision letters issued by PCSE. Memos reflecting any changes also issued by PCSE.

Applications for Changes of Superintendent and Change of Directors are managed by the medical directorate.

All ICBs are invited to attend PSRC. The Pharmacy Manual sets out the process in detail (NHS England » Pharmacy Manual).

b. Existing contractors

Existing pharmaceutical contractors are maintained on a database which forms our Pharmaceutical List. This is a list of contractors broken down by Health and Wellbeing Board. It includes contractor code, full address, contact details including shared NHS mail addresses. A consolidated version of the Pharmaceutical List is available on NHS Futures.

The Dispensing Doctors List is also maintained by the P&O team. This is a list of all dispensing doctors across the region, broken down by Health and Wellbeing Board. It includes contractor code, full address (of main surgery and any branch surgeries), contact details including telephone numbers and NHS mail addresses.

A database of GOS contractors with a mandatory and/or additional services contract is maintained by the P&O team. It includes contractor code, contract type, full address and contact details.

c. Quality issues and links to ICB quality teams

Appendix 4 sets out the quality arrangements which will continue to follow this process.

6. Governance

a. Pharmaceutical Services Regulations Committee (PSRC)

Each ICB has set out its governance and leadership arrangements in a constitution formally approved by NHS England. Each ICB scheme of delegation and reservation will be required to set out decision making responsibilities for the Pharmaceutical Services Regulations Committee (PSRC) which are nationally mandated.

HWE ICB will coordinate and host the Pharmaceutical Services Regulations Committee [PSRC]. This means that the secretariat, chairing responsibilities, agenda setting, management of the committee to agreed Terms of Reference as set out in the Pharmacy Manual (see Appendix 3) and involvement of lead representatives from each ICB.

HWE ICB will host the resources required to deliver the PSRC and deliver the agreed actions, decisions, proposals formed at the PSRC on behalf of the six ICBs. The constitution of the PSRC will ensure that proposals and decision making covering the six ICBs in East of England is effectively enabled. Each of the six ICBs will nominate a lead and senior representative for the PSRC.

b. Optometry governance / committee

All administrative processes relating to the issue of GOS contracts are managed by NHSBSA to ensure a standard, national approach to contract administration. The administrative processes are aligned with the Eye Health Policy Handbook. A “tracker” is sent and reviewed by the P&O team to enable oversight.

Contract terminations, not instigated by the contractor, are managed by the P&O team. Any decision to terminate a contract would be made at the local Primary Care Commissioning or relevant ICB Assurance Committees.

7. Reporting

PSRC will provide standard quarterly reports to the local PCCC or equivalent on decisions made at PSRC. The P&O Contracting Team will provide updates as necessary to respective systems as issues arise.

General Optometry Services matters will be reported to PCCC or equivalent including information to support decision making as and when matters arise, and this will be supported by the P&O Contracting Team.

Appendix 1

Signatures for and on behalf of the parties to this Memorandum of Understanding
(Attached with MOU)

Appendix 2

P&O Contracting Function [taken from the Delegation Agreement]
(Attached with MOU)

Appendix 3

PSRC Terms of Reference [to be updated in line with changes to Pharmacy Manual]
(Attached with MOU)

Appendix 4

Quality Mapping Swim Lane Diagram
(Attached with MOU)

Appendix 5

Pharmacy Optometry Staff Structure
(Attached with MOU)

Appendix 6

SOP for NHSE retained functions - NHSE to provide
(Awaiting document)

Item 7 Appendix 2 - Appendix 1

Signatures for and on behalf of the parties to this Memorandum of Understanding:

Name and role of Signatory	For and on behalf of:	Date	Signature
Name: Dr Jane Halpin Title: Chief Executive Officer	NHS Hertfordshire and West Essex ICB		
Name: Title:	NHS Bedfordshire, Luton and Milton Keynes ICB		
Name: Title:	NHS Cambridgeshire and Peterborough ICB		
Name: Title:	NHS Mid and South Essex ICB		
Name: Title:	NHS Norfolk and Waveney ICB		
Name: Title:	NHS Suffolk and North East Essex ICB		

Extracts from Delegation Agreement

Schedule 2C: Primary Ophthalmic Services

1. Introduction

Function		Current Role/Responsibilities
1.1	This Part 1 of Schedule 2C *(Primary Ophthalmic Services)* sets out general provisions regarding the carrying out of the Delegated Functions, being, in summary:	
1.1.1	Decisions in relation to the management of Primary Ophthalmic Services;	*P&O band 7s provide oversight: review and approve the spreadsheet. Band 3-6 colleagues support the NHSBSA to do administration e.g. new optician/ relocate/ new partners etc. Provide a spreadsheet for oversight on a weekly basis. Interface with Finance prior to issuing a new contract to obtain a code.* *Site visits – some conducted by NHSBSA and some by a clinical adviser (CA);* *If opticians act fraudulently and there is a need to terminate the contract, this action resides with P&O team. There are no market entry regs as long as individual practitioners pass checks for inclusion on the performers list.*
1.1.2	Undertaking reviews of Primary Ophthalmic Services in the Area;	• *CA undertakes. e.g. BSA do Post Payment Verification (PPV) checks – opticians do as many sight tests as they want and get paid for sight tests. BSA do post payment verification. e.g. seeing patients too frequently or claiming for patients who do not qualify as eligible for NHS sight tests. CA will assess if recalling too frequently or not from clinical perspective i.e. there might be a clinical reason for more regular checks. No one in P&O team is clinical.* • *Counter fraud work with BSA e.g. do notes review. Under professional standards, if meet requirement for counter fraud, (individual named practitioner), Medical Directorate triage; fact find, investigate etc. Clinical advisers paid by MD. Professional standards must have clinical adviser to undertake reviews – employed on sessional basis*
1.1.3	Management of the Delegated Funds in the Area;	• *P&O/ finance – interface into system. The P&O finance resource will be delegated to the host system.*

Function		Current Role/Responsibilities
1.1.4	Co-ordinating a common approach to the commissioning of Primary Ophthalmic Services with other commissioners in the Area where appropriate;	• *P&O **contract** not commission. E.g. looking at new services for homeless patients – working with Transformation team to commission a service. Transformation team retained function of NHSE but will continue to work with P&O.*
1.1.5	Such other ancillary activities that are necessary in order to exercise the Delegated Functions.	

Part 2: General Obligations

2.1 The ICB is responsible for managing the provision of Primary Ophthalmic Services.		
2.2 When carrying out Delegated Functions in respect of Primary Ophthalmic Services, the ICB must comply with all Mandated Guidance issued by NHS England.		
2.3 The role of the ICB includes identifying and seeking to address any unmet needs which may be met through the delivery of Primary Ophthalmic Services. *i.e. System approach*		
2.4 In respect of integrated working, the ICB must:		
2.4.1	take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Eye Health Networks, Local Authorities, Healthwatch, acute and community providers, Local Optical Committees, and other stakeholders;	
2.4.2	work with NHS England and other ICBs to co-ordinate a common approach to the commissioning of Primary Ophthalmic Services generally; and	
2.4.3	work with NHS England to coordinate the exercise of their respective performance management functions.	
2.5 In relation to the Delegated Functions, the ICB agrees to perform the following general obligations:		
2.5.1	to manage the Primary Ophthalmic Services Contracts on behalf of NHS England and perform all of NHS England's obligations under each of the Primary Ophthalmic Services Contracts in	• *800 contracts with various contracts – novation of contracts and regional contracts e.g. Translation and Interpretation*

	accordance with the terms of the Primary Care Contracts as if it were named in the contract in place of NHS England;	
2.5.2	working with other organisations, including the NHS Business Services Authority and NHS England as appropriate, actively manage the performance of the Primary Ophthalmic Services Provider in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services including by taking timely action to enforce contractual breaches, serve notices or provide discretionary support;	• *NHSBSA is a mandated contractual arrangement in Schedule 6 of the delegation agreement.*
2.5.3	ensure that it obtains value for money on behalf of NHS England and avoids making any double payments under any Primary Ophthalmic Services Contracts;	• *NHSBSA – admin: PPV, correct errors. P&O is the decision maker about what is actioned.*
2.5.4	notify NHS England immediately (or in any event within two (2) Operational Days) of any breach by the ICB of its obligations to perform any of NHS England's obligations under the Primary Ophthalmic Services Contracts;	• *Action: Define who in ICB escalates to NHSE/ who in NHSE receives – tbc e.g. ICB breach.*
2.5.5	undertake any investigations relating (among other things) to whistleblowing claims, infection control and patient complaints;	• *Safeguarding and IPC is undertaken by the Nursing Directorate - more work required. Adhoc requests / scenario specific issues may require input from P&O /Medical E.g. during covid it came to light there were opticians were claiming at pre-Covid levels. There was a concern that IPC standards and cleaning between appts weren't being adhered to – this was a one-off scenario and clinical adviser x1 plus P&O team x1 undertook effort to complete a number of visits following a national request.*

2.5.6 keep a record of all of the Primary Ophthalmic Services Contracts that the ICB manages on behalf of NHS England setting out the following details in relation to each Primary Ophthalmic Services Contract: 2.5.6.1 name of the Primary Ophthalmic Services Provider; 2.5.6.2 any practice or trading name by which the Primary Ophthalmic Services Provider is known (if different to the name recorded under paragraph 2.5.6.1); 2.5.6.3 location of provision of services; and 2.5.6.4 amounts payable under the Primary Ophthalmic Services Contract (if a contract sum is payable) or amount payable in respect of each patient (if there is no contract sum).	• *Hosted so all with host system. P&O have list of contractors but not 2.5.6.4 which comes from finance. Contract re-issue project underway (Optometry only) to ensure when contracts transfer, documentation is up to date.* • *Transitions with finance*
2.6 Without prejudice to clause 9 *(Finance)* or paragraph 2.5 above, the ICB must actively manage each of the relevant Primary Ophthalmic Services Contracts including by:	
2.6.1 managing the relevant Primary Ophthalmic Services Contract, including in respect of quality standards, incentives, observance of service specifications, and monitoring of activity and finance;	• *P&O, finance, NHSBSA*
2.6.2 assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety);	• *NHSBSA undertakes PPV, complaints* • *MD undertakes concerns management (named practitioners only)*
2.6.3 managing variations to the relevant Primary Ophthalmic Services Contract or services in accordance with national policy, service user needs and clinical developments;	• *NHSBSA and P&O*
2.6.4 agreeing information and reporting requirements and managing information breaches (which will include use of the NHS Digital Data Security and Protection Toolkit);	• *The return goes to NHSBSA – a primary care activity report (PCAR) – and P&O verify the list*
2.6.5 conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes;	• *a very low requirement for P&O*
2.6.6 complying with and implementing any relevant Mandated Guidance issued from time to time.	

2.7 This paragraph is without prejudice to clause 10 (Information, Planning and Reporting) or any other provision in this Agreement. The ICB must provide NHS England with:	
2.7.1 such information relating to individual providers of Primary Ophthalmic Services in the Area as NHS England may reasonably request, to ensure that NHS England is able to continue to gather national data regarding the commissioning or performances of providers of Primary Ophthalmic Services;	• *P&O and NHSBSA*
2.7.2 such data/data sets as required by NHS England to ensure population of any national dashboards;	• *NHSBSA*
2.7.3 any other data/data sets as required by NHS England; and	
2.7.4 the ICB shall procure that providers accurately record and report information so as to allow NHS England and other agencies to discharge their functions.	
Part 2: Specific Obligations	
3 **Introduction**	
3.1 This Part 2 of Schedule 2C *(Primary Ophthalmic Services)* sets out further provision regarding the carrying out of each of the Delegated Functions.	
4 **Primary Ophthalmic Services Contract Management** in each case acknowledging that the NHS Business Services Authority provides end-to-end support services in relation to these functions, as referred to in Schedule 6. The ICB accordingly agrees to co-operate with the NHS Business Services Authority in the delivery of these functions.	
4.1 The ICB must: 4.1.1 comply with all current and future relevant national Mandated Guidance regarding General Ophthalmic Contract reviews and any other contract reviews;	• *contracting change or GOS to P&O e.g. contract variation*
4.1.2 take on the responsibility for existing services provided pursuant to a Primary Ophthalmic Services Contract, and for commissioning new services;	
4.1.3 assume the responsibility for the award of new Primary Ophthalmic Services Contracts; and	
4.1.4 monitor contract performance with a view to achieving assurance and improvement in the delivery of services in the context of the ICB; develop standard and agree structure	
5. Transparency and freedom of information	

5.1 The ICB must:	
5.1.1 Respond to requests for information from members and the public and the media, including requests made pursuant to the FOIA, whose subject-matter relates to the performance of the Delegated Functions in the ICB's Area;	• *P&O team*
5.1.2 Provide information and assistance as required to support NHS England in the preparation of responses to parliamentary questions in connection with the Delegated Functions.	• *P&O (utilise comms teams)*
6. Maintaining the Performers List	
6.1 On receiving a notice from a practitioner (who is party to a Primary Ophthalmic Services Contract) of an amendment to information recorded about them in the Performers List, pursuant to regulation 9(1) of the National Health Service (Performers Lists) (England) Regulations 2013, the ICB must support NHS England's amendment of the performers list as soon as possible after receiving the notice using the Primary Care Support services provided by NHS England, insofar as that amendment relates to a change in contractor details.	• *PCSE manage the performers list. MD has an interface with PCSE. Performers are advised to make any voluntary changes directly to PCSE, MD is notified of the change. MD can make changes to the Performers List arising out of concerns management e.g. compulsory removals*
7. Finance	
7.1 Further requirements in respect of finance will be specified in Mandated Guidance.	
8. Workforce	
8.1 The arrangements for the provision and maintenance of sufficient and appropriately qualified, trained and experienced Staff in order for the ICB to fulfil its responsibilities for each of the Delegated Functions ("the Staffing Model"), will be communicated formally to the ICB by NHS England following recommendations made by the National Moderation Panel. Further requirements in respect of workforce will be specified in Mandated Guidance.	
8.2 The ICB is not permitted to vary the Staffing Model agreed with NHS England as part of its application for delegation of the said functions	

	however a variation can be applied for by the ICB and considered by the National Moderation Panel at any time.	
9.	**Integrating optometry into communities at Primary Care Network level**	
9.1	The ICB must exercise the Delegated Functions with a view to achieving greater integration of optometrists into the Integrated Care System at the Primary Care Network level.	
10.	**Complaints**	
10.1	The ICB will handle complaints made in respect of primary ophthalmic services in accordance with the Complaints Regulations.	• *MD involved when there are complaints about named practitioners and assigns CA when required. Main complaints about P&O relate to translation services issues – particularly for deaf patients. Generally there are 3-4 per annum linked to a specific optical chain.*
11.	**Commissioning ancillary support services**	
11.1	The arrangements for the provision of ancillary services to Primary Ophthalmic Services Providers are described in Schedule 7 (Local Terms).	

Schedule 2D: Delegated Functions – Pharmaceutical Services

The provisions of this Schedule 2D form part of this Agreement only where indicated in the Particulars.

1. In this Schedule, the following additional definitions shall apply:

Advanced Services	has the meaning given to that term by the Pharmaceutical Regulations
Conditions of Inclusion	means those conditions set out at Part 9 of the Pharmaceutical Regulations
Delegated Pharmaceutical Functions	the functions set out at paragraph 2 of this Schedule
Designated Commissioner	has the meaning given to that term at paragraph 2.3 of this Schedule
Dispensing Doctor	has the meaning given to that term by the Pharmaceutical Regulations
Dispensing Doctor Decisions	means decisions made under Part 8 of the Pharmaceutical Regulations
Dispensing Doctor Lists	has the meaning given to that term by the Pharmaceutical Regulations
Drug Tariff	has the meaning given to that term by the Pharmaceutical Regulations
Electronic Prescription Service	has the meaning given to that term by the Pharmaceutical Regulations
Enhanced Services	has the meaning given to that term by the Pharmaceutical Regulations
Essential Services	is to be construed in accordance with paragraph 3 of Schedule 4 to the Pharmaceutical Regulations
Fitness to Practise Functions	has the meaning given to that term at paragraph 2.1.10 of this Schedule
Locally Commissioned Services	means services which are not Essential Services, Advanced Services, Enhanced Services or services commissioned under an LPS Scheme
LPS Chemist	has the meaning give to that term by the Pharmaceutical Regulations
LPS Scheme	has the meaning given to that term by Paragraph 1(2) of Schedule 12 to the NHS Act
NHS Chemist	has the meaning given to that term by the Pharmaceutical Regulations
Pharmaceutical Lists	has the meaning given to that term at paragraph 2.1.1. of this Schedule and any reference to a Pharmaceutical List should be construed accordingly
Pharmaceutical Regulations	means the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and reference to a Regulation refers to a provision of the Pharmaceutical Regulations, unless otherwise stated
Rurality Decisions	means decisions made under Part 7 of the Pharmaceutical Regulations

Terms of Service	means the terms upon which, by virtue of the Pharmaceutical Regulations, a person undertakes to provide Pharmaceutical Services

Function	Current Role/Responsibilities
Delegated Pharmaceutical Functions	
2. Except in so far as they fall within the scope of the Reserved Functions, and subject to paragraphs 2.2, 2.3, 4 and 5, the ICB agrees to perform the following functions of NHS England in respect of the Area (the "Delegated Pharmaceutical Functions"), in all cases in accordance with relevant Law, Mandated Guidance and other Guidance:	
2.1.1 preparing, maintaining and submitting for publication by NHS England lists of persons, other than medical practitioners or dental practitioners, who have undertaken to provide pharmaceutical services from premises situated within the Area[1], specifically:	
2.1.1.1 lists of persons who have undertaken to provide pharmaceutical services in particular by way of the provision of drugs;	• *P&O hold/manage Pharmaceutical List. This is a list of contractors e.g. Boots – want to change hours, change location. If new application not on Pharmaceutical List, an application process is required and this is managed by medical directorate i.e. fit and proper person etc. Once fit and proper, apply to P&O re need in market, gaps etc and added to Pharmaceutical List.* *e.g. provider of stomas – same process as 2.1.1*
2.1.1.2 lists of persons who have undertaken to provide pharmaceutical services only by way of the provision of appliances; and	
2.1.1.3 lists of persons participating in the Electronic Prescription Service[2] collectively referred to in this Schedule as the "Pharmaceutical Lists". In doing so, it is sufficient for the lists	

[1] Including (without limitation) updates to those lists following any removal under regulation 115 of the Pharmaceutical Regulations
[2] Regulation 10 of the Pharmaceutical Regulations

Function		Current Role/Responsibilities
	referred to at paragraphs 2.1.1.1 and 2.1.1.2 to include a marker showing which persons are also participating in the Electronic Prescription Service, rather than preparing a separate list for the purposes of paragraph 2.1.1.3.	
2.1.2	managing and determining applications by persons for inclusion in a Pharmaceutical List[3];	• *MD incl fitness to practice i.e. pharmacist, new pharmacy = PSRC*
2.1.3	managing and determining applications by persons included in a Pharmaceutical List;	• *PSRC*
2.1.4	responsibilities for financial resources related to the Delegated Pharmaceutical Functions as described in Mandated Guidance issued by NHS England;	• *finance to finance*
2.1.5	overseeing the compliance of those included in the Pharmaceutical Lists with:	• *P&O manages terms of service which includes many aspects e.g. breaches etc, e.g. not complying with opening hours. This is business as usual.* • *If there is an issue with a clinician, e.g. performance issue with individual and not advised the P&O team, this constitutes a breach of contract.* • *MD related to individual performer e.g. clinical advisers, panels*
2.1.5.1	their Terms of Service and identifying and investigating breaches, including possible breaches, of those terms;	• *MD. GPHC also undertake visits to pharmacy – can place sanctions on pharmacies.*
2.1.5.2	relevant Conditions of Inclusion;	• *This is a national framework – falls to P&O, Transformation or national team. E.g. introduce new advanced services = Transformation, pharmacy quality scheme = national, pilots = Transformation team*
2.1.5.3	requirements of the Community Pharmacy Contractual Framework.	• *P&O team manage DSQS process.*
2.1.5.4	Management of the Dispensing Services Quality Scheme for those dispensing practices who wish to participate	

[3] Schedule 2 of the Pharmaceutical Regulations

Function		Current Role/Responsibilities
2.1.6	exercising powers in respect of Performance Related Sanctions and Market Exit[4];	• *The MD cover this although when a pharmacy is to be closed, P&O are involved to ensure the required notice period.*
2.1.7	exercising all other rights, and complying with all other obligations, of NHS England in respect of the Terms of Service and Conditions of Inclusion of those included in the Pharmaceutical Lists;	• *P&O and MD (MD for conditions)*
2.1.8	communicating to those included in the Pharmaceutical Lists any announcement made by NHS England modifying Terms of Service of any person included in the Pharmaceutical Lists as a consequence of a disease being, or in anticipation of a disease being imminently:	
2.1.8.1	pandemic; and	• *P&O*
2.1.8.2	a serious risk or potentially a serious risk to human health[5];	• *P&O*
2.1.9	communicating to those included in the Pharmaceutical Lists any other matters which NHS England may require the ICB to communicate from time to time;	• *P&O*
2.1.10	performing functions in respect of the disqualification of practitioners, and related measures concerning a practitioners inclusion in the Pharmaceutical Lists, set out in Chapter 6 of Part 7 to the NHS Act and the provisions of the Pharmaceutical Regulations made under that Chapter ("the Fitness to Practise Functions");	• *Medical Directorate*
2.1.11	performing functions in respect of enforcement, reviews and appeals relating to the Fitness to Practise Functions[6];	• *Medical Directorate*

[4] Part 10 of the Pharmaceutical Regulations
[5] Regulation 11(3) of the Pharmaceutical Regulations
[6] Part 11 of the Pharmaceutical Regulations

Function		Current Role/Responsibilities
2.1.12	making LPS Schemes[7], subject to the requirements of paragraph 5;	• *East of England does not have any LPS Schemes. If it did, it would be P&O*
2.1.13	overseeing the compliance of those who are party to Local Pharmaceutical Services Contracts with the terms of those contracts and identifying and investigating breaches, including possible breaches, of the terms of those contracts;	• *P&O*
2.1.14	exercising all rights, and complying with all obligations, of NHS England under Local Pharmaceutical Services Contracts;	• *P&O*
2.1.15	determining LPS matters[8] in respect of LPS Schemes;	• *P&O*
2.1.16	determining Rurality Decisions and other rurality matters[9];	• *P&O*
2.1.17	determining Dispensing Doctor Decisions[10];	• *P&O*
2.1.18	preparing and maintaining Dispensing Doctor Lists[11];	• *P&O*
2.1.19	making arrangements for the provision of adequate pharmaceutical service delivery across the ICB area;	• *local authority with input from P&O*
2.1.20	making arrangements for the delivery of Essential Services, Advanced Services and Enhanced Services;	• *P&O and Transformation team*
2.1.21	supporting implementation and delivery of all elements of the Community Pharmacy Contractual Framework;	• *P&O and Transformation and national*
2.1.22	consulting with patients, the public and other stakeholders to the extent required by the duty of public involvement and consultation under section 14Z45 of the NHS Act;	• *new services liaise*

[7] Section 134 NHS Act and Part 13 of the Pharmaceutical Regulations.
[8] Part 13 of the Pharmaceutical Regulations
[9] Part 7 of the Pharmaceutical Regulations
[10] Part 8 of the Pharmaceutical Regulations
[11] Regulation 46 of the Pharmaceutical Regulations

Function		Current Role/Responsibilities
2.1.23	responding to Appeals to the Secretary of State and First Tier Tribunal in respect of the Delegated Pharmaceutical Functions[12];	• *P&O e.g. applicant and MD e.g. person*
2.1.24	responding to Claims in respect of the Delegated Pharmaceutical Functions; query	
2.1.25	recovering overpayments from NHS Chemists, LPS Chemists, Dispensing Doctors and Primary Medical Services Providers[13];	• *NHSBSA e.g. meds delivery service, pharmacy over claimed, to PSRC*
2.1.26	bringing any legal proceedings in respect of the Delegated Pharmaceutical Functions;	
2.1.27	making any notifications to, and consulting with, third parties in respect of the Delegated Pharmaceutical Functions;	• *P&O/ Med Dir*
2.1.28	recognising one or more Local Pharmaceutical Committees which it considers are representative of Pharmaceutical Services Providers in the ICB's Area and liaising with and consulting such Local Pharmaceutical Committees as required by the Pharmaceutical Regulations;	• *P&O/ Med Dir*
2.1.29	commissioning the provision of NHS Smartcards to Pharmaceutical Services Providers and their staff by registration authorities;	• *NHS digital*
2.1.30	making any payments due to NHS Chemists suspended from a Pharmaceutical List in accordance with the determination made by the Secretary of State in respect of such payments;	• *MD are actively involved in the suspensions process as it falls within the managing concerns framework. Finance are informed when a suspension has occurred so that payments can be made. The national professional standards team have oversight of all suspensions across the country and report to DH*
2.1.31	undertaking any investigations relating (among other things) to whistleblowing claims (relating to a superintendent pharmacist, a	• *A CA is engaged by the MD if it is about a named practitioner, or if it is an investigation into an organisation = P&O, or regulator or counter fraud*

[12] Schedule 3 of the Pharmaceutical Regulations
[13] Regulation 94 of the Pharmaceutical Regulations

Function	Current Role/Responsibilities
director or the operation of a pharmacy contractor), infection control and patient complaints.	
2.2 Where the Area comprises the areas of two or more Health and Wellbeing Boards in their entirety:	
2.2.1 the Delegated Pharmaceutical Functions shall be exercised so as to maintain separately in respect of each Health and Wellbeing Board area:	• *P&O*
2.2.1.1 Pharmaceutical Lists in respect of premises in that Health and Wellbeing Board area;	• *P&O*
2.2.1.2 a list of LPS Chemists providing local pharmaceutical services at or from premises in that Health and Wellbeing Board area[14]; and	• *P&O*
2.2.1.3 a Dispensing Doctor List (together the "Relevant Lists"); and	• *P&O*
2.2.2 the ICB shall comply with such Contractual Notices as NHS England may issue from time to time concerning the arrangements for the exercise of the Delegated Pharmaceutical Functions across two or more Health and Wellbeing Board areas.	• *P&O*
2.3 Where the Area comprises part of the area of a Health and Wellbeing Board (the "Relevant Health and Wellbeing Board"):	
2.3.1 NHS England shall by Contractual Notice designate: 2.3.1.1 the ICB; 2.3.1.2 another ICB whose area comprises in part the area of the Relevant Health and Wellbeing Board; or 2.3.1.3 NHS England;	

[14] Regulation 114 of the Pharmaceutical Regulations

Function	Current Role/Responsibilities
as the body responsible for maintaining as the body responsible for maintaining the Relevant Lists (as defined in paragraph 2.2.1 of this Schedule 2D) in respect of the Relevant Health and Wellbeing Board ("the Designated Commissioner");	
the ICB shall exercise the Delegated Pharmaceutical Functions in respect of that part of the Relevant Health and Wellbeing Board's area that falls within the Area but in doing so shall liaise with any Designated Commissioner for the purposes of maintaining the accuracy of the Relevant Lists (as defined in paragraph 2.2.1 of this Schedule 2D) in respect of the Relevant Health and Wellbeing Board; and	
2.3.2 the ICB shall comply with all Contractual Notices issued by NHS England for the purposes of determining responsibilities in the circumstances described in this paragraph 3.3.	
Prescribed support	
3. Notwithstanding the inclusion of the following within the Delegated Functions, the ICB shall discharge the functions set out at:	
3.1 Paragraph 3.1.1 (maintaining Pharmaceutical Lists)	• *P&O*
3.2 Paragraph 3.1.2 (managing applications for inclusion)	• *MD*
3.3 Paragraph 3.1.3 (managing applications from those included in a list)	• *P&O*
3.4 Paragraph 3.1.5 (overseeing compliance with Terms of Service and Conditions of Inclusion)	• *P&O or MD depending on scenario*
3.5 Paragraph 3.1.10 (Fitness to Practise)	• *MD*
3.6 Paragraph 3.1.18 (maintaining and publishing Dispensing Doctors Lists)	• *P&O*
3.7 Paragraph 3.1.25 (recovery of overpayments)	• *NHSBSA and P&O if specific requests needs to go to PSRC* with the assistance and support of the NHS Business Services Authority, Primary Care Support England or such other person as NHS England shall designate by Contractual Notice for these purposes from time to time and in accordance with the allocation of operational responsibilities described by NHS England in Mandated Guidance.
LPS Schemes	

Function	Current Role/Responsibilities
4. The ICB shall not without the prior written consent of NHS England make any new LPS Schemes.	
Barred Persons	
5. The ICB must ensure that persons barred from involvement in specific elements of the Delegated Functions are excluded from such involvement in accordance with the Pharmaceutical Regulations.	• *Med Dir*
Other Services	
6. The provisions of this schedule are without prejudice to the ability of the ICB to make arrangements for the provision of Locally Commissioned Services for the purposes of the NHS in accordance with its own commissioning functions and using its own financial resources.	•
Payments	
7. In exercising the Delegated Pharmaceutical Functions, the ICB must ensure that:	
7.1 all payments to which the Drug Tariff applies are made solely in accordance with the Drug Tariff; and	• *finance*
7.2 any other payments for services (including without limitation those relating to LPS Schemes and Enhanced Services) are made in accordance with recognised contractual mechanisms intended to apply to those services.	• *Ad hoc = P&O e.g. Bank Holiday commissioning*
Flu vaccinations	
8 The Parties acknowledge and agree that:	
8.1 responsibility for arranging any national scheme for flu vaccinations remains with NHS England as part of its Section 7A Functions; and Public Health,	• *P&O attend wider Public Health meetings re the delivery of flu programme from a pharmacy perspective*
8.2 where any such national scheme is arranged by NHS England, the ICB is required to commission flu vaccines as Advanced Services. For the purposes of this Agreement, this forms part of the ICB's responsibilities under clause.	• *Advanced Service, pharmacy register intent to provide i.e. register. No input from commissioning or system. Like DES is optional.*
Integration	
9 In respect of integrated working, the ICB must:	•

Function	Current Role/Responsibilities
9.1.1 take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Authorities, Healthwatch, acute and community providers, professional representative groups, contractor representative groups and other stakeholders;	
9.1.2 work with NHS England and other ICBs to co-ordinate a common approach to the commissioning of Pharmaceutical Services generally; and	
9.1.3 work with NHS England to coordinate the exercise of their respective performance management functions.	• *Contract assurance – P&O, visits c.15 pa. Take a clinician from MD – P&O pay for this clinician*
Integrating pharmacy into communities at Primary Care Network level	
10 The ICB must exercise the Delegated Functions with a view to achieving greater integration of community pharmacy into the Integrated Care System at the Primary Care Network level including participation in network governance arrangements.	
Complaints	
11 The ICB will handle complaints made in respect of Pharmaceutical Services and Local Pharmaceutical Services in accordance with the Complaints Regulations.	• *Not many complaints. Look into contractual issue – P&O. If about a pharmacist – med dir. Or direct to pharmacy. Medical advisers help with responses.*
Commissioning ancillary support services	
12 The arrangements for the provision of ancillary services to Pharmaceutical Services Providers are described in Schedule 7 (Local Terms).	
Finance	
12.1 Further requirements in respect of finance will be specified in Mandated Guidance.	
Workforce	
14.1 Further requirements in respect of workforce will be specified in Mandated Guidance.	

SCHEDULE 1

Reserved Functions

1.	**Introduction**	
	1.1	In accordance with clause **Error! Reference source not found.** of this Agreement, all functions of NHS England other than those defined as Delegated Functions are Reserved Functions.
	1.2	This SCHEDULE 3 (Reserved Functions) sets out further provision regarding the carrying out of the Reserved Functions.
	1.3	The ICB will work collaboratively with NHS England and will support and assist NHS England to carry out the Reserved Functions.
2.	**Management of the national performers list – (Medical Directorate)**	
	2.1	Subject to Paragraph 2.2, NHS England will continue to perform its functions under the National Health Service (Performers Lists) (England) Regulations 2013.
	2.2	The ICB will carry out administrative tasks in respect of the Performers Lists as described at: 2.2.1 Paragraph 9 of Part 2, Schedule 2A; 2.2.2 Paragraph 9 of Part 2, Schedule 2B; and 2.2.3 Paragraph 6 of Part 2, Schedule 2C.
	2.3	NHS England's functions in relation to the management of the national performers list include: 2.3.1 considering applications and decision-making in relation to inclusion on the national performers list, inclusion with conditions and refusals; 2.3.2 identifying, managing and supporting primary care performers where concerns arise; and 2.3.3 managing suspension, imposition of conditions and removal from the national performers list.
	2.4	NHS England may hold local Performance Advisory Group ("PAG") meetings to consider all complaints or concerns that are reported to NHS England in relation to a named performer and NHS England will determine whether an initial investigation is to be carried out.

2.5	NHS England may notify the ICB of all relevant PAG meetings at least seven (7) days in advance of such meetings. NHS England may require a representative of the ICB to attend such meetings to discuss any performer concerns and/or quality issues that may impact on individual performer cases.	
2.6	The ICB must develop a mechanism to ensure that all complaints regarding any named performer are escalated to the Local NHS England Team for review. The ICB will comply with any Mandated Guidance issued by NHS England in relation to the escalation of complaints about a named performer.	• *There is currently a process in place between MD and the complaints team. It is expected that this process will continue. (If this process needs to be broadened to incorporate existing complaints management within systems then a meeting to discuss would be necessary as will impact on resources if there are a greater number of complaints than current)*
3.	**Management of the revalidation and appraisal process – (Medical Directorate)**	
3.1	NHS England will continue to perform its functions under the Medical Profession (Responsible Officers) Regulations 2010 (as amended by the Medical Profession (Responsible Officers) (Amendment) Regulations 2013).	
3.2	All functions in relation to GP appraisal and revalidation will remain the responsibility of NHS England, including: 3.2.1 the funding of GP appraisers; 3.2.2 quality assurance of the GP appraisal process; and 3.2.3 the responsible officer network	
3.3	Funding to support the GP appraisal is incorporated within the global sum payment to Primary Medical Services Provider.	
3.4	The ICB must not remove or restrict the payments made to Primary Medical Services Provider in respect of GP appraisal.	
3.5	Appraisal arrangements in respect of all other primary care practitioner groups shall also be Reserved Functions.	
4.	**Administration of payments and related performers list management activities – (National professional standards team)**	
4.1	NHS England reserves its functions in relation to the administration of payments to individual performers and related performers list management activities under the National Health Service (Performers Lists) (England) Regulations 2013 and other relevant legislation.	
4.2	NHS England may continue to pay practitioners who are suspended from the national performers list in accordance with relevant determinations made by the Secretary of State.	

4.3	For the avoidance of doubt, the ICB is responsible for any ad hoc or discretionary payments to Primary Medical Services Providers (including those under section 96 of the NHS Act) in accordance with **Error! Reference source not found.** (Delegated Functions) Part 1 paragraphs **Error! Reference source not found.** and **Error! Reference source not found.** of this Agreement, including where such payments may be considered a consequence of actions taken under the National Health Service (Performers Lists) (England) Regulations 2013.
5.	**Section 7A and Capital Expenditure Functions (Retained NHSE functions)**
5.1	In accordance with clause **Error! Reference source not found.**, NHS England retains the Section 7A Functions and will be responsible for taking decisions in relation to the Section 7A Functions.
5.2	In accordance with clauses **Error! Reference source not found.** and **Error! Reference source not found.**, the ICB will provide certain management and/or administrative services to NHS England in relation to the Section 7A Functions.
5.3	In accordance with clause **Error! Reference source not found.Error! Reference source not found.**, NHS England retains the Capital Expenditure Functions and will be responsible for taking decisions in relation to the Capital Expenditure Functions.
5.4	In accordance with clauses **Error! Reference source not found.** and **Error! Reference source not found.**, the ICB will provide certain management and/or administrative services to NHS England in relation to the Capital Expenditure Functions.
6.	**Such other ancillary activities that are necessary in order to exercise the Reserved Functions – (Medical Directorate)**
6.1	NHS England will continue to comply with its obligations under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.
6.2	The ICB must assist NHS England's controlled drug accountable officer ("CDAO") to carry out its functions under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.
6.3	The ICB must nominate a relevant senior individual within the ICB (the "ICB CD Lead") to liaise with and assist NHS England to carry out its functions under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.
6.4	The ICB CD Lead must, in relation to the Delegated Functions: 6.4.1 on request provide NHS England's CDAO with all reasonable assistance in any investigation involving the Delegated Functions; 6.4.2 report all complaints involving controlled drugs to NHS England's CDAO; 6.4.3 report all incidents or other concerns involving the safe use and management of controlled drugs to NHS England's CDAO; 6.4.4 analyse the controlled drug prescribing data available; and

6.4.5 on request supply (or ensure organisations from whom the ICB commissions services involving the regular use of controlled drugs supply) periodic self–declaration and/or self-assessments to NHS England's CDAO.

7. Reserved Functions – Primary Medical Services

7.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Primary Medical Services Functions"):

7.1.1 determining the outcomes expected from Primary Medical Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes and the Department of Health and Social Care mandate;

7.1.2 designing and delivering national transformation programmes in support of national priorities;

7.1.3 the negotiation and agreement of matters concerning General Medical Services contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary medical services nationally;

7.1.4 the development of national standard Primary Medical Service contracts and national contract variations and guidance to ensure an equitable approach to applying nationally agreed changes to all Primary Medical Services providers;

7.1.5 the provision of commissioning and contracting policy and guidance to support ICBs to meet their delegated duties;

7.1.6 the provision of nationally contracted services delivering digital, logistical and support services for Primary Medical Services in England (including but not limited to):

7.1.6.1 Payments;

7.1.6.2 Pensions;

7.1.6.3 Patient Registration;

7.1.6.4 Medical Records;

7.1.6.5 Performer List;

7.1.6.6 Supplies;

7.1.6.7 Call and Recall for Cervical screening (CSAS); and

7.1.6.8 Pharmacy Market Management. (via P&O process)

7.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

8. Reserved Functions – Primary Dental Services

8.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Primary Dental Services Functions"):

8.1.1 determining the outcomes expected from Primary Dental Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes; designing and delivering national transformation programmes in line with any applicable commissioning policies and guidance;

8.1.2 the negotiation and agreement of matters concerning Dental Services Contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary dental services nationally;

8.1.3 the development of national standard Dental Service Contracts and national contract variations and guidance to ensure an equitable approach to applying nationally agreed changes to all Primary Dental Services providers;

8.1.4 the provision of all dental commissioning and contracting policy and guidance to support ICBs to meet their delegated duties; and

8.1.5 the provision of nationally contracted services delivering digital, logistical and support services for Primary Dental Services in England (including but not limited to):

8.1.5.1 Payments;

8.1.5.2 Pensions;

8.1.5.3 Performer List; and

8.1.5.4 Market Management.

8.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

9. Reserved Functions – Primary Ophthalmic Services

9.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Ophthalmic Functions"):

9.1.1 the Primary Ophthalmic Services Contracts policy and associated documentation;

9.1.2 the negotiation and agreement of matters concerning Primary Ophthalmic Services with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of Ophthalmic Services nationally; and

9.1.3 the provision of nationally contracted services delivering digital, logistical and support services for Primary Ophthalmic Services in England (including but not limited to):

9.1.3.1 Payments;

9.1.3.2 Performers List;

9.1.3.3 Market Management/Entry; and 9.1.3.4 Contract management, assurance and post-payment verification.	
9.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services	
10. Reserved Functions – Pharmaceutical Services and Local Pharmaceutical Services – Medical Directorate	
10.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Pharmaceutical Functions"): 10.1.1 publication of Pharmaceutical Lists; national (P&O manage from regional perspective) 10.1.2 functions of NHS England as a determining authority in relation to pharmaceutical remuneration under Part 12 of the Pharmaceutical Regulations; 10.1.3 functions in respect of lists of performers of pharmaceutical services and assistants, noting that as at the date of this Agreement regulations for the purposes of these functions have not been made[15]; 10.1.4 the negotiation and agreement of matters concerning NHS pharmaceutical services with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of Pharmaceutical Services nationally; 10.1.5 the provision of commissioning and contracting policy and guidance to support ICBs to meet their delegated duties; and 10.1.6 administration of the pharmacist pre-registration training grant scheme.	• *We record a list of pre-reg trainees with their start date and end date and where they are/were training. The full cost of training is £18,440, paid monthly over 1 year.*

[15] Part 7, Chapter 4A of the NHS Act (not currently in force)

Terms of Reference

NHS England and NHS Improvement
East Region
Pharmaceutical Services Regulation Committee

Terms of Reference

Pharmaceutical Services Regulation Committee

Issue Date: **June 2019**

Prepared by: **Melanie Wilson**

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Reviewers

This document must be reviewed by:

Reviewer name	Title/responsibility	Date	Version
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Related documents

Title	Owner	Location
TOR for PCPHOG	NHS England and NHS Improvement	
Conflicts of Interest	NHS England and NHS Improvement	

Document control

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Contents

1. Purpose

NHS England and NHS Improvement has established local committees to be known as Pharmaceutical Services Regulations Committees (“PSRC”) and appointed regional Pharmacy Contract Managers (PCMs).

Each PSRC is authorised by NHS England and NHS Improvement to undertake any activity within these Terms of Reference. These Terms of Reference specifically refer and apply to the East Region PSRC.

2. General Responsibilities of the Group

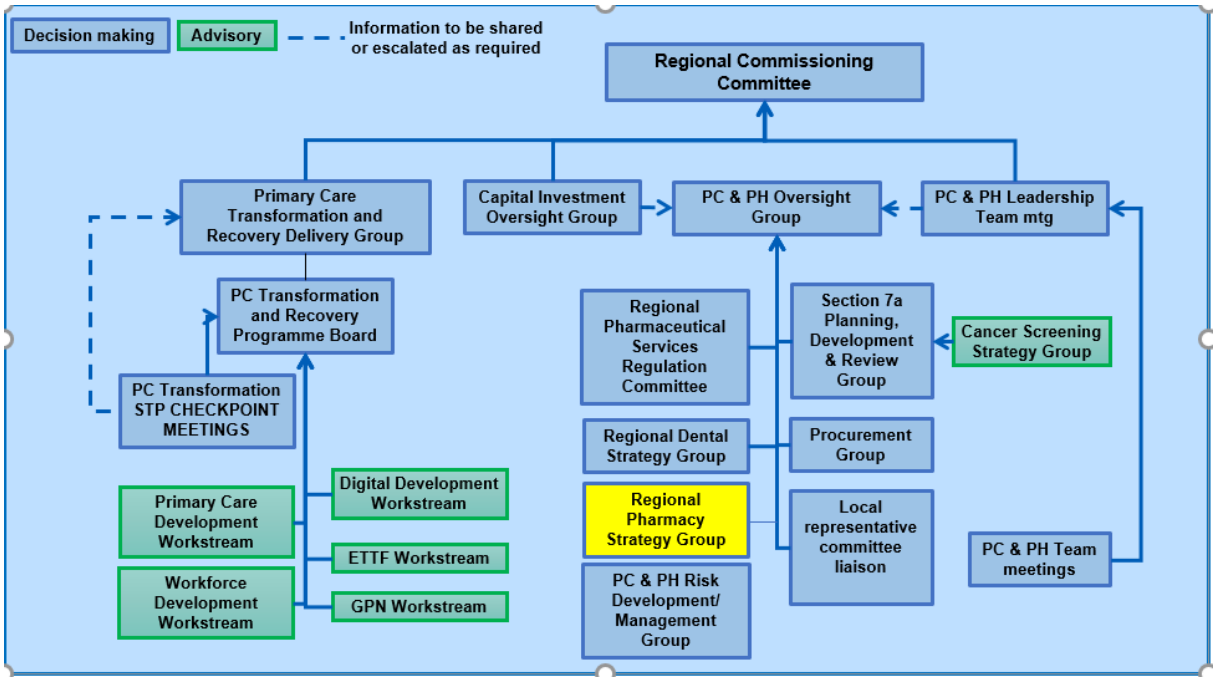
NHS England and NHS Improvement has delegated decision making to each PSRC in relation to matters under the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (the "Regulations") listed in Chapter 3 of the Pharmacy Manual, where the decision maker is listed as the PSRC and in accordance with **Appendix 1**.

All decisions made by PSRC will be:

- made in line with the timescales set out within the Regulations;
- fully reasoned; and
- documented within the minutes of the PSRC meeting (if the decision has been made by that committee) or otherwise in a note made by the PCM.

3. Accountability and Lines of Reporting

Each PSRC will report quarterly to the Primary Care and Public Health Oversight Group (PCPHOG) on the decisions taken and the outcome of any appeals on those decisions. Where it has been considered appropriate to cancel a PSRC or hold an additional meeting for any reason this will be added to the report to the PCPHOG.



3.1 Delegated Decision Making

If the decision maker is listed as "PSRC", only the regional PSRC may make that decision. (Appendix 1)

If the decision maker is listed as "PCM or PSRC", the decision may be made by the PCM or (in circumstances described in Chapter 2 of the Pharmacy Manual) by the local PSRC.

If the decision maker is listed as the "PSRC or PLDP", (Performer List Decision Panel) the decision may be made by the regional PSRC or (in circumstances described in chapter 2 of the Pharmacy Manual) by the regional PLDP.

3.2 PCM Decision Making

Persons ineligible to be a PCM are listed in Regulation 62 and in paragraph 26(1) of Schedule 2 to the Regulations. The PCM will sign a declaration to confirm that he or she is not barred by virtue of this paragraph. (Appendix 3)

NHS England and NHS Improvement has delegated decision making through the PSRC to each PCM in relation to matters under the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (the "Regulations") listed in Chapter 3 of the Pharmacy Manual, where the decision maker is listed as "PCM or PSRC".

If, for whatever reason, the PCM is unable to make a decision within the required timeframe (or at all), that decision shall be taken by the PSRC.

The PCM will report monthly to the PSRC on decisions taken and the outcome of any appeals on those decisions.

The PCM will also maintain a register of applications received, including details of the status and progress of each application.

3.3 The Role of the Performer List Decision Making Panel

NHS England and NHS Improvement has established regional PLDPs.

NHS England and NHS Improvement may delegate decision making through the PSRC to each PLDP in relation to matters under the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (the "Regulations") listed in Chapter 3 of the Pharmacy Manual, where the decision maker is listed as "PSRC or PLDP". The PSRC may delegate such matters to the PLDP for whatever reason.

The PSRC must ensure that the members of the PLDP are eligible to take part in the matter by ensuring that no members are a type of person listed in Regulation 62 and in paragraph 26 of Schedule 2 to the Regulations.

The PLDP will report monthly to the PSRC on decisions taken and the outcome of any appeals on those decisions.

4. Membership

4.1 The voting membership of each PSRC is as follows:

- Director of Primary Care and Public Health (or their suitable, nominated deputy) who will Chair the meeting in the absence of the Head of Commissioning (Primary Care).
- Head of Commissioning (Primary Care) (or their suitable, nominated deputy) who will Chair the meeting; and
- Up to two Lay Members.

All members of the PSRC must have good knowledge and understanding of the Regulations in order to reduce the likelihood of a successful appeal against decisions made. It is essential that members build up expertise in the Regulations and therefore consistency of attendance is expected.

Due to the knowledge and understanding of the Regulations that is required, PSRC lay members are considered to be “expert volunteers” for the purposes of NHS

England and NHS Improvement's volunteering policy and should receive the appropriate fee.

Each member of PSRC has a vote and the Chair has the casting vote, if necessary.

Each PSRC will be quorate if any two of the three categories of voting members shown in 4.1 are present, one of which must by an NHS officer.

Each PSRC may obtain such legal or other independent professional advice as it considers necessary and may co-opt persons with relevant experience and expertise if required.

Each PSRC must follow current NHS England and NHS Improvement processes for obtaining legal advice.

The following persons will be co-opted to each PSRC:

- Pharmacy Contract Manager (or equivalent); and
- Pharmacy professional adviser (or equivalent) if applicable.

The PSRC can co-opt anyone for specific agenda items but they will be non-voting as are the two roles above. In recognition of transition to Integrated Care Systems (ICSs) by 1 April 2023, ICS representatives will be invited to each meeting. ICS representatives will be non-voting observers.

Persons ineligible to be voting or co-opted members of a PSRC are listed in Regulation 62 and in paragraph 26(1) of Schedule 2 to the Regulations. All voting and co-opted members must sign a declaration to confirm that they are not barred by virtue of this paragraph.

The Chair can require any co-opted member to leave the room before discussion of a matter and not return until the relevant decision has been made. The minutes will record the absences of the relevant co-opted member.

No member may take part in a decision if, in the opinion of the remaining voting members, the circumstances set out in paragraph 26(2) of Schedule 2 to the Regulations apply (reasonable suspicion of bias). (**Appendix 2**)

Health and Wellbeing Boards (HWBs) are responsible for identifying current or future needs, improvements or better access to, a pharmaceutical service or pharmaceutical services in general via the pharmaceutical needs assessment (PNA). The PSRC will inform Systems of any closure of Pharmacies and other issues which may have a detrimental impact on local services.

5. Frequency of Meetings

Meetings will be held on a monthly basis.

6. Secretariat

Secretariat support will be provided by the Pharmacy and Optometry administration team.

7. Agenda and Papers

Agendas and papers will be circulated electronically one week before the meeting.

8. Conflicts of interest

Members must advise the Chair of any potential conflict of interest upon receipt of the papers for a meeting. Discussion of those potential conflicts will take place at the beginning of each meeting and will be recorded. Where a conflict is perceived to exist in relation to a matter, the member with that conflict will leave the room before discussion of that matter and will not return until the relevant decision has been made and the reasons for it have been recorded

Appendix 1 – Delegated Decision Making

Regulatory provision	Decision Maker	Chapter of Manual
Regulations 13 and 14 – determination of application (current need)	PSRC	Chapter 12 Chapter 22
Regulations 15 and 16 – determination of application (future need)	PSRC	Chapter 13 Chapter 22
Regulations 17 and 19 – determination of application (current improvement/better access)	PSRC	Chapter 14 Chapter 22
Regulations 18 and 19 – determination of application (unforeseen benefits)	PSRC	Chapter 15 Chapter 22
Regulations 20 and 21 – determination of application (future improvement / better access)	PSRC	Chapter 16 Chapter 22
Regulation 23 – determination of application (application from NHS chemist in respect of providing directed services)	PSRC	Chapter 24
Regulation 24 – determination of application (relocation involving no significant change)	PSRC	Chapter 17 Chapter 22
Regulation 25 – determination of application (distance selling pharmacies)	PSRC	Chapter 18
Regulation 26(1) – determination of application (change of ownership)	PCM or PSRC	Chapter 19
Regulation 26(2) – determination of application (relocation involving no significant change/change of ownership)	PSRC	Chapter 21 Chapter 22
Regulation 26A – determination of preliminary matters including refusal of application for reasons set out in Regulation 26A(5)(b)	PCM	Chapter 20

Regulatory provision	Decision Maker	Chapter of Manual
Regulation 26A – determination of application (consolidation onto an existing site)	PSRC	Chapter 20
Regulation 27 – determination of application (for temporary listing arising out of suspension)	PSRC	Chapter 25
Regulation 28 – determination of application (exercising right of return to the pharmaceutical list)	PCM or PSRC	Chapter 26
Regulation 29 – determination of application (temporary arrangements during emergencies / because of circumstances beyond the control of NHS chemists)	PCM or PSRC	Chapter 27
Regulation 30 – refusal on language requirement for some NHS pharmacists	PSRC or PLDP	Chapter 4
Regulation 31 - refusal: same or adjacent premises	PSRC	
Regulation 32 - deferrals arising out of LPS designations	PCM or PSRC	
Regulation 33 – determination of suitability of an applicant to be included in a pharmaceutical list on fitness grounds	PSRC or PLDP	Chapter 4
Regulation 34 – determination of deferral of application to be included in a pharmaceutical list on fitness grounds	PSRC or PLDP	Chapter 4
Regulation 35 – determination of conditional inclusion of an applicant to be included in a pharmaceutical list on fitness grounds	PSRC or PLDP	Chapter 4
Regulation 36 – determination of whether an area is a controlled locality (or is part of a controlled locality), as a result of a local medical committee or local pharmaceutical committee request for	PSRC	Chapter 33

Regulatory provision	Decision Maker	Chapter of Manual
such a determination or because NHS England is satisfied that such a determination is required (and make arrangements for any controlled locality to be clearly delineated on a published map)		
Regulation 40 – applications for new pharmacy premises in controlled localities: refusals because of preliminary matters	PSRC	
Regulations 41 and 42 – determination of whether premises are (or a best estimate is) in a reserved location (and make arrangements for any reserved location to be clearly delineated on a published map)	PSRC	Chapter 32
Regulation 44 - prejudice test in respect of routine applications for new pharmacy premises in a part of a controlled locality that is not a reserved location	PSRC	Chapter 32
Regulation 48(2) - determination of patient application ('serious difficulty' applications)	PCM or PSRC	Chapter 34
Regulation 50 – consideration of 'gradualisation' (i.e. the postponement of the discontinuation of services by dispensing doctors) for an application in relation to premises in, or within 1.6 kilometres of, a controlled locality	PSRC	Chapter 33
Regulations 51 to 60 – determination of doctor application (outline consent and premises approval) including the taking effect of decisions, relocations, gradual introduction of premises approval, temporary provisions in cases of relocations or additional premises where premises approval has not taken effect, practice amalgamations, and lapse of outline consent and premises approval.	PSRC	Chapter 34
Regulation 61 - temporary arrangements during emergencies or circumstances beyond the control of a dispensing doctor.	PCM or PSRC	Not discussed

Regulatory provision	Decision Maker	Chapter of Manual
Regulation 65(5) to (7) – direction to increase core opening hours	PCM or PSRC	Chapter 36
Regulation 67 – agreement of a shorter notice period for withdrawal from a pharmaceutical list	PSRC	
Regulation 69 – determination of whether there has been a breach of terms of service	PSRC	Chapter 38
Regulation 70 – determination of whether to issue a breach notice with or without an accompanying withholding of payments in connection with a breach of terms of service. Determination of whether to rescind a breach notice.	PSRC	Chapter 38
Regulation 71 – determination of whether to issue a remedial notice with or without an accompanying withholding of payments in connection with a breach of terms of service. Determination of whether to rescind a remedial notice.	PSRC	Chapter 38
Regulation 72 – determination of whether to withhold remuneration	PSRC	Chapter 38
Regulation 73 – determination of whether to remove premises or a chemist from the pharmaceutical list (following remedial or breach notice)	PSRC	Chapter 38
Regulation 74 – determination of whether to remove premises or a chemist from the pharmaceutical list (death, incapacity or cessation of service)	PSRC	Chapter 38
Regulation 79 – determination of review of fitness conditions originally imposed on the grant of an application	PSRC or PLDP	Chapter 32
Regulation 80 – determination of removal of a contractor for breach of fitness conditions	PSRC or PLDP	Chapter 31

Regulatory provision	Decision Maker	Chapter of Manual
Regulation 81 and 82 – determination of removal or contingent removal	PSRC or PLDP	Chapter 32
Regulation 83 – suspensions in fitness cases	PSRC or PLDP	Chapter 32
Regulation 84 – reviewing suspensions and contingent removal conditions	PSRC or PLDP	Chapter 32
Regulation 85 – general power to revoke suspensions in appropriate circumstances	PSRC or PLDP	Chapter 32
Regulation 94 – overpayments	PSRC	Chapter 39
Regulation 99 – designation of an LPS area	PSRC	Chapter 41
Regulation 100 – review of designation of an LPS area	PSRC	Chapter 41
Regulation 101 – cancellation of an LPS area	PSRC	Chapter 41
Regulation 104 – selection of an LPS proposal for development and decision to adopt proposal	PSRC	Chapter 41
Regulation 108 – right of return for LPS contractor	PSRC	Chapter 41
Schedule 2, paragraph 1(10) – whether best estimate is acceptable	PCM or PSRC	Chapter 29

Regulatory provision	Decision Maker	Chapter of Manual
Schedule 2, paragraph 11(1) – determination of whether there is missing information	PCM	Chapter 29
Schedule 2, paragraph 11(2)(b) – determination of review of reasonableness of request for missing information	PCM or PSRC	Chapter 29
Schedule 2, paragraph 14 – whether to defer consideration of application	PCM or PSRC	Chapter 29
Schedule 2, paragraph 19 – determination of who is to be provided with notice of a notifiable application	PCM	Chapter 29
Schedule 2, paragraph 21(4) – determination of whether the full disclosure principle applies to information contained within a notifiable application	PSRC	Chapter 29
Schedule 2, paragraph 22(2) – whether oral representations are to be provided and who may be additional presenters as defined in Schedule 2, paragraph 25(2)	PCM or PSRC	Chapter 29
Schedule 2, paragraph 28 – determination of who is to be notified of decisions on routine and excepted applications	PCM or PSRC	Chapter 29
Schedule 3, paragraph 30 – determination of who is to have a third party right of appeal against decisions on routine and excepted applications	PCM or PSRC	Chapter 29
Schedule 2, paragraph 31 – consideration of a notification of address following a 'best estimate' routine application. Where this may lead to a refusal under regulation 31, the matter should be escalated to the PSRC	PCM or PSRC	Chapter 29
Schedule 2, paragraph 32 – determination of whether to accept a change to premises	PCM or PSRC	

Regulatory provision	Decision Maker	Chapter of Manual
Schedule 2, paragraph 33 – determination as to whether the future circumstances have arisen	PCM	
Schedule 2, paragraph 34(4)(c)(i) and 34A(4)(b)(i) – extension of latest date for receipt of notice of commencement	PCM or PSRC	Chapters 12 - 21, 24 - 27
Schedule 2, paragraph 35 – notice requiring the commencement of pharmaceutical services	PCM or PSRC	
Schedule 4, paragraph 23(1) / Schedule 5, paragraph 13(1) – consideration of a request to temporarily suspend the provision of services (fixed period)	PSRC	
Schedule 4, paragraph 23(7) / Schedule 5, paragraph 13(6) – consideration of a notification of a change of supplementary opening hours where the number of supplementary hours is reduced and the change is intended to come into effect sooner than three months after receipt of notification of the change	PSRC	Chapter 37
Schedule 4, paragraph 23(7) / Schedule 5, paragraph 13(6) – consideration of a notification of a change of supplementary opening hours where the number of supplementary hours is increased and the change is intended to come into effect sooner than three months after receipt of notification of the change	PCM or PSRC	Chapter 37
Schedule 4, paragraph 23(7) / Schedule 5, paragraph 13(6) – arranging for amendments to be made to the relevant pharmaceutical list following notification of a change of supplementary opening hours (where change is not intended to come into effect sooner than three months after receipt of notification of change)	PCM or PSRC	Chapter 37
Schedule 4, paragraph 23-25 / Schedule 5, paragraph 13-15 – decision to direct a contractor to open at certain times on certain days	PSRC	Chapter 37

Regulatory provision	Decision Maker	Chapter of Manual
Schedule 4, paragraph 23 (10) / Schedule 5, paragraph 9 – review of reason for temporary suspension within the control of the contractor	PSRC	
Determination of applications to provide MURs at locations other than listed premises	PCM or PSRC	Chapter 35
Approval of responses to an appeal against, or challenge to, decisions of the PSRC	PCM or PSRC	
Approval of responses to an appeal against, or challenge to, decisions of the PCM	PCM or PSRC	
Determination of further action where CPAF identifies concerns	PCM or PSRC	Chapter 38
Determination of further action where the contractor fails or refuses to agree a date and time for a visit	PCM or PSRC	Chapter 38
Determination of action where any of the following are identified: • Patient safety issues; • NHS England is at risk of material financial loss; and/or • Possible fraudulent or criminal activity.	PCM or PSRC	Chapter 38
Determination of action where the contractor fails to complete the required actions or fails to respond to a visit report	PCM or PSRC	Chapter 38
Determination of action where the contractor exceeds the maximum number of AURs that may be done in any one year	PCM	Chapter 38

Appendix 2

The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013

SCHEDULE 2

Persons barred from taking part in decision making on routine and excepted applications

Paragraph 26

(1) No person is to take part in determining or deferring any routine or excepted application who—

(a) is a person who is included in a pharmaceutical list or is an employee of such a person;

(b) assists in the provision of pharmaceutical services under Chapter 1 of Part 7 of the 2006 Act (pharmaceutical services and local pharmaceutical services – provision of pharmaceutical services);

(c) is an LPS chemist, or provides or assists in the provision of local pharmaceutical services;

(d) is a provider of primary medical services;

(e) is a member of a provider of primary medical services that is a partnership or a shareholder in a provider of primary medical services that is a company limited by shares;

(f) is employed or engaged by a primary medical services provider; or

(g) is employed or engaged by an APMS contractor in any capacity relating to the provision of primary medical services, whether or not their involvement would give rise to a reasonable suspicion of bias.

(2) No other person is to take part in determining or deferring a particular routine or excepted application if because of an interest or association they have, or because of a pressure to which they may be subject, their involvement would give rise to a reasonable suspicion of bias.

Appendix 3

Conflicts of Interest and Commercial in Confidence Declaration for Pharmaceutical Services Regulation Committee Members & Attendees

NHS England & NHS Improvement (East Region)

PART 1 – PERSONAL DETAILS

Your Name	Organisation you are employed/connected with	Position/Job Title	Role

PART 2 – CONFLICTS OF INTEREST

Conflicts of interest arise when an individual or organisation is in a position to exploit a professional or official capacity, including acquiring or using information or being involved in processes connected to contractual management of pharmaceutical services, for personal or business benefit. The existence of a conflict of interest does not, in itself, indicate that a person or organisation has acted in an unprofessional manner or breached any regulations. In some situations, conflicts of interest are unavoidable. This declaration is supported by NHS England & NHS Improvement (East Region).

Persons ineligible to be a Pharmacy Contract Managers (PCMs) are listed in Regulation 62 and in paragraph 26(1) of Schedule 2 to the Regulations. The PCMs will be required to sign the declaration to confirm that he or she is not barred by virtue of this paragraph.

Conflicts of Interest are usually categorised as **Actual, Potential or Perceived.**

Actual conflicts of interest exist where financial or other personal or professional considerations compromise an individual's objectivity, professional judgment, professional integrity, and/or ability to perform his or her responsibilities.
Potential conflicts of interest exist in situations where an individual, a member of the individual's family, or a close personal relation has financial interests, personal relationships, or professional associations with an outside individual or organisation, such that his or her activities that could appear to be biased by that interest or relationship.
Perceived conflict of interest is described as this also, even if that individual has agreed not to act on those outside interests, as it could be viewed as a conflict by an interested or impartial party.
Examples of conflicts of interest that are relevant in healthcare include (N.B. this list is not exhaustive):

- Being a potential provider of services.
- Partnership (such as in a general practice) or employment in a professional partnership, such as a limited liability partnership.
- Directorships, including non-executive directorships held in private companies or PLCs.
- Ownership or part-ownership of private companies, businesses or consultancies likely or possible seeking to do business with the NHS or its contractors.

- Shareholding in organisations likely or possibly seeking to do business with the NHS or its contractors.
- A clinician making onward referrals to other establishments (which may be linked to an individual or business).
- Personal interest or that of a family member, close friend or other acquaintance, in any of the above.

Please list below any **Actual, Potential or Perceived** conflicts of interest arising from your involvement as a Pharmaceutical Services Regulation Committee Member or Attendee. If any other conflicts than those declared below are discovered, they will be reported to the commissioning lead for mitigation.

Brief description of conflict	**Organisation/ People/Bodies involved**	**Position/Job Title/Role in organisation**	**Actual/ Potential/ Perceived**

Please demonstrate how you propose to deal with the actual, potential or perceived conflicts you have detailed above so that they do not prejudice in a fair, non-discriminatory and equitable way and demonstrate how you would ensure this conflict of interest was avoided.

Please be aware this will be evaluated by the commissioning lead on how the conflict can be mitigated which may be over and above your statement.

Avoidance of Conflict/Mitigation plan:

PART 3 –
COMMERCIAL IN CONFIDENCE

Code of Business Conduct for all Pharmaceutical Services Regulations Committee Members and Attendees, plus any other member co-opted on to the planned workstreams and/or any evaluation panels associated with pharmaceutical contractual management processes and/or those requiring information on process.

I acknowledge and agree that:

1. I will carry out the duties as part of a Pharmaceutical Services Regulations Committee Member or Attendee, any defined workstreams or evaluations in a thorough, transparent, non-discriminatory and objective manner and in accordance with the requirements of the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 as amended;

2. The documents made available to me (in electronic and/or hard copy format) for the purpose of performing my duties are classified "Commercial in Confidence", and I confirm that none of these documents nor their contents will or have been released, disclosed or divulged by me, or on my behalf, to any third party without the relevant authorisation to receive them (or without the prior written consent of NHS England and NHS Improvement;

3. I understand that the release or disclosure of such material to a third party without such authorisation will be regarded very seriously and may result in disciplinary or litigation action against me/my organisation;

4. In Part 2, I have declared any actual, potential, or perceived conflicts of interest in relation to any duties I may perform as a Pharmaceutical Services Regulations Committee Member or Attendee. If this situation changes, I shall immediately inform the commissioning lead or their nominated deputy and complete a new declaration;

5. Any conflict of interest identified, either in Part 2 or outside of my declarations, will be escalated to the commissioning lead for evaluation and action.

PART 4 –

SIGNATURE

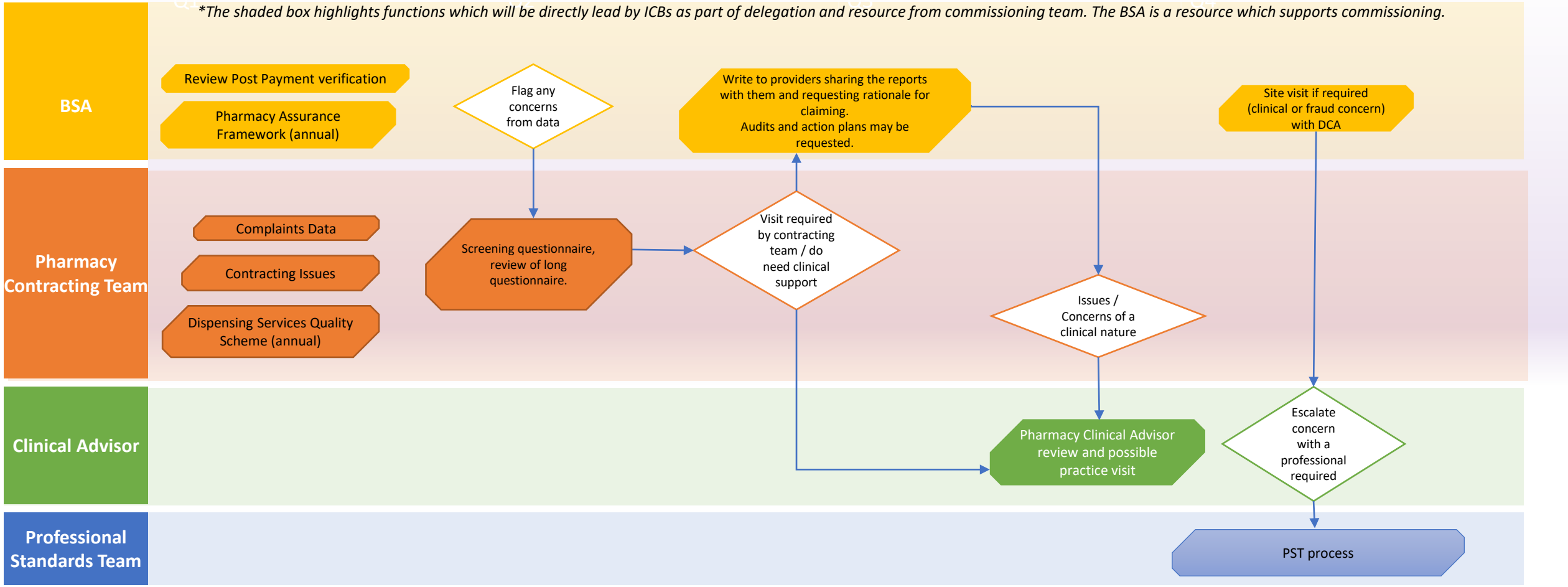
I confirm that the information I have given in Part 1 and Part 2 is to the best of my knowledge and if this changes I will update this immediately by informing the commissioning lead (or nominated deputy) as soon as I am aware. I have read and understood Part 2 and Part 3 and sign below to show my agreement to the conditions stated.

Name:

Signature:
Date:

Pharmacy Quality Review and Audits

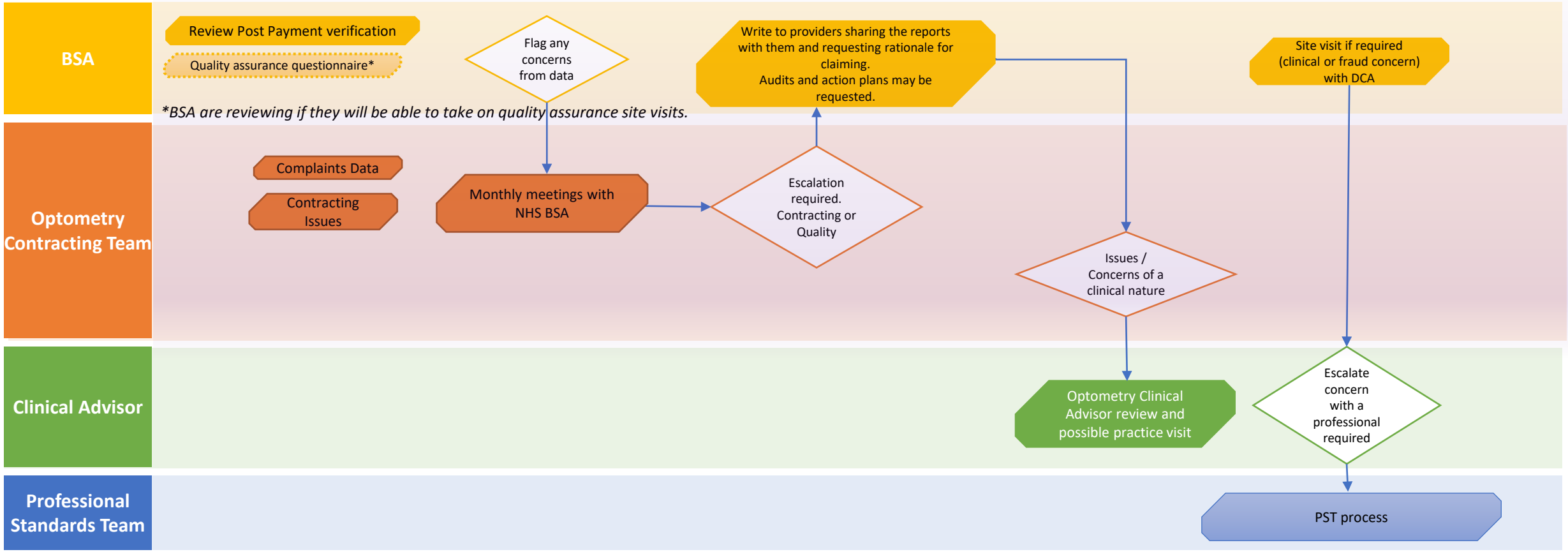
- Pharmacy quality in terms of contractual, clinical and professional are monitored by Contracting and BSA team, utilising the clinical advice and professional standards team review process where escalation is required.
- Direct Commissioning Nursing and Leadership Team sit on Professional Standards Team professional review process only.



Optometry Quality Review and Audits

- Optometry quality in terms of contractual, clinical and professional are monitored by contracting and BSA team, utilising the clinical advice and professional standards team review process where escalation is required.
- Direct Commissioning Nursing and Leadership Team sit on Professional Standards Team professional review process only.

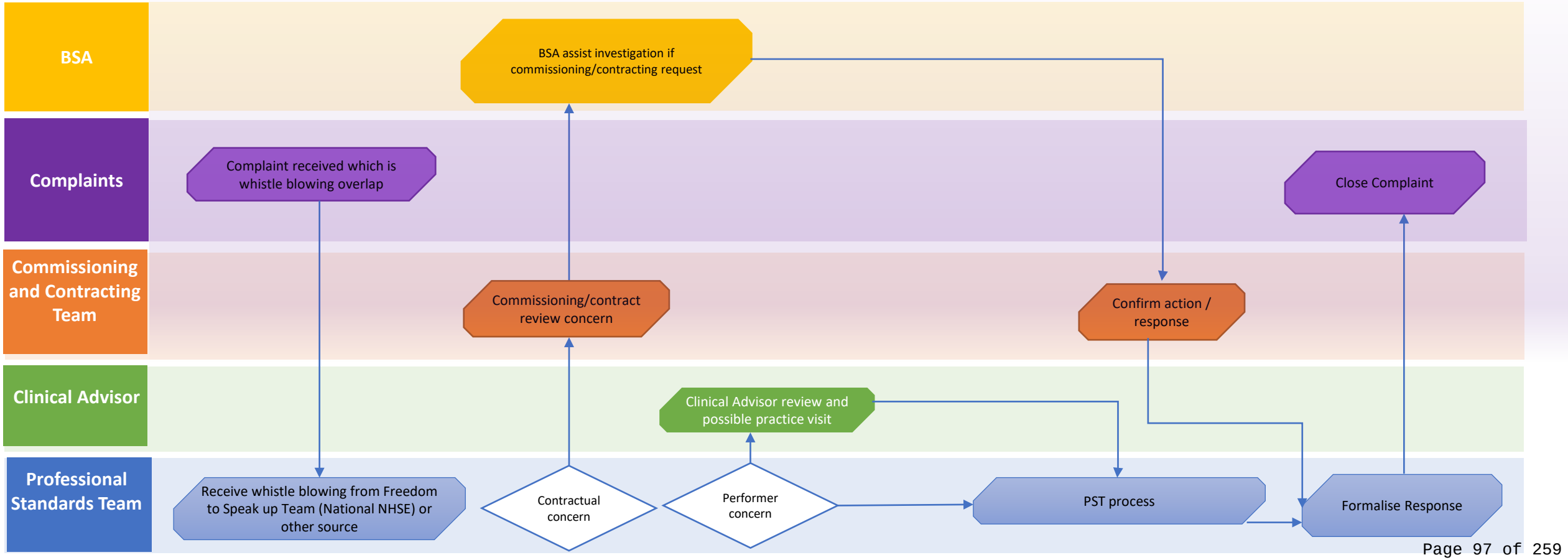
**The shaded box highlights functions which will be directly lead by ICBs as part of delegation and resource from commissioning team. The BSA is a resource which supports commissioning.*



Whistle Blowing

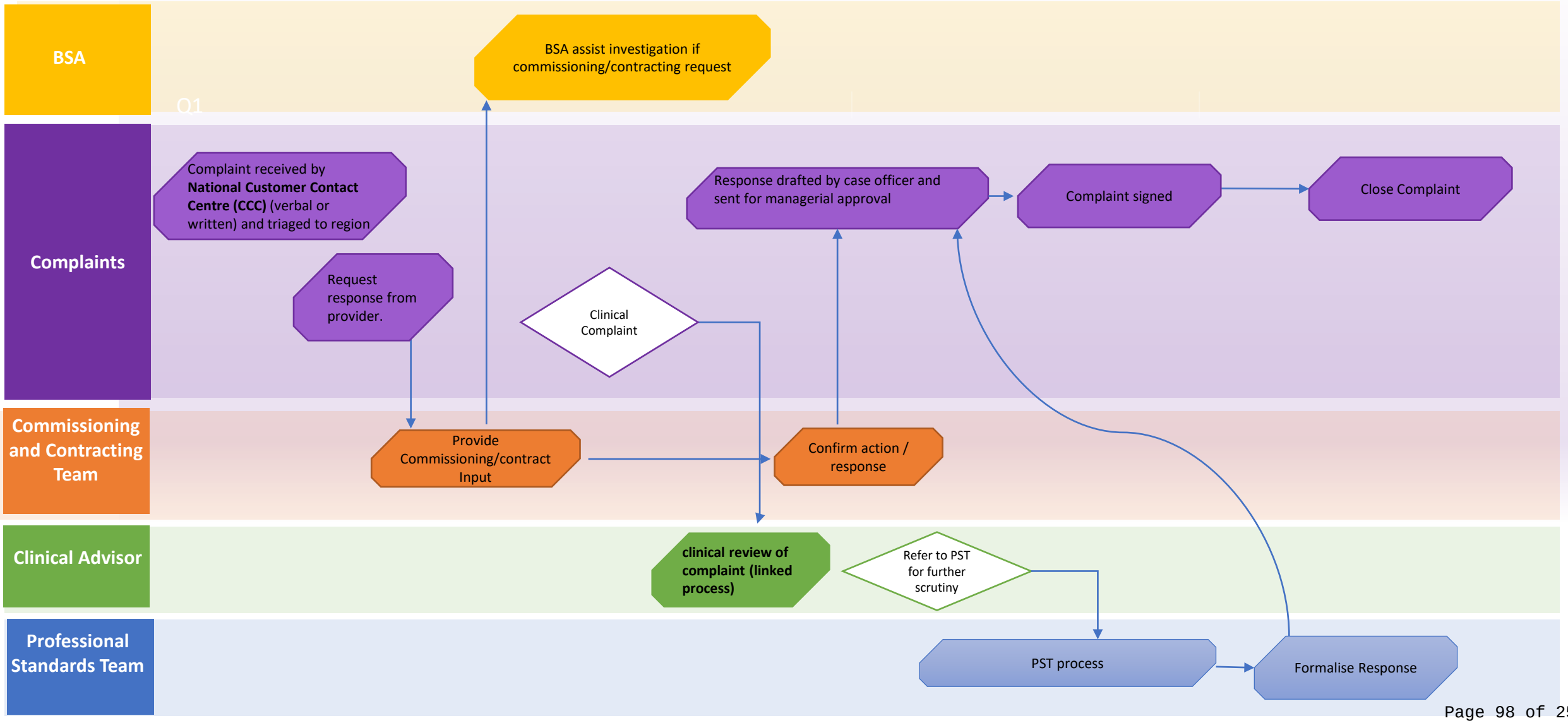
- National Freedom to Speak Up remains in place, Professional standards team who deals with these remain at region. Interface with POD Commissioning required and complaints.

**The shaded box highlights functions which will be directly lead by ICBs as part of delegation and resource from commissioning team. The BSA is a resource which supports commissioning. Complaints will be a delegated function with the workforce model TBC.*



Complaints

**The shaded box highlights functions which will be directly lead by ICBs as part of delegation and resource from commissioning team. The BSA is a resource which supports commissioning. Complaints will be a delegated function with the workforce model TBC.*



Complaints Process (Clinical review)

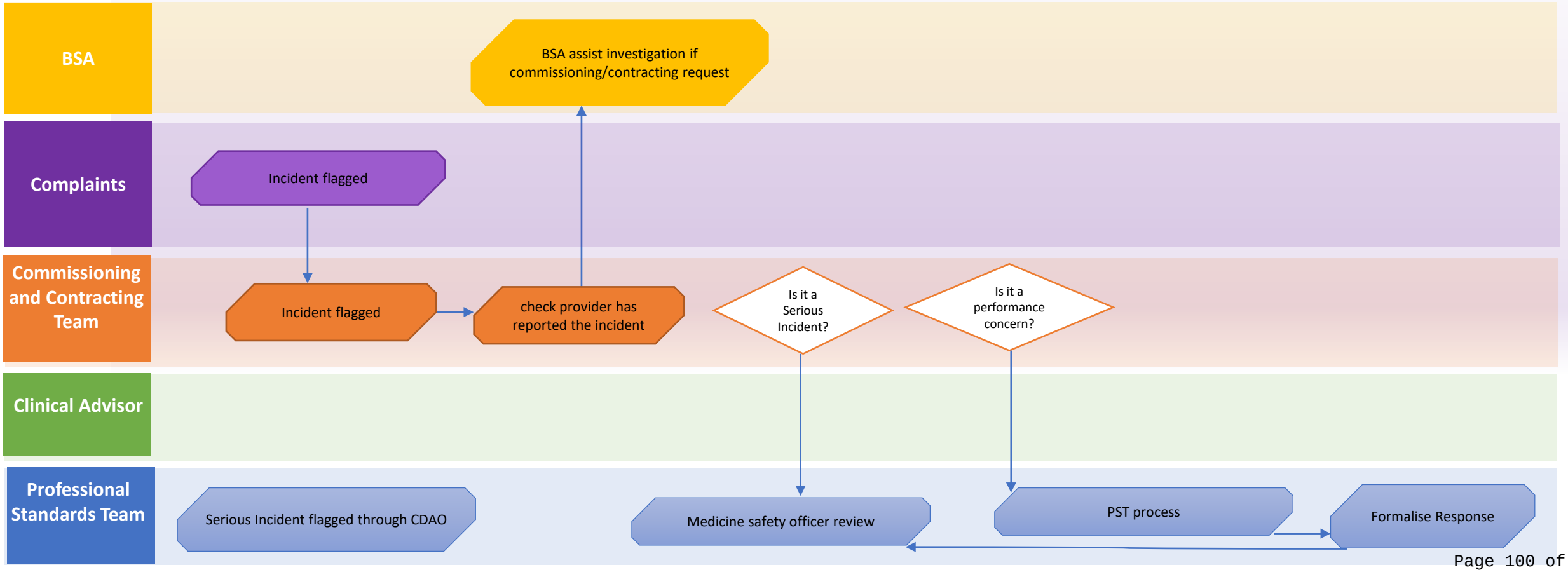
- Retained process for NHSE, led by Professional Standards Team. Interface required.

Correct as at 18/10/2022

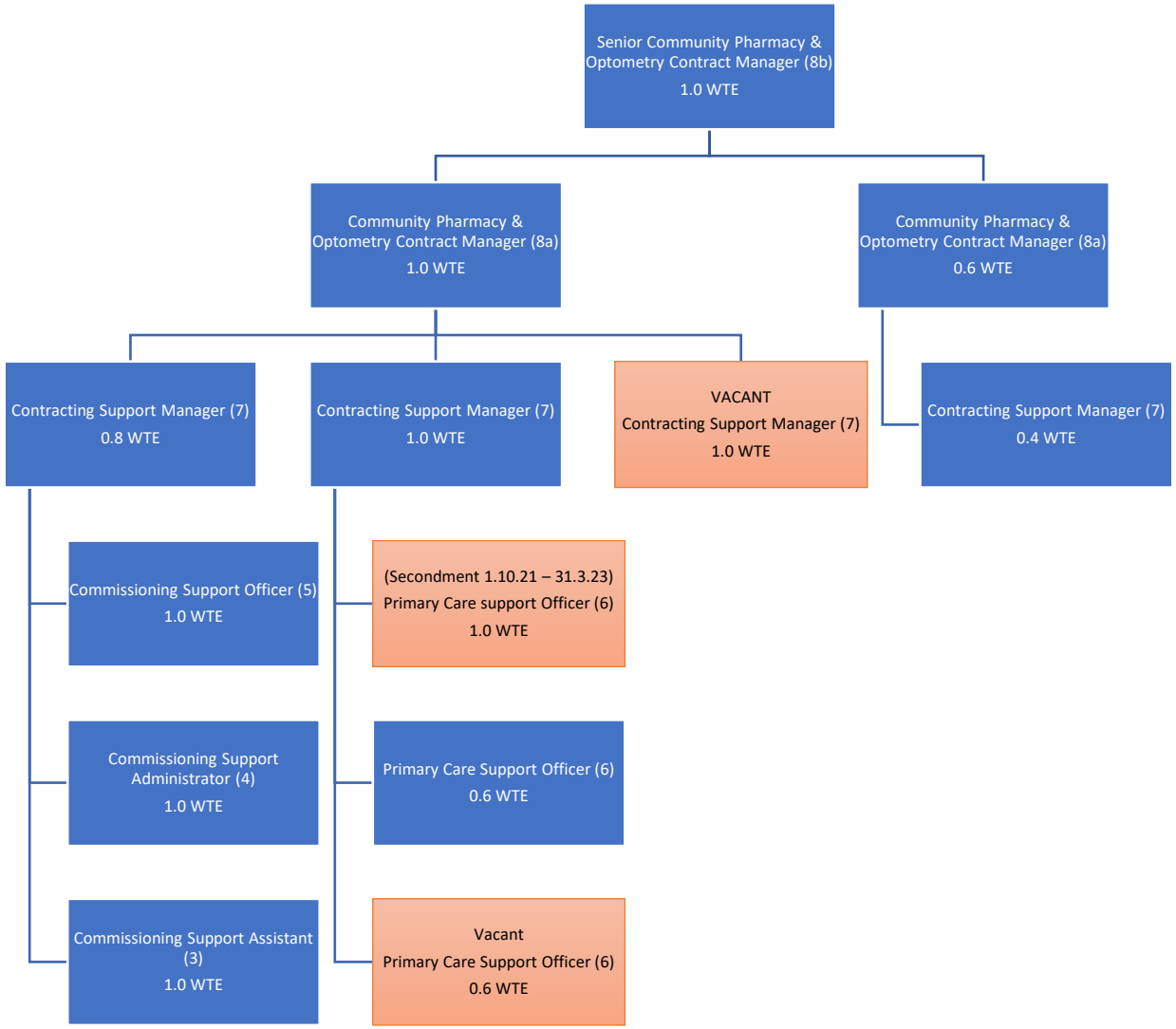
Serious Incident

There will be subtle differences in processes between POD functions. For example in Optometry, they would refer the SI to the GOC and some may notify NHS. Optometry does not have a set SI process in their contracts so difficult to state a definitive process. The clinician may be referred to the professional standards team as a concern if it progressed to going to a GOC investigation.

**The shaded box highlights functions which will be directly lead by ICBs as part of delegation and resource from commissioning team. The BSA is a resource which supports commissioning. Complaints will be a delegated function with the workforce model TBC.*



Proposed Pharmacy & Optometry Team January 2023



Dated 2023

(1) **NHS ENGLAND**

- and -

(2) **NHS BEDFORDSHIRE, LUTON AND MILTON KEYNES INTEGRATED CARE BOARD**

Delegation Agreement in Respect of

(i) Primary Medical Care Services
(ii) Primary Dental Services and Prescribed Dental Services
(iii) Primary Ophthalmic Services
(iv) Pharmaceutical Services and Local Pharmaceutical Services

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Clause heading and number — Page number

DELEGATION AGREEMENT FOR SPECIFIED FUNCTIONS

1. PARTICULARS

1.1 This Agreement records the particulars of the agreement made between NHS England and the Integrated Care Board (ICB) named below.

Integrated Care Board	Bedfordshire, Luton and Milton Keynes
Area	[Insert Area of the ICB as defined in its Constitution]
Date of Agreement	[Date]
	[Date]
ICB Representative	[Insert details of name of the manager of this Agreement for the ICB]
ICB Email Address for Notices	[Insert Address]
NHS England Representative	[Insert details of name of the manager of this Agreement for NHS England]
NHS England Email Address for Notices	[Insert Address]

1.2 **The following Delegated Functions are included in this Agreement[1]:**

Delegated Functions	Schedule	Included	Effective Date of Delegation
Primary Medical Services Functions	Schedule 2A –	Yes	1st July 2022
Primary Dental Services and Prescribed Dental Services Functions	Schedule 2B –	Yes	1st April 2023
Primary Ophthalmic Services Functions	Schedule 2C –	Yes	1st April 2023
Pharmaceutical Services and Local Pharmaceutical Services Functions	Schedule 2D –	Yes	1st April 2023

1.3 This Agreement comprises:

1.3.1 the Particulars (clause 1);

[1] This table must be completed to indicate which services are included in the Delegation.

1.3.2 the Terms and Conditions (clauses 2 to 31);

1.3.3 the Schedules; and

1.3.4 the Mandated Guidance

Signed by **NHS England**

[Name]

[Title]

(for and on behalf of NHS England)

Signed by **[Insert name] Integrated Care Board**

[Insert name of Authorised Signatory]

[Insert title of Authorised Signatory]

[for and on behalf of] [ ] Integrated Care Board

TERMS AND CONDITIONS

2. **INTERPRETATION**

2.1 This Agreement is to be interpreted in accordance with Schedule 1 (Definitions and Interpretation).

2.2 If there is any conflict or inconsistency between the provisions of this Agreement, that conflict or inconsistency must be resolved according to the following order of priority:

2.2.1 the Particulars and Terms and Conditions (clauses 1 to 31);

2.2.2 all Schedules excluding Local Terms;

2.2.3 Mandated Guidance; and

2.2.4 Local Terms.

2.3 This Agreement constitutes the entire agreement and understanding between the Parties relating to the Delegation and supersedes all previous agreements, promises and understandings between them, whether written or oral, relating to its subject matter.

2.4 Where it is indicated that a provision in this Agreement is not used, that provision is not relevant and has no application in this Agreement.

2.5 Where a particular clause is included in this Agreement but is not relevant to the ICB because that clause relates to matters which do not apply to the ICB (for example, if the clause only relates to functions that are not Delegated Functions in respect of the ICB), that clause is not relevant and has no application to this Agreement.

3. **BACKGROUND**

3.1 By this Agreement NHS England delegates the Delegated Functions to the ICB under section 65Z5 of the NHS Act while retaining the Reserved Functions.

3.2 Arrangements made under section 65Z5 may be made on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the ICB.

3.3 This Agreement sets out the terms that apply to the exercise of the Delegated Functions by the ICB and the Parties' associated responsibilities and measures required to ensure the effective and efficient exercise of the Delegated Functions and Reserved Functions.

4. **TERM**

4.1 This Agreement has effect from the Date of Agreement set out in the Particulars and will remain in force unless terminated in accordance with clause 26 *(Termination)* below.

5. **PRINCIPLES**

5.1 In complying with the terms of this Agreement, NHS England and the ICB must:

5.1.1 at all times have regard to the Triple Aim;

5.1.2 at all times act in good faith and with integrity towards each other;

5.1.3 have regard to the intention that commissioning functions in respect of Primary Medical Services, Primary Dental Services and Primary Ophthalmic Services will in future be directly conferred on the ICB;

5.1.4 consider how it can meet its legal duties to involve patients and the public in shaping the provision of services, including by working with local

communities, under-represented groups and those with protected characteristics for the purposes of the Equality Act 2010;

5.1.5 consider how in performing their obligations they can address health inequalities;

5.1.6 at all times exercise functions effectively, efficiently and economically;

5.1.7 act in a timely manner;

5.1.8 share information and best practice, and work collaboratively to identify solutions and enhance the evidence base for the commissioning and provision of health services, eliminate duplication of effort, mitigate risk and reduce cost; and

5.1.9 have regard to the needs and views of the other Party and as far as is lawful and reasonably practicable, take such needs and views into account.

6. DELEGATION

6.1 In accordance with its statutory powers under section 65Z5 of the NHS Act, NHS England hereby delegates the exercise of the Delegated Functions to the ICB to empower it to commission a range of services for its Population, as further described in this Agreement ("**Delegation**").

6.2 The Delegated Functions are the functions described as being delegated to the ICB as have been identified as included in clause 1 (*Particulars*) and included as a Schedule to this Agreement.

6.3 The Delegation in respect of each Delegated Function has effect from the relevant Effective Date of Delegation.

6.4 NHS England may by Contractual Notice allocate Contracts to the ICB such that they are included as part of the Delegation. The Delegated Functions must be exercised both in respect of the relevant Contract and any related matters concerning any Provider that is a party to Contract or Arrangement.

6.5 Subsequent to the Effective Date of Delegation and for the duration of this Agreement, unless otherwise agreed any new Contract entered into in respect of the Delegated Functions shall be managed by the ICB in accordance with the provisions of this Agreement.

6.6 NHS England may by Contractual Notice add or remove Contracts to or from the list of those allocated to the ICB for the purposes of this Agreement. In particular, NHS England may add or remove Contracts where this is associated with an extension or reduction of the scope of the Delegated Functions.

6.7 Decisions of the ICB in respect of the Delegated Functions and made in accordance with the terms of this Agreement shall be binding on NHS England and the ICB.

6.8 Unless expressly provided for in this Agreement, the ICB is not authorised by this Agreement to take any step or make any decision in respect of Reserved Functions. Any such purported decision of the ICB is invalid and not binding on NHS England unless ratified in writing by NHS England in accordance with the NHS England Scheme of Delegation and Standing Financial Instructions. NHS England may, acting reasonably and solely to the extent that the decision relates to the Delegated Functions, substitute its own decision for any decision which the ICB purports to make where NHS England reasonably considers that the impact of the ICB decision could, in relation to the Delegated Functions, cause the ICB to be acting unlawfully, in breach of this Agreement including Mandated Guidance, or in breach of any Contract. The ICB must

provide any information, assistance and support as NHS England requires to enable it to determine whether to make any such decision.

6.9 The terms of clause 6.8 are without prejudice to the ability of NHS England to enforce the terms of this Agreement or otherwise take action in respect of any failure by the ICB to comply with this Agreement.

7. EXERCISE OF DELEGATED FUNCTIONS

7.1 The ICB agrees that it will exercise the Delegated Functions in accordance with:

7.1.1 the terms of this Agreement including Mandated Guidance;

7.1.2 any Contractual Notices;

7.1.3 all applicable Law and Guidance;

7.1.4 the ICB's constitution;

7.1.5 the requirements of any assurance arrangements made by NHS England, and;

7.1.6 Good Practice.

7.2 In exercising the Delegated Functions, the ICB must comply with the Mandated Guidance set out at Schedule 9 (*Mandated Guidance)* or otherwise referred to in the Schedules to this Agreement and such further Mandated Guidance as may be issued by NHS England from time to time, including on the Direct Commissioning Guidance Webpage.

7.3 NHS England may, at its discretion, issue Contractual Notices from time to time relating to the manner in which the Delegated Functions must be exercised by the ICB. Contractual Notices will have effect as variations to this Agreement.

7.4 The ICB must establish effective, safe, efficient and economic arrangements for the discharge of the Delegated Functions.

7.5 The ICB must give due consideration to whether any of the Delegated Functions should be exercised collaboratively with other NHS bodies or Local Authorities including, without limitation, by means of arrangements under section 65Z5 and section 75 of the NHS Act.

7.6 The ICB must develop an operational scheme(s) of delegation defining those individuals or groups of individuals, including committees, who may discharge aspects of the Delegated Functions. For the purposes of this clause, the ICB may include the operational scheme(s) of delegation within its general organisational scheme of delegation.

7.7 Subject to clauses 7.1 to 7.6, the ICB may determine the arrangements for the exercise of the Delegated Functions.

7.8 The ICB must perform the Delegated Functions:

7.8.1 in such a manner as to ensure NHS England's compliance with NHS England's statutory duties in respect of the Delegated Functions and to enable NHS England to fulfil its Reserved Functions; and

7.8.2 having regard to NHS England's accountability to the Secretary of State and Parliament in respect of both the Delegated Functions and Reserved Functions.

8. **PERFORMANCE OF THE RESERVED FUNCTIONS**

8.1 NHS England will exercise the Reserved Functions, including but not limited to those set out in the relevant Schedules to this Agreement.

8.2 For the avoidance of doubt, the Parties acknowledge that the Delegation may be amended, and additional functions may be delegated to the ICB, in which event consequential changes to this Agreement shall be agreed with the ICB pursuant to clause 25 (*Variations*) of this Agreement.

8.3 Where appropriate NHS England will work collaboratively with the ICB when exercising the Reserved Functions.

8.4 If there is any conflict or inconsistency between functions that are named as Delegated Functions and functions that are named as Reserved Functions, then such functions shall be interpreted as Reserved Functions unless and until NHS England confirms otherwise. In the event that an ICB identifies such a conflict or inconsistency it will inform NHS England as soon as is reasonably practicable.

8.5 The Parties acknowledge that where the ICB shall provide administrative and management services to NHS England in relation to certain Reserved Functions these shall be as set out in clause 9.14. and Schedule 10 *(Administrative and Management Services*).

8.6 The Parties further acknowledge that NHS England may ask the ICB to provide certain administrative and management services to NHS England in relation to other Reserved Functions.

8.7 Notwithstanding any arrangement for or provision of administrative or management services in respect of certain Reserved Functions, NHS England shall retain and be accountable for the exercise of such Reserved Functions.

9. **FINANCE**

9.1 Without prejudice to any other provision in this Agreement, the ICB must comply with such financial processes as required by NHS England for the management, reporting and accounting of funds used for the purposes of the Delegated Functions.

9.2 The ICB acknowledges that it will receive funds from NHS England in respect of the Delegated Functions (the “Delegated Funds”) and that these are in addition to the funds allocated to it within its Annual Allocation.

9.3 Subject to clause 9.4 and any provisions in the Schedules or Mandated Guidance, the ICB may use:

9.3.1 its Annual Allocation and the Delegated Funds in the exercise of the Delegated Functions; and

9.3.2 the Delegated Funds and its Annual Allocation in the exercise of the ICB’s functions other than the Delegated Functions.

9.4 The ICB’s expenditure on the Delegated Functions must be no less than that necessary to:

9.4.1 ensure that NHS England is able to fulfil its functions, including without limitation the Reserved Functions, effectively and efficiently;

9.4.2 meet all liabilities arising under or in connection with all Contracts allocated to the ICB in accordance with clauses 6.4 to 6.6 in so far as they relate to the Delegated Functions;

9.4.3 meet national commitments from time to time on expenditure on specific Delegated Functions including, without limitation, the Community Pharmacy Contractual Framework.

9.5 NHS England may increase or reduce the Delegated Funds in any Financial Year, by sending a notice to the ICB of such increase or decrease:

9.5.1 in order to take into account any monthly adjustments or corrections to the Delegated Funds that NHS England considers appropriate, including without limitation adjustments following any changes to the Delegated Functions, changes in allocations, changes in Contracts, to implement Mandated Guidance under Clause 7.4 or otherwise;

9.5.2 in order to comply with a change in the amount allocated to NHS England by the Secretary of State pursuant to section 223B of the NHS Act;

9.5.3 to take into account any Losses of NHS England for which the ICB is required to indemnify NHS England under clause 15;

9.5.4 to take into account any adjustments that NHS England considers appropriate (including without limitation in order to make corrections or otherwise to reflect notional budgets) to reflect funds transferred (or that should have been transferred) to the ICB in respect of the Delegated Functions and/or funds transferred (or that should have been transferred) to the ICB and in respect of which the ICB has management or administrative responsibility under Schedule 10 of this Agreement; or

9.5.5 in order to ensure compliance by NHS England with its obligations under the NHS Act (including without limitation, Part 11 of the NHS Act) or any action taken or direction made by the Secretary of State in respect of NHS England under the NHS Act.

9.6 NHS England acknowledges that the intention of paragraph 9.5 is to reflect genuine corrections and adjustments to the Delegated Funds and may not be used to change the allocation of the Delegated Funds unless there are significant or exceptional circumstances that would require such corrections or adjustments.

9.7 The ICB acknowledges that it must comply with its statutory financial duties, including those under Part 11 of the NHS Act to the extent that these sections apply in relation to the receipt of the Delegated Funds.

9.8 NHS England may in respect of the Delegated Funds:

9.8.1 notify the ICB regarding the required payment of sums by the ICB to NHS England in respect of charges referable to the valuation or disposal of assets and such conditions as to records, certificates or otherwise;

9.8.2 by notice, require the ICB to take such action or step in respect of the Delegated Funds, in order to ensure compliance by NHS England of its duties or functions under the NHS (including without limitation, Part 11 of the NHS Act) or any action taken or direction made by the Secretary of State under the NHS Act.

9.9 The Schedules to this Agreement identify further financial provisions in respect of the exercise of the Delegated Functions including but not limited to Schedule 5 (*Financial Provisions and Decision Making Limits*).

9.10 NHS England may issue Mandated Guidance in respect of the financial arrangements in respect of the Delegated Functions.

Payment and Transfer

9.11 NHS England will pay the Delegated Funds to the ICB using the revenue transfer process as used for the Annual Allocation or using such other process as notified to the ICB from time to time.

9.12 Without prejudice to any other obligation upon the ICB, the ICB agrees that it must use its resources for the purposes of the Delegated Functions in accordance with:

9.12.1 the terms and conditions of this Agreement including any Mandated Guidance issued by NHS England from time to time in relation to the use of resources for the purposes of the Delegated Functions (including in relation to the form or contents of any accounts);

9.12.2 the business rules as set out in NHS England's planning guidance or such other documents issued by NHS England from time to time;

9.12.3 any Capital Investment Guidance; and

9.12.4 the HM Treasury guidance *Managing Public Money* (dated September 2022)

9.13 Without prejudice to any other obligation upon the ICB, the ICB agrees that it must provide:

9.13.1 all information, assistance and support to NHS England in relation to the audit and/or investigation (whether internal or external and whether under Law or otherwise) in relation to the use of or payment of resources for the purposes of the Delegated Functions and the discharge of those functions;

9.13.2 such reports in relation to the expenditure on the Delegated Functions as set out in Mandated Guidance, the Schedules to this Agreement or as otherwise required by NHS England.

Administrative and/or Management Services

9.14 The provisions of Schedule 10 (*Administrative and Management Services)* in relation to Administrative and/or Management Services shall apply.

Pooled Funds

9.15 Subject to the provisions of this Agreement, the ICB may, for the purposes of exercising the Delegated Functions under this Agreement, establish and maintain a pooled fund in respect of any part of the Delegated Funds with:

9.15.1 NHS England in accordance with sections 13V or 65Z6 of the NHS Act;

9.15.2 one or more ICBs in accordance with section 65Z6 of the NHS Act as part of a Further Arrangement; or

9.15.3 NHS England and one or more ICBs in accordance with section 13V of the NHS Act; and

9.15.4 NHS England and one or more ICBs in accordance with section 65Z6 of the NHS Act.

9.16 At the date of this Agreement, details of the pooled funds (including any terms as to the governance and payments out of such pooled fund) of NHS England and the ICB are set out in the Local Terms.

10. INFORMATION, PLANNING AND REPORTING

10.1 The ICB must provide to NHS England:

10.1.1 all information or explanations in relation to the exercise of the Delegated Functions (including in relation to this Agreement), (and in such form) as requested by NHS England from time to time; and

10.1.2 all such information (and in such form), that may be relevant to NHS England in relation to the exercise by NHS England of its other duties or functions including, without limitation, the Reserved Functions.

10.2 The provisions of this clause 10 are without prejudice to the ability of NHS England to exercise its other powers and duties in obtaining information from and assessing the performance of the ICB.

Forward Plan and Annual Report

10.3 Before the start of each Financial Year, the ICB must describe in its joint forward plan prepared in accordance with section 14Z52 of the NHS Act how it intends to exercise the Delegated Functions.

10.4 The ICB must report on its exercise of the Delegated Functions in its annual report prepared in accordance with section 14Z58 of the NHS Act.

Risk Register

10.5 The ICB must maintain a risk register in respect of its exercise of the Delegated Functions and periodically review its content. The risk register must follow such format as may be notified by NHS England to the ICB from time to time.

11. FURTHER ARRANGEMENTS

11.1 The ICB must give due consideration to whether any of the Delegated Functions should be exercised collaboratively with other NHS bodies or Local Authorities including, without limitation, by means of arrangements under section 65Z5 and section 75 of the NHS Act.

11.2 The ICB may only make arrangements with another person (a "Sub-Delegate") concerning the exercise of the Delegated Functions ("Further Arrangements"), including without limitation arrangements under section 65Z5 and section 75 of the NHS Act, with the prior written approval of NHS England.

11.3 The approval of any Further Arrangements may:

11.3.1 include approval of the terms of the proposed Further Arrangements; and

11.3.2 require conditions to be met by the ICB and the Sub-Delegate in respect of that arrangement.

11.4 All Further Arrangements must be made in writing.

11.5 The ICB must not:

11.5.1 terminate Further Arrangements; or

11.5.2 make any material changes to the terms of Further Arrangements,

11.5.3 without the prior written approval of NHS England.

11.6 If the ICB enters into a Further Arrangement it must ensure that the Sub-Delegate does not make onward arrangements for the exercise of any or all of the Delegated Functions without the prior written approval of NHS England.

11.7 The terms of this clause 11 do not prevent the ICB from making arrangements for assistance and support in the exercise of the Delegated Functions with any person, where such arrangements reserve the consideration and making of any decision in respect of a Delegated Function to the ICB.

11.8 NHS England requires the ICB to make arrangements for assistance and support in the exercise of the Delegated Functions with those persons described in the Schedules including, but not limited to Schedule 6 (*Mandated Assistance and Support*) and with such other persons as NHS England may require from time to time.

11.9 Where Further Arrangements are made, and unless NHS England has otherwise given prior written agreement, any positive obligation or duty on the part of the ICB under this Agreement that is relevant to those Further Arrangements shall also require the ICB to ensure that all Sub-Delegates comply with that positive obligation or duty and support the ICB in doing so. In the same way, any negative duty or obligation on the part of the ICB under this Agreement that is relevant to Further Arrangement shall also require the ICB to ensure that all Sub-Delegates comply with that negative obligation or duty and support the ICB in doing so.

12. STAFFING AND WORKFORCE

12.1 The Staffing Model in respect of each Delegated Function shall at the Effective Date of Delegation be as approved by the relevant National Moderation Panel.

12.2 Where the staffing arrangements include the deployment of NHS England Staff to the ICB for the purposes of carrying out the relevant Delegated Functions then the provisions of Schedule 8 (*Deployment of NHS England Staff to the* ICB) shall apply.

12.3 The ICB must comply with any Mandated Guidance issued by NHS England from time to time in relation to the NHS England Staff.

12.4 For the avoidance of doubt, any breach by the ICB of the terms of this clause 12 (Staffing), including any breach of any Mandated Guidance issued in accordance with clause 12.3 above, will be a breach of the terms and conditions of this Agreement for the purposes of clauses 9.5 and 15.2.

13. BREACH

13.1 If the ICB does not comply with the terms of this Agreement, then NHS England may:

13.1.1 exercise its rights under this Agreement; and/or

13.1.2 take such steps as it considers appropriate in the exercise of its other functions concerning the ICB.

13.2 Without prejudice to clause 13.1, if the ICB does not comply with the terms of this Agreement (including if the ICB exceeds its delegated authority under the Delegation), NHS England may (at its sole discretion):

13.2.1 waive its rights in relation to such non-compliance in accordance with clause 13.3;

13.2.2 ratify any decision in accordance with clause 6.8;

13.2.3 substitute a decision in accordance with clause 6.9;

13.2.4 revoke the whole or part of the Delegation and terminate this Agreement in accordance with clause 26 *(Termination)* below;

13.2.5 exercise the Escalation Rights in accordance with clause 14 *(Escalation Rights)*; and/or

13.2.6 exercise its rights under common law.

13.3 NHS England may waive any non-compliance by the ICB with the terms of this Agreement provided that the ICB provides a written report to NHS England as required by clause 13.4 and, after considering the ICB's written report, NHS England is satisfied that the waiver is justified.

13.4 If:

13.4.1 the ICB does not comply (or, based on the risk register maintained by the ICB in accordance with clause 10.5 or any other information available to it the ICB considers that it may not be able to comply) with this Agreement; or

13.4.2 NHS England notifies the ICB that it considers the ICB has not complied, or may not be able to comply with, this Agreement,

then the ICB must provide a written report to NHS England within ten (10) Operational Days of the non-compliance (or the date on which the ICB considers that it may not be able to comply with this Agreement) or such notification pursuant to clause 13.4.2 setting out:

13.4.3 details of and reasons for the non-compliance (or likely non-compliance) with the Agreement and/or the Delegation; and

13.4.4 a plan for how the ICB proposes to remedy the non-compliance.

14. ESCALATION RIGHTS

14.1 If the ICB does not comply with this Agreement, NHS England may exercise the following Escalation Rights:

14.1.1 NHS England may require a suitably senior representative of the ICB to attend a review meeting within ten (10) days of NHS England becoming aware of the non-compliance; and

14.1.2 NHS England may require the ICB to prepare an action plan and report within twenty (20) days of the review meeting (to include details of the non-compliance and a plan for how the ICB proposes to remedy the non-compliance).

14.2 Nothing in clause 14 *(Escalation Rights)* will affect NHS England's right to substitute a decision in accordance with clause 6.9, revoke the Delegation and/or terminate this Agreement in accordance with clause 26 *(Termination)* below.

15. LIABILITY AND INDEMNITY

15.1 NHS England is liable in respect of any Losses arising in respect of NHS England's negligence, fraud, recklessness or deliberate breach in respect of the Delegated Functions and occurring after the Effective Date of Delegation and, if the ICB suffers any Losses in respect of such actions by NHS England, NHS England shall make such adjustments to the Annual Allocation (or other amounts payable to the ICB) in order to reflect any Losses suffered by the ICB (except to the extent that the ICB is liable for such Losses pursuant to clause 15.3).

15.2 For the avoidance of doubt, NHS England remains liable for a Claim relating to facts, events or circumstances concerning the Delegated Functions before the Effective Date of Delegation.

15.3 The ICB is liable to (and shall pay) NHS England for any Losses suffered by NHS England that result from or arise out of the ICB's negligence, fraud, recklessness or breach of the Delegation (including any actions that are taken that exceed the authority

conferred by the Delegation) or this Agreement and, in respect of such Losses, NHS England may, at its discretion and without prejudice to any other rights, either require payment from the ICB or make such adjustments to the Delegated Funds pursuant to clause 9.5. The ICB shall not be liable to the extent that the Losses arose prior to the Effective Date of Delegation.

15.4 Each Party acknowledges and agrees that any rights acquired, or liabilities (including liabilities in tort) incurred, in respect of the exercise by the ICB of any Delegated Function are enforceable by or against the ICB only, in accordance with section 65Z5(6) of the NHS Act.

15.5 The ICB indemnifies NHS England and shall keep it indemnified on a continuing basis from and against any and all Losses which NHS England may incur by reason of any claim by any NHS England Staff:

15.5.1 arising out of a breach of duty by the ICB (whether under common law, statute or otherwise) to the extent that such claim is not met by either the ICB's or NHS England's insurance or indemnity cover;

15.5.2 under the Equality Act 2010 or Part V of the Employment Rights Act 1996 arising out of acts or omissions by the ICB (or any of its employees, directors or officers);

15.5.3 arising from any acts or omissions by the ICB resulting in the termination of their employment, including any claim arising from any instruction by the ICB to NHS England to discipline or dismiss any person.

15.6 Each Party shall co-operate with the other in making all reasonable efforts to minimise any liabilities and Losses in connection with the employment of NHS England Staff in Delegated Functions.

15.7 Each Party will at all times take all reasonable steps to minimise and mitigate any Losses or other matters for which one Party is entitled to be indemnified by or to bring a claim against the other under this Agreement.

16. CLAIMS AND LITIGATION

16.1 Nothing in this clause 16 *(Claims and Litigation)* shall be interpreted as affecting the reservation to NHS England of the Reserved Functions.

16.2 Except in the circumstances set out in clause 16.5 and subject always to compliance with this clause 16 *(Claims and Litigation)*, the ICB shall be responsible for and shall retain the conduct of any Claim.

16.3 The ICB must:

16.3.1 comply with any policy issued by NHS England from time to time in relation to the conduct of or avoidance of Claims and/or the pro-active management of Claims;

16.3.2 if it receives any correspondence, issue of proceedings, claim document or other document concerning any Claim or potential Claim, immediately notify NHS England and send to NHS England all copies of such correspondence;

16.3.3 co-operate fully with NHS England in relation to such Claim and the conduct of such Claim;

16.3.4 provide, at its own cost, to NHS England all documentation and other correspondence that NHS England requires for the purposes of considering and/or resisting such Claim; and/or

16.3.5 at the request of NHS England, take such action or step or provide such assistance as may in NHS England's discretion be necessary or desirable having regard to the nature of the Claim and the existence of any time limit in relation to avoiding, disputing, defending, resisting, appealing, seeking a review or compromising such Claim or to comply with the requirements of the provider of an Indemnity Arrangement in relation to such Claim.

16.4 Subject to clauses 16.3 and 16.5 and Schedule 5 (*Financial Provisions and Decision Making Limits*) the ICB is entitled to conduct the Claim in the manner it considers appropriate and is also entitled to pay or settle any Claim on such terms as it thinks fit.

NHS England Stepping into Claims

16.5 NHS England may, at any time following discussion with the ICB, send a notice to the ICB stating that NHS England will take over the conduct of the Claim and the ICB must immediately take all steps necessary to transfer the conduct of such Claim to NHS England unless and until NHS England transfers conduct back to the ICB. In such cases:

16.5.1 NHS England shall be entitled to conduct the Claim in the manner it considers appropriate and is also entitled to pay or settle any Claim on such terms as it thinks fit, provided that if NHS England wishes to invoke clause 16.5.3 it agrees to seek the ICB's views on any proposal to pay or settle that Claim prior to finalising such payment or settlement; and

16.5.2 the Delegation shall be treated as being revoked to the extent that and for so long as NHS England has assumed responsibility for exercising those of the Delegated Functions that are necessary for the purposes of having conduct of the Claim; and

16.5.3 NHS England may, at its discretion and without prejudice to any other rights, either require payment from the ICB for such Claim Losses or make an adjustment to the Delegated Funds pursuant to clause 9.5.3 for the purposes of meeting any Claim Losses associated with that Claim.

Claim Losses

16.6 The ICB and NHS England shall notify each other within a reasonable time period of becoming aware of any Claim Losses.

16.7 The ICB acknowledges that NHS England will pay to the ICB the funds that are attributable to the Delegated Functions. Accordingly, the ICB acknowledges that it must pay any Claim Losses out of either the Delegated Funds or its Annual Allocation. NHS England may, in respect of any Claim Losses, at its discretion and without prejudice to any other rights, either require payment from the ICB for such Claim Losses or pursuant to clause 9.5.3 make such adjustments to the Delegated Funds to take into account the amount of any Claim Losses (other than any Claim Losses in respect of which NHS England has retained any funds, provisions or other resources to discharge such Claim Losses). For the avoidance of doubt, in circumstances where NHS England suffers any Claim Losses, then NHS England shall be entitled to recoup such Claim Losses pursuant to clause 9.5.3. If and to the extent that NHS England has retained any funds, provisions or other resources to discharge such Claim Losses, then NHS England may either use such funds to discharge the Claim Loss or make an upward adjustment to the amounts paid to the ICB pursuant to clause 9.5.3.

17. DATA PROTECTION, FREEDOM OF INFORMATION AND TRANSPARENCY

17.1 The Parties must ensure that all Personal Data processed by or on behalf of them in the course of carrying out the Delegated Functions and Reserved Functions is processed in accordance with the relevant Party's obligations under Data Protection

Legislation and Data Guidance and the Parties must assist each other as necessary to enable each other to comply with these obligations.

17.2 The ICB must respond to any information governance breach in accordance with IG Guidance for Serious Incidents. If the ICB is required under Data Protection Legislation to notify the Information Commissioner's Office or a Data Subject of an information governance breach then as soon as reasonably practical and in any event on or before the first such notification is made the ICB must fully inform NHS England of the information governance breach. This clause does not require the ICB to provide NHS England with information which identifies any individual affected by the information governance breach where doing so would breach Data Protection Legislation.

17.3 Whether or not a Party is a Data Controller or Data Processor will be determined in accordance with Data Protection Legislation and any Data Guidance from a Regulatory or Supervisory Body. The Parties acknowledge that a Party may act as both a Data Controller and a Data Processor.

17.4 Each Party acknowledges that the other is a public authority for the purposes of the Freedom of Information Act 2000 (**"FOIA"**) and the Environmental Information Regulations 2004 (**"EIR"**).

17.5 Each Party may be statutorily required to disclose further information about the Agreement and the Relevant Information in response to a specific request under FOIA or EIR, in which case:

17.5.1 each Party shall provide the other with all reasonable assistance and co-operation to enable them to comply with their obligations under FOIA or EIR;

17.5.2 each Party shall consult the other regarding the possible application of exemptions in relation to the information requested; and

17.5.3 subject only to clause 16 *(Claims and Litigation)*, each Party acknowledges that the final decision as to the form or content of the response to any request is a matter for the Party to whom the request is addressed.

17.6 NHS England may, from time to time, issue a FOIA or EIR protocol or update a protocol previously issued relating to the dealing with and responding to FOIA or EIR requests in relation to the Delegated Functions. The ICB shall comply with such FOIA or EIR protocols.

17.7 Schedule 4 (*Further Information Governance and Sharing* Provisions) makes further provision about information sharing and information governance.

18. IT INTER-OPERABILITY

18.1 NHS England and the ICB will work together to ensure that all relevant IT systems operated by NHS England and the ICB in respect of the Delegated Functions and the Reserved Functions are inter-operable and that data may be transferred between systems securely, easily and efficiently.

18.2 The Parties will use their respective reasonable endeavours to help develop initiatives to further this aim.

19. CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY

19.1 The ICB must and must ensure that, in delivering the Delegated Functions, all Staff comply with Law, with Managing Conflicts of Interest in the NHS and other Guidance, and with Good Practice, in relation to gifts, hospitality and other inducements and actual or potential conflicts of interest.

19.2 Without prejudice to the general obligations set out in clause 19.1, the ICB must maintain a register of interests in respect of all persons making decisions concerning the Delegated Functions. This register must be publicly available. For the purposes of this clause, the ICB may rely on an existing register of interests rather than creating a further register.

20. PROHIBITED ACTS AND COUNTER-FRAUD

20.1 The ICB must not commit any Prohibited Act.

20.2 If the ICB or its Staff commits any Prohibited Act in relation to this Agreement with or without the knowledge of NHS England, NHS England will be entitled:

20.2.1 to revoke the Delegation; and

20.2.2 to recover from the ICB the amount or value of any gift, consideration or commission concerned; and

20.2.3 to recover from the ICB any loss or expense sustained in consequence of the carrying out of the Prohibited Act.

20.3 The ICB must put in place and maintain appropriate arrangements, including without limitation Staff training, to address counter-fraud issues, having regard to any relevant Guidance (including from the NHS Counter Fraud Authority).

20.4 If requested by NHS England or the NHS Counter Fraud Authority, the ICB must allow a person duly authorised to act on behalf of the NHS Counter Fraud Authority or on behalf of NHS England to review, in line with the appropriate standards and counter-fraud arrangements put in place by the ICB.

20.5 The ICB must implement any reasonable modifications to its counter-fraud arrangements required by a person referred to in clause 20.4 in order to meet the appropriate standards within whatever time periods as that person may reasonably require.

20.6 The ICB must, on becoming aware of:

20.6.1 any suspected or actual bribery, corruption or fraud involving public funds; or

20.6.2 any suspected or actual security incident or security breach involving Staff or involving NHS resources;

20.6.3 promptly report the matter to NHS England and to the NHS Counter Fraud Authority.

20.7 On the request of NHS England or NHS Counter Fraud Authority, the ICB must allow the NHS Counter Fraud Authority or any person appointed by NHS England, as soon as it is reasonably practicable and in any event not later than 5 Operational Days following the date of the request, access to:

20.7.1 all property, premises, information (including records and data) owned or controlled by the ICB; and

20.7.2 all Staff who may have information to provide;

20.7.3 relevant to the detection and investigation of cases of bribery, fraud or corruption, or security incidents or security breaches directly or indirectly in connection with this Agreement.

21. CONFIDENTIAL INFORMATION OF THE PARTIES

21.1 Except as this Agreement otherwise provides, Confidential Information is owned by the disclosing Party and the receiving Party has no right to use it.

21.2 Subject to clauses 21.3 to 21.5, the receiving Party agrees:

21.2.1 to use the disclosing Party's Confidential Information only in connection with the receiving Party's performance under this Agreement;

21.2.2 not to disclose the disclosing Party's Confidential Information to any third party or to use it to the detriment of the disclosing Party; and

21.2.3 to maintain the confidentiality of the disclosing Party's Confidential Information.

21.3 The receiving Party may disclose the disclosing Party's Confidential Information:

21.3.1 in connection with any Dispute Resolution;

21.3.2 in connection with any litigation between the Parties;

21.3.3 to comply with the Law;

21.3.4 to any appropriate Regulatory or Supervisory Body;

21.3.5 to its Staff, who in respect of that Confidential Information will be under a duty no less onerous than the Receiving Party's duty under clause 21.2;

21.3.6 to NHS Bodies for the purposes of carrying out their functions;

21.3.7 as permitted under or as may be required to give effect to clause 20 (*NHS Counter-Fraud*); and

21.3.8 as permitted under any other express arrangement or other provision of this Agreement.

21.4 The obligations in clauses 21.1 and 21.2 will not apply to any Confidential Information which:

21.4.1 is in or comes into the public domain other than by breach of this Agreement;

21.4.2 the receiving Party can show by its records was in its possession before it received it from the disclosing Party; or

21.4.3 the receiving Party can prove it obtained or was able to obtain from a source other than the disclosing Party without breaching any obligation of confidence.

21.5 This clause 21 does not prevent NHS England from making use of or disclosing any Confidential Information disclosed by the ICB where necessary for the purposes of exercising its functions in relation to the ICB.

21.6 The Parties acknowledge that damages would not be an adequate remedy for any breach of this clause 21 by the receiving Party, and in addition to any right to damages, the disclosing Party will be entitled to the remedies of injunction, specific performance and other equitable relief for any threatened or actual breach of this clause 21.

21.7 This clause 21 will survive the termination of this Agreement for any reason for a period of 5 years.

21.8 This clause 21 will not limit the application of the Public Interest Disclosure Act 1998 in any way whatsoever.

22. **INTELLECTUAL PROPERTY**

22.1 The ICB grants to NHS England a fully paid-up, non-exclusive, perpetual licence to use the ICB Deliverables for the purposes of the exercise of its statutory and contractual functions.

22.2 NHS England grants the ICB a fully paid-up, non-exclusive licence to use the NHS England Deliverables for the purpose of performing this Agreement and the Delegated Functions.

22.3 The ICB must co-operate with NHS England to enable it to understand and adopt Best Practice (including the dissemination of Best Practice to other commissioners or providers of NHS services), and must supply such materials and information in relation to Best Practice as NHS England may reasonably request, and (to the extent that any IPR attaches to Best Practice), grants NHS England a fully paid-up, non-exclusive, perpetual licence for NHS England to use Best Practice IPR for the commissioning and provision of NHS services and to share any Best Practice IPR with other commissioners of NHS services (and other providers of NHS services) to enable those parties to adopt such Best Practice.

23. **NOTICES**

23.1 Any notices given under this Agreement must be sent by e-mail to the other Party's address set out in the Particulars.

23.2 Notices by e-mail will be effective when sent in legible form, but only if, following transmission, the sender does not receive a non-delivery message.

24. **DISPUTES**

24.1 This clause does not affect NHS England's right to exercise its functions for the purposes of assessing and addressing the performance of the ICB.

24.2 If a Dispute arises out of or in connection with this Agreement then the Parties must follow the procedure set out in this clause:

24.2.1 either Party must give to the other written notice of the Dispute, setting out its nature and full particulars ("**Dispute Notice**"), together with relevant supporting documents. On service of the Dispute Notice, the Agreement Representatives must attempt in good faith to resolve the Dispute;

24.2.2 if the Agreement Representatives are, for any reason, unable to resolve the Dispute within twenty (20) days of service of the Dispute Notice, the Dispute must be referred to the Chief Executive Officer (or equivalent person) of the ICB and a director of or other person nominated by NHS England (and who has authority from NHS England to settle the Dispute) who must attempt in good faith to resolve it; and

24.2.3 if the people referred to in clause 24.2.2 are for any reason unable to resolve the Dispute within twenty (20) days of it being referred to them, the Parties may attempt to settle it by mediation in accordance with the CEDR model mediation procedure. Unless otherwise agreed between the Parties, the mediator must be nominated by CEDR Solve. To initiate the mediation, a Party must serve notice in writing ('Alternative Dispute Resolution' (**ADR**) **notice**) to the other Party to the Dispute, requesting a mediation. A copy of the ADR notice should be sent to CEDR Solve. The mediation will start not later than ten (10) days after the date of the ADR notice.

24.3 If the Dispute is not resolved within thirty (30) days after service of the ADR notice, or either Party fails to participate or to continue to participate in the mediation before the

expiration of the period of thirty (30) days, or the mediation terminates before the expiration of the period of thirty (30) days, the Dispute must be referred to the Secretary of State, who shall resolve the matter and whose decision shall be binding upon the Parties.

25. VARIATIONS

25.1 The Parties acknowledge that the scope of the Delegated Functions may be reviewed and amended from time to time including by revoking this Agreement and making alternative arrangements.

25.2 NHS England may notify the ICB of a Variation Proposal in respect of this Agreement.

25.3 The Variation Proposal will set out the variation proposed and the date on which NHS England requires the variation to take effect.

25.4 The ICB must respond to a Variation Proposal within thirty (30) Operational Days following the date that it is issued by serving notice on NHS England confirming either:

25.4.1 that it accepts the Variation Proposal; or

25.4.2 that it refuses to accept the Variation Proposal, and sets out reasonable grounds for that refusal.

25.5 If the ICB accepts the Variation Proposal, the ICB agrees (without delay) to take all necessary steps (including executing a variation agreement) in order to give effect to any variation by the date on which the proposed variation will take effect as set out in the Variation Proposal.

25.6 If the ICB refuses to accept the Variation Proposal or to take such steps as are required to give effect to the variation, NHS England may terminate this Agreement in respect of some or all of the Delegated Functions.

25.7 The provisions of this clause 25 are without prejudice to the ability of NHS England to issue Contractual Notices which have the effect of varying this Agreement.

26. TERMINATION

26.1 The ICB may:

26.1.1 notify NHS England that it requires NHS England to revoke the Delegation; and

26.1.2 terminate this Agreement;

with effect from the end of 31 March in any calendar year, provided that:

26.1.3 on or before 30 September of the previous calendar year, the ICB sends written notice to NHS England of its requirement that NHS England revoke the Delegation and intention to terminate this Agreement; and

26.1.4 the ICB meets with NHS England within ten (10) Operational Days of NHS England receiving the notice set out at clause 26.1.3 above to discuss arrangements for termination and transition of the Delegated Functions to a successor commissioner,

in which case NHS England shall revoke the Delegation and this Agreement shall terminate with effect from the end of 31 March in the next calendar year.

26.2 NHS England may revoke the Delegation in whole or in part with effect from 23.59 hours on 31 March in any year, provided that it gives notice to the ICB of its intention to

terminate the Delegation on or before 30 September in the year prior to the year in which the Delegation will terminate, and in which case clause 26.4 will apply.

26.3 The Delegation may be revoked in whole or in part, and this Agreement may be terminated by NHS England at any time, including in (but not limited to) the following circumstances:

26.3.1 the ICB acts outside of the scope of its delegated authority;

26.3.2 the ICB fails to perform any material obligation of the ICB owed to NHS England under this Agreement;

26.3.3 the ICB persistently commits non-material breaches of this Agreement;

26.3.4 NHS England is satisfied that its intervention powers under section 14Z61 of the NHS Act apply;

26.3.5 to give effect to legislative changes, including conferral of any of the Delegated or Reserved Functions on the ICB;

26.3.6 failure to agree to a variation in accordance with clause 25 *(Variations)*;

26.3.7 NHS England and the ICB agree in writing that the Delegation shall be revoked and this Agreement shall terminate on such date as is agreed; and/or

26.3.8 the ICB merges with another ICB or other body.

26.4 This Agreement will terminate upon revocation or termination of the full Delegation (including revocation and termination in accordance with this clause 26 *(Termination)*) except that the provisions referred to at clause 28 (*Provisions Surviving Termination*) will continue in full force and effect.

26.5 Without prejudice to clause 13.3 and to avoid doubt, NHS England may waive any right to terminate this Agreement under this clause 26.5 *(Termination)*. Any such waiver is only effective if given in writing and shall not be deemed a waiver of any subsequent right or remedy.

26.6 As an alternative to termination of the Agreement in respect of all the Delegated Functions, NHS England may alternatively terminate the Agreement in respect of specified Delegated Functions (or aspects of such Delegated Functions) only, in which case this Agreement shall otherwise remain in effect.

27. CONSEQUENCE OF TERMINATION

27.1 Termination of this Agreement, or termination of the ICB's exercise of any of the Delegated Functions, will not affect any rights or liabilities of the Parties that have accrued before the date of that termination or which later accrue.

27.2 Subject to clause 27.4, on or pending termination of this Agreement or termination of the ICB's exercise of any of the Delegated Functions, NHS England, the ICB and if appropriate any successor delegate will:

27.2.1 agree a plan for the transition of the Delegated Functions from the ICB to the successor delegate, including details of the transition, the Parties' responsibilities in relation to the transition, the Parties' arrangements in respect of those staff engaged in the Delegated Functions and the date on which the successor delegate will take responsibility for the Delegated Functions;

27.2.2 implement and comply with their respective obligations under the plan for transition agreed in accordance with clause 27.2.1 above; and

27.2.3 act with a view to minimising any inconvenience or disruption to the commissioning of healthcare in the Area.

27.3 For a reasonable period before and after termination of this Agreement or termination of the ICB's exercise of any of the Delegated Functions, the ICB must:

27.3.1 co-operate with NHS England and any successor delegate in order to ensure continuity and a smooth transfer of the Delegated Functions; and

27.3.2 at the reasonable request of NHS England:

(a) promptly provide all reasonable assistance and information to the extent necessary to effect an orderly assumption of the Delegated Functions by a successor delegate;

(b) deliver to NHS England all materials and documents used by the ICB in the exercise of any of the Delegated Functions; and

27.3.3 use all reasonable efforts to obtain the consent of third parties to the assignment, novation or termination of existing contracts between the ICB and any third party which relate to or are associated with the Delegated Functions.

27.4 Where any or all of the Delegated Functions or Reserved Functions are to be directly conferred on the ICB, the Parties will co-operate with a view to ensuring continuity and a smooth transfer to the ICB.

28. PROVISIONS SURVIVING TERMINATION

28.1 Any rights, duties or obligations of any of the Parties which are expressed to survive, including those referred to in clause 28.2, or which otherwise by necessary implication survive the termination for any reason of this Agreement, together with all indemnities, will continue after termination, subject to any limitations of time expressed in this Agreement.

28.2 The surviving provisions include the following clauses together with such other provisions as are required to interpret and give effect to them:

28.2.1 Clause 9 (*Finance*);

28.2.2 Clause 12 (*Staffing and Workforce*);

28.2.3 Clause 15 *(Liability and Indemnity*);

28.2.4 Clause 16 (*Claims and Litigation*);

28.2.5 Clause 17 (*Data Protection, Freedom of Information and Transparency*);

28.2.6 Clause 24 (*Disputes*);

28.2.7 Clause 26 (*Termination*);

28.2.8 Schedule 4 (*Further Information Governance and Sharing Provisions*).

29. COSTS

29.1 Each Party is responsible for paying its own costs and expenses incurred in connection with the negotiation, preparation and execution of this Agreement.

30. **SEVERABILITY**

30.1 If any provision or part of any provision of this Agreement is declared invalid or otherwise unenforceable, that provision or part of the provision as applicable will be severed from this Agreement. This will not affect the validity and/or enforceability of the remaining part of that provision or of other provisions.

31. **GENERAL**

31.1 Nothing in this Agreement will create a partnership or joint venture or relationship of principal and agent between NHS England and the ICB.

31.2 A delay or failure to exercise any right or remedy in whole or in part shall not waive that or any other right or remedy, nor shall it prevent or restrict the further exercise of that or any other right or remedy.

31.3 This Agreement does not give rise to any rights under the Contracts (Rights of Third Parties) Act 1999 to enforce any term of this Agreement.

SCHEDULE 1

Definitions and Interpretation

1. The headings in this Agreement will not affect its interpretation.

2. Reference to any statute or statutory provision, Law, Guidance, Mandated Guidance or Data Guidance, includes a reference to that statute or statutory provision, Law, Guidance, Mandated Guidance or Data Guidance as from time to time updated, amended, extended, supplemented, re-enacted or replaced in whole or in part.

3. Reference to a statutory provision includes any subordinate legislation made from time to time under that provision.

4. References to clauses and schedules are to the clauses and schedules of this Agreement, unless expressly stated otherwise.

5. References to any body, organisation or office include reference to its applicable successor from time to time.

6. Any references to this Agreement or any other documents or resources includes reference to this Agreement or those other documents or resources as varied, amended, supplemented, extended, restated and/or replaced from time to time and any reference to a website address for a resource includes reference to any replacement website address for that resource.

7. Use of the singular includes the plural and vice versa.

8. Use of the masculine includes the feminine and all other genders.

9. Use of the term “including” or “includes” will be interpreted as being without limitation.

10. The following words and phrases have the following meanings:

Additional Pharmaceutical Services	Services provided in accordance with a direction under section 127 of the NHS Act (also referred to as advanced services and enhanced services in the Pharmaceutical Regulations);
Agreement	means this agreement between NHS England and the ICB comprising the Particulars, the Terms and Conditions, the Schedules and the Mandated Guidance;
Agreement Representatives	means the ICB Representative and the NHS England Representative as set out in the Particulars;
Annual Allocation	means the funds allocated to the ICB annually under section 223G of the NHS Act
APMS Contract	means an agreement or contract for the provision of primary medical services made under section 83(2) of the NHS Act (including any arrangements which are made in reliance on a combination of that section and other powers to arrange for primary medical services);
Area	means the area described in the Particulars;

Assigned Staff	means those NHS England staff as agreed between NHS England and the ICB from time to time;
Best Practice	means any methodologies, pathway designs and processes relating to this Agreement or the Delegated Functions developed by the ICB or its Staff for the purposes of delivering the Delegated Functions and which are capable of wider use in the delivery of healthcare services for the purposes of the NHS, but not including inventions that are capable of patent protection and for which patent protection is being sought or has been obtained, registered designs, or copyright in software;
Caldicott Principles	means the patient confidentiality principles set out in the report of the Caldicott Committee (December 1997 as amended by the 2013 Report, The Information Governance Review – "*To Share or Not to Share?"*) and now included in the NHS Confidentiality Code of Practice, as may be amended from time to time;
Capital	shall have the meaning set out in the Capital Investment Guidance or such other replacement Mandated Guidance as issued by NHS England from time to time;
Capital Expenditure Functions	means those functions of NHS England in relation to the use and expenditure of Capital funds (but excluding the Premises Costs Directions Functions);
Capital Investment Guidance	means any Mandated Guidance issued by NHS England from time to time in relation to the development, assurance and approvals process for proposals in relation to: • the expenditure of Capital, or investment in property, infrastructure or information and technology; and • the revenue consequences for commissioners or third parties making such investment;
CEDR	means the Centre for Effective Dispute Resolution;
Claims	means, for or in relation to the Delegated Functions (a) any litigation or administrative, mediation, arbitration or other proceedings, or any claims, actions or hearings before any court, tribunal or the Secretary of State, any governmental, regulatory or similar body, or any department, board or agency or (b) any dispute with, or any investigation, inquiry or enforcement proceedings by, any governmental, regulatory or similar body or agency;
Claim Losses	means all Losses arising in relation to any Claim;
Combined Authority	means a body of that name established under the provisions of the Local Democracy, Economic Development and Construction Act 2009;
Community Dental Services	means specialised dental services commissioned for patients who are unable to access treatment from Primary Dental

	Services due to a disability or medical condition, being a form of Prescribed Dental Service;
Community Pharmacy Contractual Framework	means the Community Pharmacy Contractual Framework as published by the Department of Health and Social Care from time to time;
Complaints Regulations	means the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009/309;
Confidential Information	means any information or data in whatever form disclosed, which by its nature is confidential or which the disclosing Party acting reasonably states in writing to the receiving Party is to be regarded as confidential, or which the disclosing Party acting reasonably has marked 'confidential' (including, financial information, strategy documents, tenders, employee confidential information, development or workforce plans and information, and information relating to services) but which is not information which is disclosed in response to a FOIA request, or information which is published as a result of NHS England or government policy in relation to transparency;
Contracts	Means any Prescribed Dental Services Contract, Primary Care Contract or Arrangement or other contract or arrangement in respect of the commissioning of any other Delegated Services;
Contractual Notice	means a contractual notice issued by NHS England to the ICB, or some or all ICBs (as the case may be), from time to time and relating to the allocation of contracts for the purposes of the Delegated Functions and/or the manner in which the Delegated Functions should be exercised by the ICB;
CQC	means the Care Quality Commission;
Data Controller	shall have the same meaning as set out in the UK GDPR;
Data Guidance	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement regarding information governance, confidentiality, privacy or compliance with Data Protection Legislation to the extent published and publicly available or their existence or contents have been notified to the ICB by NHS England and/or any relevant Regulatory or Supervisory Body. This includes but is not limited to guidance issued by NHS Digital, the National Data Guardian for Health & Care, the Department of Health and Social Care, NHS England, the Health Research Authority, the UK Health Security Agency and the Information Commissioner;
Data Processor	shall have the same meaning as set out in the UK GDPR;
Data Protection Legislation	means the UK GDPR, the Data Protection Act 2018 and all applicable Law concerning privacy, confidentiality or the processing of personal data including but not limited to the Human Rights Act 1998, the Health and Social Care (Safety

	and Quality) Act 2015, the common law duty of confidentiality and the Privacy and Electronic Communications (EC Directive) Regulations 2003;
Data Sharing Agreement	means a data sharing agreement which should be in substantially the same form as the Data Sharing Agreement template shared by NHS England in respect of this Agreement;
Data Subject	shall have the same meaning as set out in the UK GDPR;
Delegated Functions	means the statutory functions delegated by NHS England to the ICB under the Delegation and as set out in detail in this Agreement;
Delegated Funds	means the funds defined in Clause 9.2;
Delegated Services	Means the services commissioned in exercise of the Delegated Functions;
Delegation	means the delegation of the Delegated Functions from NHS England to the ICB as described at clause 6.1;
Dental Care Services	means: (i) Primary Dental Services; and (ii) the Prescribed Dental Services;
Dental Services Contract	means: (i) a GDS Contract; (ii) a PDS Agreement (except for any Community Dental Services PDS Agreement, which constitutes a Prescribed Dental Services Contract); and (iii) any other contract for the provision of health services made pursuant to NHS England's functions under Part 5 of the NHS Act; in each case as amended or replaced from time to time and including all ancillary or related agreements directly relating to the subject matter of such agreements, contracts or arrangements;
Dental Services Provider	means a natural or legal person who holds a Dental Services Contract;
Direct Commissioning Guidance Webpage	means the webpage maintained by NHS England at https://www.england.nhs.uk/commissioning/how-commissioning-is-changing/;
Dispute	a dispute, conflict or other disagreement between the Parties arising out of or in connection with this Agreement;
Effective Date of Delegation	means the Effective Date of Delegation as set out in the Particulars;

EIR	means the Environmental Information Regulations 2004
Enhanced Services	means the nationally defined enhanced services, as set out in such directions made by the Secretary of State pursuant to his powers contained in sections 98A, 114A, 125A and 168A of the NHS Act as are in force from time to time, or which may be prescribed by NHS England under its Reserved Functions, and any other enhanced services schemes locally developed by the ICB in the exercise of its Delegated Functions (and excluding, for the avoidance of doubt, any enhanced services arranged or provided pursuant to the Section 7A Functions);
Escalation Rights	means the escalation rights as defined in clause 14 *(Escalation Rights)*;
Financial Year	shall bear the same meaning as in section 275 of the NHS Act;
FOIA	the Freedom of Information Act 2000;
Further Arrangements	means arrangements for the exercise of Delegated Functions as defined at clause 11.2;
GDS Contract	means a General Dental Services contract made under section 100 of the NHS Act;
GMS Contract	means a General Medical Services contract made under section 84(1) of the NHS Act;
Good Practice	means using standards, practices, methods and procedures conforming to the law, reflecting up-to-date published evidence and exercising that degree of skill and care, diligence, prudence and foresight which would reasonably and ordinarily be expected from a skilled, efficient and experienced commissioner;
Guidance	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which the ICB has a duty to have regard (and whether specifically mentioned in this Agreement or not), to the extent that the same are published and publicly available or the existence or contents of them have been notified to the ICB by any relevant Regulatory or Supervisory Body but excluding Mandated Guidance;
HSCA	means the Health and Social Care Act 2012;
ICB	means an Integrated Care Board established pursuant to section 14Z25 of the NHS Act and named in the Particulars;
ICB Deliverables	all documents, products and materials developed by the ICB or its Staff in relation to this Agreement and the Delegated Functions in any form and required to be submitted to NHS England under this Agreement, including data, reports, policies, plans and specifications;

IG Guidance for Serious Incidents	IG Guidance for Serious Incidents NHS Digital's Checklist Guidance for Information Governance Serious Incidents Requiring Investigation June 2013, available at: https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-informationgovernance/data-security-and-protection-toolkit
Indemnity Arrangement	means either: (i) a policy of insurance; (ii) an arrangement made for the purposes of indemnifying a person or organisation; or (iii) a combination of (i) and (ii);
Information Law	the UK GDPR, the Data Protection Act 2018, regulations and guidance made under section 13S and section 251 of the NHS Act; guidance made or given under sections 263 and 265 of the HSCA; the Freedom of Information Act 2000; the common law duty of confidentiality; the Human Rights Act 1998 and all other applicable laws and regulations relating to processing of Personal Data and privacy;
IPR	means inventions, copyright, patents, database right, trademarks, designs and confidential know-how and any similar rights anywhere in the world whether registered or not, including applications and the right to apply for any such rights;
Law	means any applicable law, statute, rule, bye-law, regulation, direction, order, regulatory policy, guidance or code, rule of court or directives or requirements of any regulatory body, delegated or subordinate legislation or notice of any regulatory body (including any Regulatory or Supervisory Body);
Local Authority	means a county council in England, a Combined Authority, a district council in England, a London borough council, the Common Council of the City of London or the Council of the Isles of Scilly;
Local Incentive Schemes	means an incentive scheme developed by the ICB in the exercise of its Delegated Functions to extend the range or quality of essential and additional services provided under a Primary Medical Services Contract and support national frameworks in order to meet differing local population needs;
Local Pharmaceutical Services Contract	means • a contract entered into pursuant to section 134 of the NHS Act; or • a contract entered into pursuant to Paragraph 1 of Schedule 12 to the NHS Act;
Local Terms	means the terms set out in Schedule 7 *(Local Terms)* and/or such other Schedule or part thereof as designated as Local Terms;
Losses	means all damages, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional

	services) proceedings, demands and charges whether arising under statute, contract or common law;
Managing Conflicts of Interest in the NHS	the NHS publication by that name available at: https://www.england.nhs.uk/about/board-meetings/committees/coi/
Mandated Guidance	means any protocol, policy, guidance, guidelines, framework or manual relating to the exercise of the Delegated Functions and issued by NHS England to the ICB as Mandated Guidance from time to time, in accordance with clause 7.2 which at the Effective Date of Delegation shall include the Mandated Guidance set out in the Schedules**;**
National Moderation Panel	Means the NHS England panel in respect of the relevant Delegated Function that will have the delegated authority to approve the ICB arrangements in respect of a Delegated Function;
Need to Know	has the meaning set out in paragraph 6.2 of Schedule 4 (*Further Information Governance and Sharing Provisions)*;
NHS Act	means the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022 or other legislation from time to time);
NHS Business Services Authority	means the Special Health Authority established under the NHS Business Services Authority (Establishment and Constitution Order) 2005 SI 2005/2414;
NHS Counter Fraud Authority	means the Special Health Authority established by and in accordance with the NHS Counter Fraud Authority (Establishment, Constitution, and Staff and Other Transfer Provisions) Order 2017/958;
NHS England	means the body established by section 1H of the NHS Act;
NHS England Deliverables	means all documents, products and materials NHS England in which NHS England holds IPRs which are relevant to this Agreement, the Delegated Functions or the Reserved Functions in any form and made available by NHS England to the ICB under this Agreement, including data, reports, policies, plans and specifications;
NHS England Functions	means all functions of NHS England as set out in Legislation excluding any functions that have been expressly delegated;
Non-Personal Data	means data which is not Personal Data;
Out of Hours Contract	means a primary medical services contract for the provision of primary medical services solely during the out of hours period (6.30pm Monday to Thursday until 8am the next day, 6.30pm Friday to 8am Monday, Christmas Day, Good Friday and bank holidays);
Operational Days	a day other than a Saturday, Sunday, Christmas Day, Good Friday or a bank holiday in England;

Particulars	means the Particulars of this Agreement as set out in clause 1 *(Particulars)*;
Party/Parties	means a party or both parties to this Agreement;
PDS Agreement	means a Personal Dental Services Agreement made under section 107 of the NHS Act;
Performers Lists	The lists of healthcare professionals maintained by NHS England pursuant to the National Health Service (Performers Lists) (England) Regulations 2013;
Personal Data	shall have the same meaning as set out in the UK GDPR and shall include references to Special Category Personal Data where appropriate;
Pharmaceutical List	means a list of persons who undertake to provide pharmaceutical services pursuant to regulation 10 of the Pharmaceutical Regulations;
Pharmaceutical Regulations	means the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013/349;
Pharmaceutical Services	means:- (i) services provided pursuant to arrangements under section 126 of the NHS Act; and (ii) Additional Pharmaceutical Services
Pharmaceutical Services Arrangement	means an arrangement for the provision of Pharmaceutical Services, including inclusion in a Pharmaceutical List;
Pharmaceutical Services Provider	means a natural or legal person who is party to a Pharmaceutical Services Arrangement or Local Pharmaceutical Services Contract;
PMS Agreement	means an agreement made in accordance with section 92 of the NHS Act;
Population	means the individuals for whom the ICB is responsible for commissioning health services;
Premises Agreements	means tenancies, leases and other arrangements in relation to the occupation of land for the delivery of services under the Primary Medical Services Contracts;
Premises Costs Directions	means the National Health Service (General Medical Services Premises Costs) Directions 2013, as amended;
Premises Costs Directions Functions	means NHS England's functions in relation to the Premises Costs Directions;
Prescribed Dental Services	means the dental services prescribed by such regulations made pursuant to section 3B(1)(a) of the NHS Act as are in force from time to time (including, for the avoidance of doubt,

services commonly known as secondary care dental services and Community Dental Services);

Prescribed Dental Services Contract means any contract for the provision of Prescribed Dental Services;

Primary Care Contract or Arrangement (PCCA) means:

(i) a Primary Medical Services Contract;

(ii) a Dental Services Contract;

(iii) a Primary Ophthalmic Services Contract;

(iv) a Local Pharmaceutical Services Contract; and

(v) a Pharmaceutical Services Arrangement.

Primary Care Functions means:-

(i) the statutory functions conferred on NHS England under Parts 4, 5, 6 and 7 of the NHS Act and secondary legislation made under those Parts; and

(ii) the other statutory functions conferred on NHS England by either primary legislation, secondary legislation or by arrangement with another person in so far as they are applicable to the discharge of those functions set out at (i) above;

Primary Care Provider means a natural or legal person who holds a Primary Care Contract, or is a Pharmaceutical Services Provider;

Primary Care Provider Personnel means all persons (whether clinical or non-clinical) employed or engaged by a Primary Care Provider or by any Sub-Contractor (including volunteers, agency, locums, casual or seconded personnel) in the provision of Services or any activity related to or connected with the provision of the Services;

Primary Care Services means the services in respect of which NHS England has a duty or power to make arrangements pursuant to the Primary Care Functions;

Primary Dental Services means primary dental care services provided under arrangements made pursuant to Part 5 of the NHS Act, and in accordance with a Dental Services Contract;

Primary Medical Services means primary medical services provided under arrangements made pursuant to Part 4 of the NHS Act, and in accordance with a Primary Medical Services Contract;

Primary Medical Services Contract means:

(i) a PMS Agreement;

(ii) a GMS Contract;

(iii) an APMS Contract; and

(iv) any other contract for the provision of health services made pursuant to NHS England's functions under Part 4 of the NHS Act;

in each case as amended or replaced from time to time and including all ancillary or related agreements directly relating to the subject matter of such agreements, contracts or arrangements but excluding any Premises Agreements and excluding any Out of Hours Contracts[2];

Primary Medical Services Provider means a natural or legal person who holds a Primary Medical Services Contract;

Primary Ophthalmic Services Contract means:

(i) a General Ophthalmic Services Contract; and

(ii) any other contract for the provision of health services made pursuant to NHS England's functions under Part 6 of the NHS Act;

in each case as amended or replaced from time to time and including all ancillary or related agreements directly relating to the subject matter of such agreements, contracts or arrangements;

Primary Ophthalmic Services Provider means a natural or legal person who holds a Primary Ophthalmic Services Contract;

Principles of Best Practice means the Mandated Guidance in relation to property and investment which is to be published either before or after the date of this Agreement;

Prohibited Act the ICB:

(i) offering, giving, or agreeing to give NHS England (or any of their officers, employees or agents) any gift or consideration of any kind as an inducement or reward for doing or not doing or for having done or not having done any act in relation to the obtaining of performance of this Agreement, the Reserved Functions, the Delegation or any other arrangement with the ICB, or for showing or not showing favour or disfavour to any person in relation to this Agreement or any other arrangement with the ICB; and

(ii) in connection with this Agreement, paying or agreeing to pay any commission, other than a payment, particulars of which (including the terms and conditions of the agreement for its payment) have been disclosed in writing to NHS England; or

(iii) committing an offence under the Bribery Act 2010;

QOF means the quality and outcomes framework;

[2] Arrangements for Out of Hours Contracts are dealt with under separate Directions outside of this Agreement and do not form part of any Delegated Functions.

Regulatory or Supervisory Body	means any statutory or other body having authority to issue guidance, standards or recommendations with which the relevant Party and/or Staff must comply or to which it or they must have regard, including: (i) CQC; (ii) NHS England; (iii) the Department of Health and Social Care; (iv) the National Institute for Health and Care Excellence; (v) Healthwatch England and Local Healthwatch; (vi) the General Medical Council; (vii) the General Dental Council; (viii) the General Optical Council; (ix) the General Pharmaceutical Council; (x) the Healthcare Safety Investigation Branch; and (xi) the Information Commissioner;
Relevant Information	means the Personal Data and Non-Personal Data processed under the Delegation and this Agreement, and includes, where appropriate, "confidential patient information" (as defined under section 251 of the NHS Act), and "patient confidential information" as defined in the 2013 Report, The Information Governance Review – "*To Share or Not to Share?"*);
Reserved Functions	means statutory functions of NHS England that it has not delegated to the ICB including but not limited to those set out in the Schedules to this Agreement;
Secretary of State	means the Secretary of State for Health and Social Care from time to time;
Section 7A Functions	means those functions of NHS England exercised pursuant to section 7A of the NHS Act and relating to Primary Care Services;
Section 7A Funds	shall have the meaning in Schedule 10 Part 2;
Special Category Personal Data	shall have the same meaning as in UK GDPR;
Specified Purpose	means the purpose for which the Relevant Information is shared and processed, being to facilitate the exercise of the ICB's Delegated Functions and NHS England's Reserved Functions as specified in paragraph 2.1 of Schedule 4 *(Further Information Governance and Sharing Provisions)* to this Agreement;

Staff or Staffing	means the Parties' employees, officers, elected members, directors, voluntary staff, consultants, and other contractors and sub-contractors acting on behalf of either Party (whether or not the arrangements with such contractors and sub-contractors are subject to legally binding contracts) and such contractors' and their sub-contractors' personnel;
Staffing Model	means the employment model for the exercise of the Delegated Functions including those as defined in Appendix 2 of the NHS England and NHS Improvement operating models: HR Framework for developing Integrated Care as may be amended or replaced from time to time;
Statement of Financial Entitlements Directions	means the General Medical Services Statement of Financial Entitlements Directions 2021, as amended or updated from time to time;
Sub-Delegate	shall have the meaning in clause 11.2;
Transfer Regulations	means the Transfer of Undertakings (Protection of Employment) Regulations 2006, as amended;
Triple Aim	means the duty to have regard to the wider effects of decisions, which is placed on each of the Parties under section 13NA (as regards NHS England) and section 14Z43 (as regards the ICB) of the NHS Act;
UK GDPR	means Regulation (EU) 2016/679 of the European Parliament and of the Council of 27th April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (General Data Protection Regulation) as it forms part of the law of England and Wales, Scotland and Northern Ireland by virtue of section 3 of the European Union (Withdrawal) Act 2018;
Variation Proposal	means a written proposal for a variation to the Agreement, which complies with the requirements of clause 25.3.

SCHEDULE 2

Delegated Functions

Schedule 2A: Primary Medical Services

Part 1: General Obligations

1. Introduction

1.1 This Part 1 of Schedule 2A *(Primary Medical Services)* sets out further provision regarding the carrying out of those Delegated Functions relating to Primary Medical Services, being in summary:

1.1.1 decisions in relation to the commissioning and management of Primary Medical Services;

1.1.2 planning Primary Medical Services in the Area, including carrying out needs assessments;

1.1.3 undertaking reviews of Primary Medical Services in respect of the Area;

1.1.4 management of the Delegated Funds in the Area;

1.1.5 co-ordinating a common approach to the commissioning and delivery of Primary Medical Services with other health and social care bodies in respect of the Area where appropriate; and

1.1.6 such other ancillary activities that are necessary in order to exercise the Delegated Functions.

2. General Obligations

2.1 The ICB is responsible for planning the commissioning of primary medical services.

2.2 The role of the ICB includes:

2.2.1 carrying out needs assessments, and regular reviews of such assessments, to determine the needs of the population in the Area; and

2.2.2 identifying and implementing changes to meet any unmet needs which may be met through the delivery of Primary Medical Services.

2.3 In respect of integrated working, the ICB must:

2.3.1 take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Authorities, Healthwatch, acute and community providers, the Local Medical Committee, and other stakeholders;

2.3.2 work with NHS England and other ICBs to co-ordinate a common approach to the commissioning of Primary Medical Services generally; and

2.3.3 work with NHS England to coordinate the exercise of their respective performance management functions.

2.4 In relation to the Delegated Functions, the ICB agrees to perform the following general obligations:

2.4.1 to manage the Primary Medical Services Contracts and perform all of NHS England's obligations under each of the Primary Medical Services Contracts

in accordance with the terms of the Primary Medical Services Contracts as if it were named in the contract in place of NHS England;

2.4.2 actively manage the performance of the Primary Medical Services Provider in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services including by taking timely action to enforce contractual breaches, serve notices or provide discretionary support;

2.4.3 ensure that it obtains value for money on behalf of NHS England, and avoids making any double payments under any Primary Medical Services Contracts;

2.4.4 notify NHS England immediately (or in any event within two (2) Operational Days) of any breach by the ICB of its obligations to perform any of NHS England's obligations under the Primary Medical Services Contracts;

2.4.5 undertake any investigations relating (among other things) to whistleblowing claims, infection control and patient complaints;

2.4.6 keep a record of all of the Primary Medical Services Contracts that the ICB manages setting out the following details in relation to each Primary Medical Services Contract:

2.4.6.1 name of the Primary Medical Services Provider;

2.4.6.2 the name by which the Primary Medical Services Provider is known (if different to the name recorded under paragraph 2.4.6.1);

2.4.6.3 location of provision of services; and

2.4.6.4 amounts payable under the Primary Medical Services Contract (if a contract sum is payable) or amount payable in respect of each patient (if there is no contract sum).

2.5 Without prejudice to clause 9 (*Finance*) of the Agreement or paragraph 2.4 above, the ICB must actively manage each of the relevant Primary Medical Services Contracts including by:

2.5.1 reviewing the performance of the relevant Primary Medical Services Contract, including in respect of quality standards, incentives and the QOF, observance of service specifications, and monitoring of activity and finance;

2.5.2 assessing quality and outcomes (including clinical effectiveness, patient experience, patient safety and addressing inequalities);

2.5.3 managing variations to the relevant Primary Medical Services Contract or services in accordance with national policy, service user needs and clinical developments;

2.5.4 agreeing information and reporting requirements and managing information breaches (which will include use of the NHS Digital Data Security and Protection Toolkit);

2.5.5 agreeing local prices, managing agreements or proposals for local variations and local modifications;

2.5.6 conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes; and

2.5.7 complying with and implementing any relevant Mandated Guidance issued from time to time.

2.6 This paragraph is without prejudice to clause 10 (*Information, Planning and Reporting*) or any other provision in this Agreement. The ICB must provide NHS England with:

2.6.1 such information relating to individual Primary Medical Services Providers in the Area as NHS England may reasonably request, to ensure that NHS England is able to continue to gather national data regarding the commissioning or performance of Primary Medical Services Providers;

2.6.2 such data/data sets as required by NHS England to ensure population of any national dashboards;

2.6.3 any other data/data sets as required by NHS England; and

2.6.4 the ICB shall procure that providers accurately record and report information so as to allow NHS England and other agencies to discharge their functions.

2.7 It should be noted that while the ICB is also required to exercise functions in respect of dispensing doctors, arrangements in respect of these functions are described in Schedule 2D (Pharmaceutical Services).

Part 2: Specific Obligations

1. Introduction

This Part 2 of Schedule 2A (Delegated Functions – Primary Medical Services) sets out further provision regarding the carrying out of each of the Delegated Functions.

2. Primary Medical Services Contract Management

The ICB must comply with any future national Mandated Guidance on equitable funding as may apply from time to time.

3. Enhanced Services

3.1 The ICB must manage the design (where applicable) and commissioning of any Enhanced Services, including re-commissioning these services annually where appropriate.

3.2 The ICB may consider any local enhanced services entered into with Primary Medical Services Providers in its Area using NHS Standard Contracts. Where these would continue to be beneficial to the Area, the ICB may manage the ongoing design and commissioning (including re-commissioning) of these services via a Local Incentives Scheme.

3.3 The ICB must ensure that it complies with any Mandated Guidance in relation to the design and commissioning of Enhanced Services.

3.4 When commissioning newly designed Enhanced Services the ICB must:

3.4.1 consider the needs of the local population in the Area;

3.4.2 develop the necessary specifications and templates for the Enhanced Services, as required to meet the needs of the local population in the Area;

3.4.3 when developing the necessary specifications and templates for the Enhanced Services, ensure that value for money will be obtained;

3.4.4 consult with Local Medical Committees and other stakeholders and comply with the duty of public involvement and consultation under section 14Z45 of the NHS Act;

3.4.5 liaise with system providers and representative bodies to ensure that the system in relation to the Directed Enhanced Services, NHS England Enhanced Services and Local Enhanced Services will be functional and secure;

3.4.6 support Data Controllers in providing 'fair processing' information as required by the UK GDPR; and

3.4.7 support Primary Medical Services Providers in entering into data processing agreements with data processors in the terms required by the UK GDPR.

4. Design of Local Incentive Schemes

4.1 The ICB may design and offer Local Incentive Schemes for Primary Medical Services Providers, sensitive to the differing needs of their particular communities. This includes in addition to or as an alternative to the national contractual frameworks (including as an alternative to QOF or Enhanced Services), provided that such schemes are voluntary, and the ICB continues to offer the national schemes.

4.2 There is no formal approvals process that the ICB must follow to develop a Local Incentive Scheme, although when designing and implementing any proposed new Local Incentive Scheme the ICB must:

4.2.1 consider the needs of the local population in the Area;

4.2.2 develop the specifications and templates for the Local Incentive Scheme;

4.2.3 consult with Local Medical Committees and other stakeholders and comply with the duty of public involvement and consultation under section 14Z45 of the NHS Act;

4.2.4 liaise with system providers and representative bodies to ensure that the system in relation to the Local Incentive Schemes will be functional and secure;

4.2.5 support Data Controllers in providing privacy information as required by the UK GDPR; and

4.2.6 support Primary Medical Services Providers in entering into data processing agreements with data processors in terms required by the UK GDPR.

4.3 The ICB must be able to:

4.3.1 demonstrate improved outcomes, reduced inequalities and value for money;

4.3.2 support ongoing national reporting requirements (where applicable); and

4.3.3 must reflect the changes agreed as part of the national PMS reviews (https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/05/implement-pms-fund-changes.pdf).

4.4 The ongoing assurance of any new Local Incentive Schemes will form part of the ICB's assurance process under any applicable assurance framework.

4.5 Any new Local Incentive Scheme must be implemented without prejudice to the right of Primary Medical Services Providers operating under a GMS Contract to obtain their entitlements which are negotiated and set nationally.

4.6 NHS England will continue to set national standing rules, to be reviewed annually, and the ICB must comply with these rules which shall for the purposes of this Agreement be Mandated Guidance.

5. Making Decisions on Discretionary Payments or Support

5.1 The ICB must manage and make decisions in relation to any discretionary payments or discretionary support to be made to Primary Medical Services Providers in a consistent, open and transparent way.

5.2 The ICB must exercise its discretion to determine the level of payment or type of support to Primary Medical Services Providers, in accordance with any relevant Mandated Guidance.

6. Making Decisions about Commissioning Urgent Care for Out of Area Registered Patients

6.1 The ICB must manage the design and commissioning of urgent care services (including home visits as required) for its patients registered out of area (including re-commissioning these services annually where appropriate).

6.2 The ICB must ensure that it complies with any Mandated Guidance in relation to the design and commissioning of these services.

6.3 For the purposes of paragraph 6.1, urgent care means the provision of primary medical services on an urgent basis.

7. Transparency and freedom of information

7.1 The ICB must:

7.1.1 Respond to requests for information from members of the public and the media, including requests made pursuant to the FOIA, whose subject-matter relates to the performance of the Delegated Functions in the ICB's Area; and

7.1.2 Provide information and assistance as required to support NHS England in the preparation of responses to parliamentary questions in connection with the Delegated Functions.

8. Planning the Provider Landscape

8.1 The ICB must plan the primary medical services provider landscape in the Area, including considering and taking decisions in relation to:

8.1.1 establishing new Primary Medical Services Providers in the Area;

8.1.2 managing Primary Medical Services Providers providing inadequate standards of patient care;

8.1.3 the procurement or award of new Primary Medical Services Contracts (in accordance with any procurement protocol or Guidance issued by NHS England from time to time);

8.1.4 closure of practices and branch surgeries;

8.1.5 dispersing the patient lists of Primary Medical Services Providers; and

8.1.6 agreeing variations to the boundaries of Primary Medical Services Providers.

8.2 In relation to any new Primary Medical Services Contract to be entered into, the ICB must, without prejudice to any obligation in paragraph 14 (*Procurement and New Contracts*) below, and paragraph 2.5 of Part 1 of this Schedule 2A:

8.2.1 consider and use the form of Primary Medical Services Contract that will ensure compliance with NHS England's obligations under Law taking into account the persons to whom such Primary Medical Services Contracts may be awarded;

8.2.2 provide to NHS England confirmation as required from time to time that it has considered and complied with its obligations under this Agreement and the Law; and

8.2.3 for the avoidance of doubt, Schedule 5 (Financial Provisions and Decision Making Limits) deals with the sign off requirements for Primary Medical Services Contracts.

9. Primary Care Networks

9.1 In managing the design and commissioning of the Network Contract Directed Enhanced Services, including re-commissioning these services annually where appropriate, the ICB must plan and manage the Primary Care Networks in the Area, complying with published specifications and Mandated Guidance, including to:

9.1.1 maintain or establish identified Network Areas to support the local population in the Area;

9.1.2 review any waived PCN list size requirements wherever possible and appropriate to best support the local population in the Area;

9.1.3 ensure that each PCN has at all times an accountable Clinical Director;

9.1.4 align each PCN with an ICB that would best support delivery of services to the local population in the Area; and

9.1.5 collaborate and work with other ICBs as appropriate to agree which ICB will be the lead ICB for the PCN.

10. Approving Primary Medical Services Provider Mergers and Closures

10.1 The ICB is responsible for approving Primary Medical Services Provider mergers and Primary Medical Services Provider closures in the Area.

10.2 The ICB must undertake all necessary consultation when taking any decision in relation to Primary Medical Services Provider mergers or Primary Medical Services Provider closures in the Area, including those set out under section 14Z45 of the NHS Act (duty for public involvement and consultation). The consultation undertaken must be appropriate and proportionate in the circumstances and should include consulting with the Local Medical Committee.

10.3 Prior to making any decision in accordance with this paragraph 10 (*Approving Primary Medical Services Provider Mergers and Closures*), the ICB must be able to clearly demonstrate the grounds for such a decision and must have fully considered any impact on the Primary Medical Services Provider's registered population and that of surrounding practices. The ICB must be able to clearly demonstrate that it has considered other options and has entered into dialogue with the Primary Medical Services Provider as to how any closure or merger will be managed.

10.4 In making any decisions pursuant to this paragraph 10 (*Approving Primary Medical Services Provider Mergers and Closures*), the ICB shall act in accordance with relevant Mandated Guidance and also take account of its obligations as set out in paragraph 14 *(Procurement and New Contracts)*, below, where applicable.

11. Making Decisions in relation to Management of Poorly Performing Primary Medical Services Providers

11.1 The ICB must make decisions in relation to the management of poorly performing Primary Medical Services Provider including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the Performers List).

11.2 In accordance with paragraph 11.1 above, the ICB must:

11.2.1 ensure regular and effective collaboration with the CQC to ensure that information on general practice is shared and discussed in an appropriate and timely manner;

11.2.2 ensure that any risks identified are managed and escalated where necessary;

11.2.3 respond to CQC assessments of Primary Medical Services Providers where improvement is required;

11.2.4 where a Primary Medical Services Provider is placed into special measures, lead a quality summit to ensure the development and monitoring of an appropriate improvement plan (including a communications plan and actions to manage primary care resilience in the locality); and

11.2.5 take appropriate contractual action, including (without limitation) in response to CQC findings.

12. Premises Costs Directions Functions

12.1 The ICB must comply with the Premises Costs Directions and will be responsible for making decisions in relation to the Premises Costs Directions Functions.

12.2 In particular, but without limiting paragraph 12.1, the ICB shall make decisions concerning:

12.2.1 applications for new payments under the Premises Costs Directions (whether such payments are to be made by way of grants or in respect of recurring premises costs); and

12.2.2 revisions to existing payments being made under the Premises Costs Directions.

12.3 The ICB must comply with any decision-making limits set out in Schedule 5 (*Financial Provisions and Decision Making Limits*) when taking decisions in relation to the Premises Costs Directions Functions.

12.4 The ICB will comply with any Guidance issued by the Secretary of State or NHS England in relation to the Premises Costs Directions, including the Principles of Best Practice, and any other Mandated Guidance in relation to the Premises Costs Directions.

12.5 The ICB must work to ensure that the premises estate is properly managed and maintained, including by ensuring strategic estates planning is in place, and work cooperatively with other ICBs as appropriate.

12.6 The ICB must ensure it maintains comprehensive records of the primary care estate and any changes to it.

12.7 The ICB must liaise where appropriate with NHS Property Services Limited and Community Health Partnerships Limited in relation to the Premises Costs Directions Functions.

12.8 The ICB must prioritise the following measures in respect of management of the primary care estate in the Area:

12.8.1 working collaboratively with landlords and tenants to maximise the use of existing estate;

12.8.2 effective asset management practices including (without limitation) regularisation of the occupation of the estate, lease events, rent reviews and up-to-date documentation management; and

12.8.3 seeking the resolution of premises disputes in a timely manner.

13. Maintaining the Performers List

On receiving a notice from a practitioner (who is party to a Primary Medical Services Contract) of an amendment to information recorded about them in the Performers List, pursuant to regulation 9(1) of the National Health Service (Performers Lists) (England) Regulations 2013, the ICB must support NHS England's amendment of the Performers List as soon as possible after receiving the notice using the Primary Care Support services provided by NHS England, insofar as that amendment relates to a change in contractor details.

14. Procurement and New Contracts

14.1 Until any new arrangements for awarding Primary Medical Services Contracts comes into force, the ICB will make procurement decisions relevant to the exercise of the Delegated Functions and in accordance with the detailed arrangements regarding procurement set out in the procurement protocol issued and updated by NHS England from time to time.

14.2 In discharging its responsibilities set out in this Schedule 2A, the ICB must comply at all times with Law and any relevant Guidance (including any applicable procurement law and/or guidance on the selection of, and award of contracts to, providers of healthcare services).

14.3 On the coming into force of new arrangements for awarding Primary Medical Services Contracts, the ICB will make decisions on awarding new contracts relevant to the exercise of the Delegated Functions.

14.4 When the ICB makes decisions in connection with the awarding of Primary Medical Services Contracts it should ensure that it is able to demonstrate compliance with requirements for the award of Primary Medical Services Contracts, including that the decision was:

14.4.1 made in the best interest of patients, taxpayers and the population;

14.4.2 robust and defensible, with conflicts of interests appropriately managed;

14.4.3 made transparently; and

14.4.4 compliant with the rules of the regime as set out in NHS England guidance.

14.5 Where the ICB wishes to develop and offer a locally designed contract, it must ensure that it has consulted with the relevant Local Medical Committees in relation to the proposal and that it can demonstrate that the scheme will:

14.5.1 improve outcomes for patients;

14.5.2 reduce inequalities in the population; and

14.5.3 provide value for money.

15. Complaints

15.1 The ICB will handle complaints made in respect of Primary Medical Services in accordance with the Complaints Regulations.

16. Commissioning ancillary support services

16.1 The ICB must procure, and undertake the management and monitoring of contracts for the provision of, such ancillary support services as are required to support the ICB in the effective discharge of the Delegated Functions, including, but not limited to the following:

16.1.1 collection and disposal of clinical waste;

16.1.2 provision of translation and interpretation services;

16.1.3 occupational health services.

17. Finance

Further requirements in respect of finance will be specified in Mandated Guidance.

18. Workforce

18.1 The arrangements for the provision and maintenance of sufficient and appropriately qualified, trained and experienced Staff in order for the ICB to fulfil its responsibilities for each of the Delegated Functions ("the Staffing Model"), will be communicated formally to the ICB by NHS England following recommendations made by the National Moderation Panel.

18.2 The ICB is not permitted to vary the Staffing Model agreed with NHS England as part of its application for delegation of the said functions however a variation can be applied for by the ICB and considered by the National Moderation Panel at any time.

Schedule 2B: Dental Care Services

The provisions of this Schedule 2B form part of this Agreement only where indicated in the Particulars.

Part 1A: General Obligations – Primary Dental Services

1. Introduction

1.1 This Part 1A of Schedule 2B *(Dental Care Services)* sets out general provisions regarding the carrying out of those Delegated Functions relating to Primary Dental Services, being in summary:

1.1.1 decisions in relation to the commissioning and management of Primary Dental Services;

1.1.2 planning Primary Dental Services in the Area, including carrying out needs assessments;

1.1.3 undertaking reviews of Primary Dental Services in the Area;

1.1.4 management of the Delegated Funds in the Area;

1.1.5 co-ordinating a common approach to the commissioning and delivery of Primary Dental Services with other health and social care bodies in respect of the Area where appropriate; and

1.1.6 such other ancillary activities that are necessary in order to exercise the Delegated Functions.

2. General Obligations

2.1 The ICB is responsible for planning the commissioning of Primary Dental Services.

2.2 When planning and commissioning Primary Dental Services, the ICB must comply with Mandated Guidance issued by NHS England.

2.3 In respect of integrated working, the ICB must:

2.3.1 take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Dental Professional Networks, Local Authorities, Healthwatch, acute and community providers, the Local Dental Committee, and other stakeholders;

2.3.2 work with NHS England and other ICBs to co-ordinate a common approach to the commissioning of Primary Dental Services generally; and

2.3.3 work with NHS England to coordinate the exercise of their respective performance management functions.

2.4 In relation to the Delegated Functions, the ICB agrees to perform the following general obligations with regard to Dental Services Contracts:

2.4.1 to manage the Dental Services Contracts and perform all of NHS England's obligations under each of the Dental Services Contracts in accordance with the terms of the Dental Services Contracts as if it were named in the contract in place of NHS England;

2.4.2 working with other organisations, including the NHS Business Services Authority and the NHS England specialised commissioning team as appropriate, actively manage the performance of the Dental Services Provider in order to secure the needs of people who use the services,

improve the quality of services and improve efficiency in the provision of the services including by taking timely action to enforce contractual breaches, serve notices or provide discretionary support;

2.4.3 ensure that it obtains value for money on behalf of NHS England, including by avoiding making any double payments under any Dental Services Contracts and reducing the number of contracts which are under-delivering so that funds can be reallocated to meet local oral health needs;

2.4.4 notify NHS England immediately (or in any event within two (2) Operational Days) of any breach by the ICB of its obligations to perform any of NHS England's obligations under the Dental Services Contracts;

2.4.5 undertake any investigations relating (among other things) to whistleblowing claims, infection control and patient complaints;

2.4.6 keep a record of all of the Dental Services Contracts that the ICB manages on behalf of NHS England setting out the following details in relation to each Dental Services Contract:

2.4.6.1 name of Dental Services Provider;

2.4.6.2 any practice or trading name by which the Dental Services Provider is known (if different to the name recorded under paragraph 2.4.6.1);

2.4.6.3 location of provision of services; and

2.4.6.4 amounts payable under the contract (if a contract sum is payable) or amount payable in respect of each patient (if there is no contract sum).

2.5 Without prejudice to clause 9 *(Finance)* or paragraph 2.4 above, the ICB must actively manage each of the relevant Dental Services Contracts including by:

2.5.1 reviewing and monitoring spending on services provided pursuant to Dental Services Contracts in the Area;

2.5.2 reviewing and monitoring spending on Primary Dental Services commissioned in the Area;

2.5.3 creating purchase orders, coding invoices and making appropriate amendments within the Compass contractor payments system;

2.5.4 managing the relevant Dental Services Contract, including in respect of quality standards, incentives, observance of service specifications, and monitoring of activity and finance;

2.5.5 assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety);

2.5.6 managing variations to the relevant Dental Services Contract or services in accordance with national policy, service user needs and clinical developments;

2.5.7 agreeing information and reporting requirements and managing information breaches (which will include use of the NHS Digital Data Security and Protection Toolkit);

2.5.8 undertaking annual contract activity negotiations, including agreeing local prices, managing agreements or proposals for local variations and local modifications;

2.5.9 conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes;

2.5.10 allocating sufficient resources for undertaking contract mediation; and

2.5.11 complying with and implementing any relevant Mandated Guidance issued from time to time.

2.6 This paragraph is without prejudice to clause 10 *(Information, Planning and Reporting)* or any other provision in this Agreement. The ICB must provide NHS England with:

2.6.1 such information relating to individual providers of Primary Dental Services in the Area as NHS England may reasonably request, to ensure that NHS England is able to continue to gather national data regarding the commissioning or performances of providers of Primary Dental Services;

2.6.2 such data/data sets as required by NHS England to ensure population of any national dashboards;

2.6.3 any other data/data sets as required by NHS England; and

2.6.4 the ICB shall procure that providers accurately record and report information so as to allow NHS England and other agencies to discharge their functions.

Part 1B: Specific Obligations – Primary Dental Services only

1. Introduction

1.1 This Part 1B of Schedule 2B *(Dental Care Services)* sets out further provision regarding the carrying out of each of the Delegated Functions in relation to Primary Dental Services.

2. Dental Services Contract Management

2.1 The ICB must:

2.1.1 comply with all current and future relevant national Mandated Guidance regarding contract reviews;

2.1.2 monitor contract performance and primary care dental spending, with a view in particular to achieving a reduction in the number of contract holders who are under-delivering, and the reallocation of unused resources to meet the oral health needs of the Area; and

2.1.3 in cooperation with the NHS Business Services Authority, monitor contract performance with a view in particular to addressing patient safety concerns and promoting patient safety.

2.2 The ICB must undertake the annual reconciliation of monies claimed by providers against the services provided under any contract for the provision of Dental Care Services made pursuant to NHS England's functions under Part 5 of the NHS Act procuring such ancillary support services as are required for the performance of this function.

3. Transparency and freedom of information

3.1 The ICB must:

3.1.1 respond to requests for information from members of the public and the media, including requests made pursuant to the FOIA, whose subject-matter relates to the performance of the Delegated Functions in the ICB's Area; and

3.1.2 provide information and assistance as required to support NHS England in the preparation of responses to parliamentary questions in connection with the Delegated Functions.

4. Planning the Provider Landscape

4.1 The ICB must plan the provider landscape in the Area, including considering and taking decisions in relation to:

4.1.1 establishing new Dental Services Providers in the Area;

4.1.2 managing Dental Services Providers providing inadequate standards of patient care;

4.1.3 the procurement or award of new Dental Services Contracts (in accordance with any procurement protocol or Guidance issued by NHS England from time to time); and

4.1.4 closure of practices.

4.2 In relation to any new Dental Services Contract to be entered into, the ICB must, without prejudice to any obligation in paragraph 9 (*Procurement and New Contracts*), below:

4.2.1 consider and use the form of Dental Services Contract that will ensure compliance with NHS England's obligations under Law taking into account the persons to whom such Dental Services Contracts may be awarded;

4.2.2 provide to NHS England confirmation as required from time to time that it has considered and complied with its obligations under this Agreement and the Law; and

4.2.3 for the avoidance of doubt, Schedule 5 (*Financial Provisions and Decision Making Limits*) deals with the sign off requirements for Dental Services Contracts.

5. Finance

5.1 Further requirements in respect of finance will be specified in Mandated Guidance.

6. Staffing and Workforce

6.1 Subject to the terms of this Agreement, the Delegated Functions will be carried out by NHS England Staff in accordance with decisions concerning the Delegated Functions made by the ICB unless the Staff carrying out the Delegated Functions have transferred to the ICB (and/or the ICB has engaged or employed Staff for that purpose).

6.2 The arrangements for the provision and maintenance of sufficient and appropriately qualified, trained and experienced Staff in order for the ICB to fulfil its responsibilities for each of the Delegated Functions ("the Staffing Model"), will be communicated formally to the ICB by NHS England following recommendations made by the National Moderation Panel. Further requirements in respect of workforce will be specified in Mandated Guidance.

6.3 The ICB is not permitted to vary the Staffing Model agreed with NHS England as part of its application for delegation of the said functions however a variation can be applied for by the ICB and considered by the National Moderation Panel at any time.

7. Integrating dentistry into communities at Primary Care Network level

7.1 The ICB must exercise the Delegated Functions with a view to achieving greater integration of dentists into the Integrated Care System at the Primary Care Network level.

8. Making Decisions in relation to Management of Poorly Performing Dental Services Providers

8.1 The ICB must make decisions in relation to the management of poorly performing Dental Services Provider including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the Performers List).

8.2 In accordance with paragraph 8.1 above, the ICB must:

8.2.1 ensure regular and effective collaboration with the CQC to ensure that information is shared and discussed in an appropriate and timely manner;

8.2.2 ensure that any risks identified are managed and escalated where necessary;

8.2.3 respond to CQC assessments of Dental Services Providers where improvement is required;

8.2.4 where a Dental Services Provider is placed into special measures, lead a quality summit to ensure the development and monitoring of an appropriate improvement plan (including a communications plan and actions to manage primary care resilience in the locality); and

8.2.5 take appropriate contractual action including (without limitation) in response to CQC findings.

9. Maintaining the Performers List

On receiving a notice from a practitioner (who is party to a Dental Services Contract) of an amendment to information recorded about them in the Performers List, pursuant to regulation 9(1) of the National Health Service (Performers Lists) (England) Regulations 2013, the ICB must support NHS England's amendment of the Performers List as soon as possible after receiving the notice using the Primary Care Support services provided by NHS England, insofar as that amendment relates to a change in contractor details.

10. Procurement and New Contracts

10.1 Until any new arrangements for awarding Dental Services Contracts come into force, the ICB will make procurement decisions relevant to the exercise of the Delegated Functions and in accordance with the detailed arrangements regarding procurement set out in the procurement protocol issued and updated by NHS England from time to time.

10.2 In discharging its responsibilities set out in this Schedule 2B, the ICB must comply at all times with Law and all relevant Guidance (including any applicable procurement law and/or guidance on the selection of, and award of contracts to, providers of healthcare services).

10.3 On the coming into force of new arrangements for awarding Dental Services Contracts, the ICB will make decisions on awarding new contracts relevant to the exercise of the Delegated Functions.

10.4 When the ICB makes decisions in connection with the awarding of Dental Services Contracts it should ensure that it is able to demonstrate compliance with requirements for the award of Dental Services Contracts, including that the decision was:

10.4.1 made in the best interest of patients, taxpayers and the population;

10.4.2 robust and defensible, with conflicts of interests appropriately managed;

10.4.3 made transparently, and

10.4.4 compliant with the rules of the regime as set out in NHS England guidance.

11. Complaints

11.1 The ICB will handle all complaints made in respect of Primary Dental Services in accordance with the Complaints Regulations.

12. Commissioning Ancillary Support Services

12.1 The ICB must procure, and undertake the management and monitoring of contracts for the provision of, such ancillary support services as are required to support the ICB in the effective discharge of the Delegated Functions, including, but not limited to the following:

12.1.1 provision of translation and interpretation services; and

12.1.2 occupational health services.

Part 2A: General Obligations – Prescribed Dental Services

1. Introduction

1.1 This Part 2A of Schedule 2B *(Dental Care Services)* sets out general provisions regarding the carrying out of those Delegated Functions relating to Prescribed Dental Services. Prescribed Dental Services constitute Community Dental Services and Secondary Care Dental Services. These include:

1.1.1 decisions in relation to the commissioning and management of Prescribed Dental Services;

1.1.2 planning Prescribed Dental Services in the Area, including carrying out needs assessments;

1.1.3 undertaking reviews of Prescribed Dental Services in the Area;

1.1.4 management of the Delegated Funds in respect of Prescribed Dental Services in the Area;

1.1.5 co-ordinating a common approach to the commissioning and delivery of Prescribed Dental Services with other health and social care bodies where appropriate; and

1.1.6 such other ancillary activities that are necessary in order to exercise the Delegated Functions.

1.2 For the purposes of this Schedule 2B, “Secondary Care Dental Services” refers to Prescribed Dental Services which are not Community Dental Services.

2. General Obligations

2.1 The ICB is responsible for commissioning Prescribed Dental Services for its Population which for the purpose of this Part 2A of Schedule 2B *(Dental Care Services)*, shall refer to a group of people for whom the ICB has core responsibility, as established under the rules published by NHS England under section 14Z31 of the Act.

2.2 In respect of integrated working, the ICB must take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Dental Professional Networks, Local Authorities, Healthwatch, acute and community providers, the Local Dental Committee, managed clinical networks and other stakeholders.

2.3 When planning and commissioning Prescribed Dental Services, the ICB must comply with Mandated Guidance issued by NHS England.

2.4 The provisions of Paragraph 2.4, 2.5 and 2.6 of Part 1A of this Schedule 2B shall apply in respect of Prescribed Dental Services as if “Dental Services Contract” includes all contracts for Prescribed Dental Services and “Primary Dental Services” include Prescribed Dental Services.

2.5 In awarding any new contract for Prescribed Dental Services, the ICB must:

2.5.1 comply with Law and all relevant Guidance (including any applicable procurement law and/or guidance on the selection of, and award of contracts to, providers of healthcare services);

2.5.2 use the current NHS Standard Contract published by NHS England from time to time; or an appropriate contract for the provision of Dental Care Services made pursuant to NHS England’s functions under Part 5 of the NHS Act; and

2.5.3 where the NHS Standard Contract is used, pay for the Services in accordance with the NHS Payment Scheme (as defined in the Health and Social Care Act 2012).

Part 2B: Specific Obligations – Prescribed Dental Services

1. Introduction

1.1 This Part 2B of Schedule 2B *(Prescribed Dental Care Services)* sets out further provision regarding the carrying out of each of the Delegated Functions in relation to Prescribed Dental Services.

2. Community Dental Services Commissioning Obligations

2.1 Community Dental Services may currently be contracted for by way of either an NHS Standard Contract or a PDS Agreement, as appropriate to the particular service. Accordingly:

2.1.1 where Community Dental Services are commissioned on PDS Agreement terms (or it is appropriate to commission a new agreement for Community Dental Services on a PDS Agreement or other agreement made pursuant to NHS England’s functions under Part 5 of the NHS Act), those contracts must be managed in accordance with the relevant provisions of Part 1A and Part 1B of this Schedule 2B as if they were Primary Dental Services for the purposes of that Part. The provisions of this Part 2A of Schedule 2B also apply; and

2.1.2 where Community Dental Services are commissioned on NHS Standard Contract terms, the provisions of this Part 2A of Schedule 2B apply in full.

3. Secondary Care Dental Services Commissioning Obligations

3.1 For the first financial year following delegation of Secondary Care Dental Services to the ICB (the "Initial Year of Delegation"), the Secondary Care Dental Services shall be commissioned through wider NHS Standard Contracts made between NHS England and the relevant providers that a) cover the whole population of England; and b) typically also cover other services. Accordingly, unless otherwise stated within a Contractual Notice, for the Initial Year of Delegation ONLY the following shall apply:

3.1.1 The commissioning responsibility for the Secondary Care Dental Service elements of the relevant NHS Standard Contracts is delegated to the ICB to the extent that they relate to its Population;

3.1.2 NHS England is, and will remain, the "co-ordinating commissioner" (as defined in the NHS Standard Contract) for those contracts, meaning that NHS England retains core contract management responsibility;

3.1.3 Delegation of commissioning responsibility for the Secondary Care Dental service elements of the relevant NHS Standard Contracts is permitted by clause GC12 of those contracts. NHS England has confirmed these delegation arrangements by letter to each affected provider so that they are aware of the ICB's role as Secondary Care Dental Services commissioner.

3.1.4 whilst the ICB is commissioner of the Secondary Care Dental Service elements of the contract that relate to its Population, it does not have any direct contract management role and must work with NHS England as co-ordinating commissioner, raising any contractual issues with NHS England for consideration and any appropriate action;

3.1.5 The ICB shall ensure that contractual payments are made to providers for the provision of Secondary Care Dental Services in respect of the ICB's Population, as required by the terms of those contracts. This may represent only a proportion of the overall payment due to the provider for Secondary Care Dental Services delivered more widely under that contract.

3.2 For all subsequent financial years following the Initial Year of Delegation the ICB will be responsible for ensuring that appropriate contractual arrangements are in place to ensure continuity of Secondary Care Dental Services for its Population.

4. Prescribed Dental Services Contract Management

4.1 Subject to Paragraph 4.2 of this Part 2B of Schedule 2B, the ICB must:

4.1.1 comply with all current and future relevant national Mandated Guidance regarding contract reviews;

4.1.2 monitor contract performance and prescribed care dental spending, with a view in particular to ensuring the delivery of agreed contract activity, and the reallocation of unused resources to meet the oral health needs of the Area;

4.1.3 monitor contract performance with a view in particular to addressing patient safety concerns and promoting patient safety; and

4.1.4 ensure appropriate oversight of the Prescribed Dental Services, including, where appropriate, procuring such ancillary support services as are required for the performance of this function.

4.2 For the Initial Year of Delegation in respect of Secondary Care Dental Services the requirements set out in paragraph 4.1 of this Part 2B of Schedule 2B do not apply and the terms of the relevant Contractual Notice shall apply.

5. Transparency and freedom of information

5.1 The ICB must:

5.1.1 respond to requests for information from members of the public and the media, including requests made pursuant to the FOIA, whose subject-matter relates to the performance of the Delegated Functions in the ICB's Area; and

5.1.2 provide information and assistance as required to support NHS England in the preparation of responses to parliamentary questions in connection with the Delegated Functions.

6. Planning the Provider Landscape

6.1 The ICB must plan the provider landscape in the Area, including considering and taking decisions in relation to:

6.1.1 establishing new providers of Prescribed Dental Services in the Area;

6.1.2 managing providers of Prescribed Dental Services providing inadequate standards of patient care; and

6.1.3 the procurement or award of new contracts for Prescribed Dental Services (in accordance with any procurement protocol or Guidance issued by NHS England from time to time).

6.2 In relation to any new contracts for Prescribed Dental Services to be entered into, the ICB must, without prejudice to any obligation in paragraph 11 (*Procurement and New Contracts*):

6.2.1 consider and use the form of contract that will ensure compliance with NHS England's obligations under Law taking into account the persons to whom such contracts may be awarded;

6.2.2 provide to NHS England confirmation as required from time to time that it has considered and complied with its obligations under this Agreement and the Law.

7. **Staffing and Workforce**

7.1 The provisions of paragraph 6 of Part 1B of this Schedule 2B shall apply.

8. Finance

8.1 The ICB must ensure the financial delivery of the Prescribed Dental Services in accordance with any Mandated Guidance provided by NHS England.

9. Integrating dentistry into communities at Primary Care Network level

9.1 The ICB must exercise the Delegated Functions with a view to achieving greater integration of dentists into the Integrated Care System at the Primary Care Network level.

10. Making Decisions in relation to Management of Poorly Performing Dental Services Providers

10.1 The ICB must make decisions in relation to the management of poorly performing providers of Prescribed Dental Services and including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards.

10.2 In accordance with paragraph 9.1 above, the ICB must:

10.2.1 ensure regular and effective collaboration with the CQC to ensure that information is shared and discussed in an appropriate and timely manner;

10.2.2 ensure that any risks identified are managed and escalated where necessary;

10.2.3 respond to CQC assessments of providers of Prescribed Dental Services where improvement is required;

10.2.4 where a providers of Prescribed Dental Services is placed into special measures, lead a quality summit to ensure the development and monitoring of an appropriate improvement plan (including a communications plan and actions to manage primary care resilience in the locality); and

10.2.5 take appropriate contractual action in response to CQC findings.

11. Maintaining the Performers List

On receiving a notice from a practitioner (who is party to a contract for Prescribed Dental Services) of an amendment to information recorded about them in the Performers List, pursuant to regulation 9(1) of the National Health Service (Performers Lists) (England) Regulations 2013, the ICB must support NHS England's amendment of the Performers List as soon as possible after receiving the notice using the Primary Care Support services provided by NHS England, insofar as that amendment relates to a change in contractor details.

12. Procurement and New Contracts

12.1 Until any new arrangements for awarding contracts for Prescribed Dental Services come into force, the ICB will make procurement decisions relevant to the exercise of the Delegated Functions and in accordance with the detailed arrangements regarding procurement set out in the procurement protocol issued and updated by NHS England from time to time.

12.2 In discharging its responsibilities set out in this Schedule 2B, the ICB must comply at all times with Law and all relevant Guidance (including any applicable procurement law and/or guidance on the selection of, and award of contracts to, providers of healthcare services).

12.3 On the coming into force of new arrangements for awarding contracts for Prescribed Dental Services, the ICB will make decisions on awarding new contracts relevant to the exercise of the Delegated Functions.

12.4 When the ICB makes decisions in connection with the awarding of contracts for Prescribed Dental Services it should ensure that it is able to demonstrate compliance with requirements for the award of contracts for Prescribed Dental Services, including that the decision was:

12.4.1 made in the best interest of patients, taxpayers and the population;

12.4.2 robust and defensible, with conflicts of interests appropriately managed;

12.4.3 made transparently, and

12.4.4 compliant with the rules of the regime as set out in NHS England guidance.

13. Commissioning Ancillary Support Services

13.1 The ICB must procure, and undertake the management and monitoring of contracts for the provision of, such ancillary support services as are required to support the ICB in the effective discharge of the Delegated Functions, including, but not limited to the following:

13.1.1 provision of translation and interpretation services; and

13.1.2 occupational health services.

14. Complaints

14.1 The ICB shall be responsible for handling complaints made in respect of Prescribed Dental Services.

Schedule 2C: Primary Ophthalmic Services

The provisions of this Schedule 2C form part of this Agreement only where indicated in the Particulars.

Part 1: General Obligations

1. Introduction

1.1 This Part 1 of Schedule 2C *(Primary Ophthalmic Services)* sets out general provisions regarding the carrying out of the Delegated Functions, being, in summary:

1.1.1 decisions in relation to the management of Primary Ophthalmic Services;

1.1.2 undertaking reviews of Primary Ophthalmic Services in the Area;

1.1.3 management of the Delegated Funds in the Area;

1.1.4 co-ordinating a common approach to the commissioning of Primary Ophthalmic Services with other commissioners in the Area where appropriate; and

1.1.5 such other ancillary activities that are necessary in order to exercise the Delegated Functions.

2. General Obligations

2.1 The ICB is responsible for managing the provision of Primary Ophthalmic Services.

2.2 When carrying out Delegated Functions in respect of Primary Ophthalmic Services, the ICB must comply with all Mandated Guidance issued by NHS England.

2.3 The role of the ICB includes identifying and seeking to address any unmet needs which may be met through the delivery of Primary Ophthalmic Services.

2.4 In respect of integrated working, the ICB must:

2.4.1 take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Eye Health Networks, Local Authorities, Healthwatch, acute and community providers, Local Optical Committees, and other stakeholders;

2.4.2 work with NHS England and other ICBs to co-ordinate a common approach to the commissioning of Primary Ophthalmic Services generally; and

2.4.3 work with NHS England to coordinate the exercise of their respective performance management functions.

2.5 In relation to the Delegated Functions, the ICB agrees to perform the following general obligations:

2.5.1 to manage the Primary Ophthalmic Services Contracts on behalf of NHS England and perform all of NHS England's obligations under each of the Primary Ophthalmic Services Contracts in accordance with the terms of the Primary Care Contracts as if it were named in the contract in place of NHS England;

2.5.2 working with other organisations, including the NHS Business Services Authority and NHS England as appropriate, actively manage the performance of the Primary Ophthalmic Services Provider in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services including by taking

timely action to enforce contractual breaches, serve notices or provide discretionary support;

2.5.3 ensure that it obtains value for money on behalf of NHS England and avoids making any double payments under any Primary Ophthalmic Services Contracts;

2.5.4 notify NHS England immediately (or in any event within two (2) Operational Days) of any breach by the ICB of its obligations to perform any of NHS England's obligations under the Primary Ophthalmic Services Contracts;

2.5.5 undertake any investigations relating (among other things) to whistleblowing claims, infection control and patient complaints;

2.5.6 keep a record of all of the Primary Ophthalmic Services Contracts that the ICB manages on behalf of NHS England setting out the following details in relation to each Primary Ophthalmic Services Contract:

2.5.6.1 name of the Primary Ophthalmic Services Provider;

2.5.6.2 any practice or trading name by which the Primary Ophthalmic Services Provider is known (if different to the name recorded under paragraph 2.5.6.1);

2.5.6.3 location of provision of services; and

2.5.6.4 amounts payable under the Primary Ophthalmic Services Contract (if a contract sum is payable) or amount payable in respect of each patient (if there is no contract sum).

2.6 Without prejudice to clause 9 *(Finance)* or paragraph 2.5 above, the ICB must actively manage each of the relevant Primary Ophthalmic Services Contracts including by:

2.6.1 managing the relevant Primary Ophthalmic Services Contract, including in respect of quality standards, incentives, observance of service specifications, and monitoring of activity and finance;

2.6.2 assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety);

2.6.3 managing variations to the relevant Primary Ophthalmic Services Contract or services in accordance with national policy, service user needs and clinical developments;

2.6.4 agreeing information and reporting requirements and managing information breaches (which will include use of the NHS Digital Data Security and Protection Toolkit);

2.6.5 conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes; and

2.6.6 complying with and implementing any relevant Mandated Guidance issued from time to time.

2.7 This paragraph is without prejudice to clause 10 (*Information, Planning and Reporting*) or any other provision in this Agreement. The ICB must provide NHS England with:

2.7.1 such information relating to individual providers of Primary Ophthalmic Services in the Area as NHS England may reasonably request, to ensure that NHS England is able to continue to gather national data regarding the

commissioning or performances of providers of Primary Ophthalmic Services;

2.7.2 such data/data sets as required by NHS England to ensure population of any national dashboards;

2.7.3 any other data/data sets as required by NHS England; and

2.7.4 the ICB shall procure that providers accurately record and report information so as to allow NHS England and other agencies to discharge their functions.

Part 2: Specific Obligations

1. Introduction

1.1 This Part 2 of Schedule 2C *(Primary Ophthalmic Services)* sets out further provision regarding the carrying out of each of the Delegated Functions.

2. Primary Ophthalmic Services Contract Management

2.1 The ICB must:

2.1.1 comply with all current and future relevant national Mandated Guidance regarding General Ophthalmic Contract reviews and any other contract reviews;

2.1.2 take on the responsibility for existing services provided pursuant to a Primary Ophthalmic Services Contract, and for commissioning new services;

2.1.3 assume the responsibility for the award of new Primary Ophthalmic Services Contracts; and

2.1.4 monitor contract performance with a view to achieving assurance and improvement in the delivery of services in the context of the ICB;

in each case acknowledging that the NHS Business Services Authority provides end-to-end support services in relation to these functions, as referred to in Schedule 6 (*Mandated Assistance and Support*). The ICB accordingly agrees to co-operate with the NHS Business Services Authority in the delivery of these functions.

3. Transparency and freedom of information

3.1 The ICB must:

3.1.1 Respond to requests for information from members and the public and the media, including requests made pursuant to the FOIA, whose subject-matter relates to the performance of the Delegated Functions in the ICB's Area; and

3.1.2 Provide information and assistance as required to support NHS England in the preparation of responses to parliamentary questions in connection with the Delegated Functions.

4. Maintaining the Performers List

4.1 On receiving a notice from a practitioner (who is party to a Primary Ophthalmic Services Contract) of an amendment to information recorded about them in the Performers List, pursuant to regulation 9(1) of the National Health Service (Performers Lists) (England) Regulations 2013, the ICB must support NHS England's amendment of the performers list as soon as possible after receiving the notice using the Primary Care Support

services provided by NHS England, insofar as that amendment relates to a change in contractor details.

5. Finance

5.1 Further requirements in respect of finance will be specified in Mandated Guidance.

6. Workforce

6.1 The arrangements for the provision and maintenance of sufficient and appropriately qualified, trained and experienced Staff in order for the ICB to fulfil its responsibilities for each of the Delegated Functions ("the Staffing Model"), will be communicated formally to the ICB by NHS England following recommendations made by the National Moderation Panel. Further requirements in respect of workforce will be specified in Mandated Guidance.

6.2 The ICB is not permitted to vary the Staffing Model agreed with NHS England as part of its application for delegation of the said functions however a variation can be applied for by the ICB and considered by the National Moderation Panel at any time.

7. Integrating optometry into communities at Primary Care Network level

7.1 The ICB must exercise the Delegated Functions with a view to achieving greater integration of optometrists into the Integrated Care System at the Primary Care Network level.

8. Complaints

8.1 The ICB will handle complaints made in respect of primary ophthalmic services in accordance with the Complaints Regulations.

9. Commissioning ancillary support services

9.1 The ICB must procure, and undertake the management and monitoring of contracts for the provision of, such ancillary support services as are required to support the ICB in the effective discharge of the Delegated Functions, including, but not limited to the following:

9.1.1 provision of translation and interpretation services; and

9.1.2 occupational health services.

Schedule 2D: Delegated Functions – Pharmaceutical Services

The provisions of this Schedule 2D form part of this Agreement only where indicated in the Particulars.

1. In this Schedule, the following additional definitions shall apply:

Advanced Services	has the meaning given to that term by the Pharmaceutical Regulations;
Conditions of Inclusion	means those conditions set out at Part 9 of the Pharmaceutical Regulations;
Delegated Pharmaceutical Functions	the functions set out at paragraph 2 of this Schedule;
Designated Commissioner	has the meaning given to that term at paragraph 2.3 of this Schedule;
Dispensing Doctor	has the meaning given to that term by the Pharmaceutical Regulations;
Dispensing Doctor Decisions	means decisions made under Part 8 of the Pharmaceutical Regulations;
Dispensing Doctor Lists	has the meaning given to that term by the Pharmaceutical Regulations;
Drug Tariff	has the meaning given to that term by the Pharmaceutical Regulations;
Electronic Prescription Service	has the meaning given to that term by the Pharmaceutical Regulations;
Enhanced Services	has the meaning given to that term by the Pharmaceutical Regulations;
Essential Services	is to be construed in accordance with paragraph 3 of Schedule 4 to the Pharmaceutical Regulations;
Fitness to Practise Functions	has the meaning given to that term at paragraph 2.1.10 of this Schedule;
Locally Commissioned Services	means services which are not Essential Services, Advanced Services, Enhanced Services or services commissioned under an LPS Scheme;
LPS Chemist	has the meaning given to that term by the Pharmaceutical Regulations;
LPS Scheme	has the meaning given to that term by Paragraph 1(2) of Schedule 12 to the NHS Act;
NHS Chemist	has the meaning given to that term by the Pharmaceutical Regulations;
Pharmaceutical Lists	has the meaning given to that term at paragraph 2.1.1. of this Schedule and any reference to a Pharmaceutical List should be construed accordingly;

Pharmaceutical Regulations	means the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and reference to a Regulation refers to a provision of the Pharmaceutical Regulations, unless otherwise stated;
Rurality Decisions	means decisions made under Part 7 of the Pharmaceutical Regulations;
Terms of Service	means the terms upon which, by virtue of the Pharmaceutical Regulations, a person undertakes to provide Pharmaceutical Services;

Delegated Pharmaceutical Functions

2. Except in so far as they fall within the scope of the Reserved Functions, and subject to paragraphs 2.2, 2.3, 4 and 5, the ICB agrees to perform the following functions of NHS England in respect of the Area (the "Delegated Pharmaceutical Functions"), in all cases in accordance with relevant Law, Mandated Guidance and other Guidance:

2.1 preparing, maintaining and submitting for publication by NHS England lists of persons, other than medical practitioners or dental practitioners, who have undertaken to provide pharmaceutical services from premises situated within the Area[3], specifically:

2.1.1 lists of persons who have undertaken to provide pharmaceutical services in particular by way of the provision of drugs;

2.1.2 lists of persons who have undertaken to provide pharmaceutical services only by way of the provision of appliances; and

2.1.3 lists of persons participating in the Electronic Prescription Service[4]

collectively referred to in this Schedule as the "Pharmaceutical Lists". In doing so, it is sufficient for the lists referred to at paragraphs 2.1.1.1 and 2.1.1.2 to include a marker showing which persons are also participating in the Electronic Prescription Service, rather than preparing a separate list for the purposes of paragraph 2.1.1.3.

2.1.4 managing and determining applications by persons for inclusion in a Pharmaceutical List[5];

2.1.5 managing and determining applications by persons included in a Pharmaceutical List;

2.1.6 responsibilities for financial resources related to the Delegated Pharmaceutical Functions as described in Mandated Guidance issued by NHS England;

2.1.7 overseeing the compliance of those included in the Pharmaceutical Lists with:

2.1.7.1 their Terms of Service and identifying and investigating breaches, including possible breaches, of those terms;

[3] Including (without limitation) updates to those lists following any removal under regulation 115 of the Pharmaceutical Regulations
[4] Regulation 10 of the Pharmaceutical Regulations
[5] Schedule 2 of the Pharmaceutical Regulations

2.1.7.2 relevant Conditions of Inclusion; and

2.1.7.3 requirements of the Community Pharmacy Contractual Framework.

2.1.8 exercising powers in respect of Performance Related Sanctions and Market Exit[6];

2.1.9 exercising all other rights, and complying with all other obligations, of NHS England in respect of the Terms of Service and Conditions of Inclusion of those included in the Pharmaceutical Lists;

2.1.10 communicating to those included in the Pharmaceutical Lists any announcement made by NHS England modifying Terms of Service of any person included in the Pharmaceutical Lists as a consequence of a disease being, or in anticipation of a disease being imminently:

2.1.11 pandemic; and

2.1.12 a serious risk or potentially a serious risk to human health[7];

2.1.13 communicating to those included in the Pharmaceutical Lists any other matters which NHS England may require the ICB to communicate from time to time;

2.1.14 performing functions in respect of the disqualification of practitioners, and related measures concerning a practitioners inclusion in the Pharmaceutical Lists, set out in Chapter 6 of Part 7 to the NHS Act and the provisions of the Pharmaceutical Regulations made under that Chapter ("the Fitness to Practise Functions");

2.1.15 performing functions in respect of enforcement, reviews and appeals relating to the Fitness to Practise Functions[8];

2.1.16 making LPS Schemes[9], subject to the requirements of paragraph 5;

2.1.17 overseeing the compliance of those who are party to Local Pharmaceutical Services Contracts with the terms of those contracts and identifying and investigating breaches, including possible breaches, of the terms of those contracts;

2.1.18 exercising all rights, and complying with all obligations, of NHS England under Local Pharmaceutical Services Contracts;

2.1.19 determining LPS matters[10] in respect of LPS Schemes;

2.1.20 determining Rurality Decisions and other rurality matters[11];

2.1.21 determining Dispensing Doctor Decisions[12];

2.1.22 preparing and maintaining Dispensing Doctor Lists[13];

[6] Part 10 of the Pharmaceutical Regulations
[7] Regulation 11(3) of the Pharmaceutical Regulations
[8] Part 11 of the Pharmaceutical Regulations
[9] Section 134 NHS Act and Part 13 of the Pharmaceutical Regulations.
[10] Part 13 of the Pharmaceutical Regulations
[11] Part 7 of the Pharmaceutical Regulations
[12] Part 8 of the Pharmaceutical Regulations
[13] Regulation 46 of the Pharmaceutical Regulations

2.1.23 making arrangements for the provision of adequate pharmaceutical service delivery across the ICB area;

2.1.24 making arrangements for the delivery of Essential Services, Advanced Services and Enhanced Services;

2.1.25 supporting implementation and delivery of all elements of the Community Pharmacy Contractual Framework;

2.1.26 consulting with patients, the public and other stakeholders to the extent required by the duty of public involvement and consultation under section 14Z45 of the NHS Act;

2.1.27 responding to Appeals to the Secretary of State and First Tier Tribunal in respect of the Delegated Pharmaceutical Functions[14];

2.1.28 responding to Claims in respect of the Delegated Pharmaceutical Functions;

2.1.29 recovering overpayments from NHS Chemists, LPS Chemists, Dispensing Doctors and Primary Medical Services Providers[15];

2.1.30 bringing any legal proceedings in respect of the Delegated Pharmaceutical Functions;

2.1.31 making any notifications to, and consulting with, third parties in respect of the Delegated Pharmaceutical Functions;

2.1.32 recognising one or more Local Pharmaceutical Committees which it considers are representative of Pharmaceutical Services Providers in the ICB's Area and liaising with and consulting such Local Pharmaceutical Committees as required by the Pharmaceutical Regulations;

2.1.33 commissioning the provision of NHS Smartcards to Pharmaceutical Services Providers and their staff by registration authorities;

2.1.34 making any payments due to NHS Chemists suspended from a Pharmaceutical List in accordance with the determination made by the Secretary of State in respect of such payments; and

2.1.35 undertaking any investigations relating (among other things) to whistleblowing claims (relating to a superintendent pharmacist, a director or the operation of a pharmacy contractor), infection control and patient complaints.

2.2 Where the Area comprises the areas of two or more Health and Wellbeing Boards in their entirety:

2.2.1 the Delegated Pharmaceutical Functions shall be exercised so as to maintain separately in respect of each Health and Wellbeing Board area:

2.2.1.1 Pharmaceutical Lists in respect of premises in that Health and Wellbeing Board area;

2.2.1.2 a list of LPS Chemists providing local pharmaceutical services at or from premises in that Health and Wellbeing Board area[16]; and

[14] Schedule 3 of the Pharmaceutical Regulations
[15] Regulation 94 of the Pharmaceutical Regulations
[16] Regulation 114 of the Pharmaceutical Regulations

2.2.1.3 a Dispensing Doctor List (together the "Relevant Lists"); and

2.2.1.4 the ICB shall comply with such Contractual Notices as NHS England may issue from time to time concerning the arrangements for the exercise of the Delegated Pharmaceutical Functions across two or more Health and Wellbeing Board areas.

2.3 Where the Area comprises part of the area of a Health and Wellbeing Board (the "Relevant Health and Wellbeing Board"):

2.3.1 NHS England shall by Contractual Notice designate:

2.3.1.1 the ICB;

2.3.1.2 another ICB whose area comprises in part the area of the Relevant Health and Wellbeing Board; or

2.3.1.3 NHS England;

as the body responsible for maintaining the Relevant Lists (as defined in paragraph 2.2.1 of this Schedule 2D) in respect of the Relevant Health and Wellbeing Board ("the Designated Commissioner");

2.3.2 the ICB shall exercise the Delegated Pharmaceutical Functions in respect of that part of the Relevant Health and Wellbeing Board's area that falls within the Area but in doing so shall liaise with any Designated Commissioner for the purposes of maintaining the accuracy of the Relevant Lists (as defined in paragraph 2.2.1 of this Schedule 2D) in respect of the Relevant Health and Wellbeing Board; and

2.3.3 the ICB shall comply with all Contractual Notices issued by NHS England for the purposes of determining responsibilities in the circumstances described in this paragraph 2.3.

Prescribed Support

3. Notwithstanding the inclusion of the following within the Delegated Functions, the ICB shall discharge the functions set out at:

3.1 Paragraph 2.1.1 (maintaining Pharmaceutical Lists)

3.2 Paragraph 2.1.2 (managing applications for inclusion)

3.3 Paragraph 2.1.3 (managing applications from those included in a list)

3.4 Paragraph 2.1.5 (overseeing compliance with Terms of Service and Conditions of Inclusion)

3.5 Paragraph 2.1.10 (Fitness to Practise)

3.6 Paragraph 2.1.18 (maintaining and publishing Dispensing Doctors Lists)

3.7 Paragraph 2.1.25 (recovery of overpayments)

with the assistance and support of the NHS Business Services Authority, Primary Care Support England or such other person as NHS England shall designate by Contractual Notice for these purposes from time to time and in accordance with the allocation of operational responsibilities described by NHS England in Mandated Guidance.

LPS Schemes

4. The ICB shall not without the prior written consent of NHS England make any new LPS Schemes.

Barred Persons

5. The ICB must ensure that persons barred from involvement in specific elements of the Delegated Functions are excluded from such involvement in accordance with the Pharmaceutical Regulations.

Other Services

6. The provisions of this schedule are without prejudice to the ability of the ICB to make arrangements for the provision of Locally Commissioned Services for the purposes of the NHS in accordance with its own commissioning functions and using its own financial resources.

Payments

7. In exercising the Delegated Pharmaceutical Functions, the ICB must ensure that:

    7.1 all payments to which the Drug Tariff applies are made solely in accordance with the Drug Tariff; and

    7.2 any other payments for services (including without limitation those relating to LPS Schemes and Enhanced Services) are made in accordance with recognised contractual mechanisms intended to apply to those services.

Flu vaccinations

8. The Parties acknowledge and agree that:

    8.1 responsibility for arranging any national scheme for flu vaccinations remains with NHS England as part of its Section 7A Functions; and

    8.2 where any such national scheme is arranged by NHS England, the ICB is required to commission flu vaccines as Advanced Services. For the purposes of this Agreement, this forms part of the ICB's responsibilities under this Agreement.

Integration

9. In respect of integrated working, the ICB must:

    9.1 take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Authorities, Healthwatch, acute and community providers, professional representative groups, contractor representative groups and other stakeholders;

    9.2 work with NHS England and other ICBs to co-ordinate a common approach to the commissioning of Pharmaceutical Services generally; and

    9.3 work with NHS England to coordinate the exercise of their respective performance management functions.

Integrating pharmacy into communities at Primary Care Network level

10. The ICB must exercise the Delegated Functions with a view to achieving greater integration of community pharmacy into the Integrated Care System at the Primary Care Network level including participation in network governance arrangements.

Complaints

11. The ICB will handle complaints made in respect of Pharmaceutical Services and Local Pharmaceutical Services in accordance with the Complaints Regulations.

Commissioning ancillary support services

12. The ICB must procure, and undertake the management and monitoring of contracts for the provision of, such ancillary support services as are required to support the ICB in the effective discharge of the Delegated Functions, including, but not limited to the following:

12.1 collection and disposal of clinical waste; and

12.2 provision of translation and interpretation services; and

12.3 occupational health services.

Finance

13. Further requirements in respect of finance will be specified in Mandated Guidance.

Workforce

14. Further requirements in respect of workforce will be specified in Mandated Guidance.

SCHEDULE 3

Reserved Functions

1. Introduction

1.1 In accordance with clause 8.4 of this Agreement, all functions of NHS England other than those defined as Delegated Functions are Reserved Functions.

1.2 This Schedule 3 (*Reserved Functions*) sets out further provision regarding the carrying out of the Reserved Functions.

1.3 The ICB will work collaboratively with NHS England and will support and assist NHS England to carry out the Reserved Functions.

2. Management of the national performers list

2.1 Subject to Paragraph 2.2, NHS England will continue to perform its functions under the National Health Service (Performers Lists) (England) Regulations 2013.

2.2 The ICB will carry out administrative tasks in respect of the Performers Lists as described at:

2.2.1 Paragraph 9 of Part 2, Schedule 2A;

2.2.2 Paragraph 9 of Part 2, Schedule 2B; and

2.2.3 Paragraph 6 of Part 2, Schedule 2C.

2.3 NHS England's functions in relation to the management of the national performers list include:

2.3.1 considering applications and decision-making in relation to inclusion on the national performers list, inclusion with conditions and refusals;

2.3.2 identifying, managing and supporting primary care performers where concerns arise; and

2.3.3 managing suspension, imposition of conditions and removal from the national performers list.

2.4 NHS England may hold local Performance Advisory Group ("PAG") meetings to consider all complaints or concerns that are reported to NHS England in relation to a named performer and NHS England will determine whether an initial investigation is to be carried out.

2.5 NHS England may notify the ICB of all relevant PAG meetings at least seven (7) days in advance of such meetings. NHS England may require a representative of the ICB to attend such meetings to discuss any performer concerns and/or quality issues that may impact on individual performer cases.

2.6 The ICB must develop a mechanism to ensure that all complaints regarding any named performer are escalated to the Local NHS England Team for review. The ICB will comply with any Mandated Guidance issued by NHS England in relation to the escalation of complaints about a named performer.

3. Management of the revalidation and appraisal process

3.1 NHS England will continue to perform its functions under the Medical Profession (Responsible Officers) Regulations 2010 (as amended by the Medical Profession (Responsible Officers) (Amendment) Regulations 2013).

3.2 All functions in relation to GP appraisal and revalidation will remain the responsibility of NHS England, including:

3.2.1 the funding of GP appraisers;

3.2.2 quality assurance of the GP appraisal process; and

3.2.3 the responsible officer network.

3.3 Funding to support the GP appraisal is incorporated within the global sum payment to Primary Medical Services Provider.

3.4 The ICB must not remove or restrict the payments made to Primary Medical Services Provider in respect of GP appraisal.

3.5 Appraisal arrangements in respect of all other primary care practitioner groups shall also be Reserved Functions.

4. Administration of payments and related performers list management activities

4.1 NHS England reserves its functions in relation to the administration of payments to individual performers and related performers list management activities under the National Health Service (Performers Lists) (England) Regulations 2013 and other relevant legislation.

4.2 NHS England may continue to pay practitioners who are suspended from the national performers list in accordance with relevant determinations made by the Secretary of State.

4.3 For the avoidance of doubt, the ICB is responsible for any ad hoc or discretionary payments to Primary Medical Services Providers (including those under section 96 of the NHS Act) in accordance with Schedule 2A (*Delegated Functions*) Part 2 paragraphs 5.1 and 5.1 of this Agreement, including where such payments may be considered a consequence of actions taken under the National Health Service (Performers Lists) (England) Regulations 2013.

5. Section 7A and Capital Expenditure Functions

5.1 NHS England retains the Section 7A Functions and will be responsible for taking decisions in relation to the Section 7A Functions.

5.2 In accordance with Schedule 10 Part 2, the ICB will provide certain management and/or administrative services to NHS England in relation to the Section 7A Functions.

5.3 NHS England retains the Capital Expenditure Functions and will be responsible for taking decisions in relation to the Capital Expenditure Functions.

5.4 In accordance with Schedule 10 Part 1, the ICB will provide certain management and/or administrative services to NHS England in relation to the Capital Expenditure Functions.

6. Such other ancillary activities that are necessary in order to exercise the Reserved Functions

6.1 NHS England will continue to comply with its obligations under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

6.2 The ICB must assist NHS England's controlled drug accountable officer ("CDAO") to carry out its functions under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

6.3 The ICB must nominate a relevant senior individual within the ICB (the "ICB CD Lead") to liaise with and assist NHS England to carry out its functions under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

6.4 The ICB CD Lead must, in relation to the Delegated Functions:

6.4.1 on request provide NHS England's CDAO with all reasonable assistance in any investigation involving the Delegated Functions;

6.4.2 report all complaints involving controlled drugs to NHS England's CDAO;

6.4.3 report all incidents or other concerns involving the safe use and management of controlled drugs to NHS England's CDAO;

6.4.4 analyse the controlled drug prescribing data available; and

6.4.5 on request supply (or ensure organisations from whom the ICB commissions services involving the regular use of controlled drugs supply) periodic self–declaration and/or self-assessments to NHS England's CDAO.

7. Reserved Functions – Primary Medical Services

7.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Primary Medical Services Functions"):

7.1.1 determining the outcomes expected from Primary Medical Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes and the Department of Health and Social Care mandate;

7.1.2 designing and delivering national transformation programmes in support of national priorities;

7.1.3 the negotiation and agreement of matters concerning General Medical Services contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary medical services nationally;

7.1.4 the development of national standard Primary Medical Service contracts and national contract variations and guidance to ensure an equitable approach to applying nationally agreed changes to all Primary Medical Services providers;

7.1.5 the provision of commissioning and contracting policy and guidance to support ICBs to meet their delegated duties;

7.1.6 the provision of nationally contracted services delivering digital, logistical and support services for Primary Medical Services in England (including but not limited to):

7.1.6.1 Payments;

7.1.6.2 Pensions;

7.1.6.3 Patient Registration;

7.1.6.4 Medical Records;

7.1.6.5 Performer List;

7.1.6.6 Supplies;

7.1.6.7 Call and Recall for Cervical screening (CSAS); and

7.1.6.8 Pharmacy Market Management.

7.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

8. Reserved Functions – Primary Dental Services

8.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Primary Dental Services Functions"):

8.1.1 determining the outcomes expected from Primary Dental Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes; designing and delivering national transformation programmes in line with any applicable commissioning policies and guidance;

8.1.2 the negotiation and agreement of matters concerning Dental Services Contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary dental services nationally;

8.1.3 the development of national standard Dental Service Contracts and national contract variations and guidance to ensure an equitable approach to applying nationally agreed changes to all Primary Dental Services providers;

8.1.4 the provision of all dental commissioning and contracting policy and guidance to support ICBs to meet their delegated duties; and

8.1.5 the provision of nationally contracted services delivering digital, logistical and support services for Primary Dental Services in England (including but not limited to):

8.1.5.1 Payments;

8.1.5.2 Pensions;

8.1.5.3 Performer List; and

8.1.5.4 Market Management.

8.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

9. Reserved Functions – Primary Ophthalmic Services

9.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Ophthalmic Functions"):

9.1.1 the Primary Ophthalmic Services Contracts policy and associated documentation;

9.1.2 the negotiation and agreement of matters concerning Primary Ophthalmic Services with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of Ophthalmic Services nationally; and

9.1.3 the provision of nationally contracted services delivering digital, logistical and support services for Primary Ophthalmic Services in England (including but not limited to):

9.1.3.1 Payments;

9.1.3.2 Performers List;

9.1.3.3 Market Management/Entry; and

9.1.3.4 Contract management, assurance and post-payment verification.

9.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

10. Reserved Functions – Pharmaceutical Services and Local Pharmaceutical Services

10.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Pharmaceutical Functions"):

10.1.1 publication of Pharmaceutical Lists;

10.1.2 functions of NHS England as a determining authority in relation to pharmaceutical remuneration under Part 12 of the Pharmaceutical Regulations;

10.1.3 functions in respect of lists of performers of pharmaceutical services and assistants, noting that as at the date of this Agreement regulations for the purposes of these functions have not been made[17];

10.1.4 the negotiation and agreement of matters concerning NHS pharmaceutical services with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of Pharmaceutical Services nationally;

10.1.5 the provision of commissioning and contracting policy and guidance to support ICBs to meet their delegated duties; and

10.1.6 administration of the pharmacist pre-registration training grant scheme.

11. Reserved Functions – Primary Dental Services

11.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Primary Dental Services Functions"):

11.1.1 determining the outcomes expected from Primary Dental Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes; designing and delivering national transformation programmes in line with any applicable commissioning policies and guidance;

11.1.2 the negotiation and agreement of matters concerning Dental Services Contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary dental services nationally;

11.1.3 the development of national standard Dental Service Contracts and national contract variations and guidance to ensure an equitable approach to applying nationally agreed changes to all Primary Dental Services providers;

11.1.4 the provision of all dental commissioning and contracting policy and guidance to support ICBs to meet their delegated duties;

[17] Part 7, Chapter 4A of the NHS Act (not currently in force)

11.1.5 the provision of nationally contracted services delivering digital, logistical and support services for Primary Dental Services in England (including but not limited to):

11.1.5.1 Payments

11.1.5.2 Pensions

11.1.5.3 Performer List

11.1.5.4 Market Management.

11.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

12. Reserved Functions - Prescribed Dental Services

12.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Prescribed Dental Services Functions"):

12.1.1 determining the outcomes expected from Prescribed Dental Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes; designing and delivering national transformation programmes in line with any applicable commissioning policies and guidance;

12.1.2 in respect of any Prescribed Dental Services contracted pursuant to NHS England's functions under Part 5 of the NHS Act the negotiation and agreement of matters concerning those contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary dental services nationally;

12.1.3 in respect of any Prescribed Dental Services contracted pursuant to NHS England's functions under Part 5 of the NHS Act, the development of standard contracts and national contract variations and guidance;

12.1.4 the provision of all dental commissioning and contracting policy and guidance to support ICBs to meet their delegated duties;

12.1.5 in respect of any Prescribed Dental Services contracted pursuant to NHS England's functions under Part 5 of the NHS Act, the provision of nationally contracted services delivering digital, logistical and support services in England (including but not limited to):

12.1.5.1 Payments

12.1.5.2 Pensions

12.1.5.3 Performer List

12.1.5.4 Market Management.

12.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

SCHEDULE 4

Further Information Governance and Sharing Provisions

1. Introduction

1.1 The purpose of this Schedule 4 *(Further Information Governance and Sharing Provisions* is to set out the scope for the secure and confidential sharing of information between the Parties on a **Need To Know** basis, in order to enable the Parties to exercise their functions in pursuance of this Agreement.

1.2 References in this Schedule 4 *(Further Information Governance and Sharing Provisions)* to the **Need to Know** basis or requirement (as the context requires) should be taken to mean that the Data Controllers' personnel will only have access to Personal Data or Special Category Personal Data if it is lawful for such personnel to have access to such data for the Specified Purpose in paragraph 2.1 and the function they are required to fulfil at that particular time, in relation to the Specified Purpose, cannot be achieved without access to the Personal Data or Special Category Personal Data specified.

1.3 This Schedule and the Data Sharing Agreements entered into under this Schedule are designed to:

1.3.1 provide information about the reasons why Relevant Information may need to be shared and how this will be managed and controlled by the Parties;

1.3.2 describe the purposes for which the Parties have agreed to share Relevant Information;

1.3.3 set out the lawful basis for the sharing of information between the Parties, and the principles that underpin the exchange of Relevant Information;

1.3.4 describe roles and structures to support the exchange of Relevant Information between the Parties;

1.3.5 apply to the sharing of Relevant Information relating to Delegated Functions in respect of

1.3.5.1 Primary Care Providers and Primary Care Provider Personnel; and

1.3.5.2 Dental Services Providers and their personnel;

1.3.5.3 All other providers of Delegated Functions.

1.3.6 apply to the sharing of Relevant Information whatever the medium in which it is held and however it is transmitted;

1.3.7 ensure that Data Subjects are, where appropriate, informed of the reasons why Personal Data about them may need to be shared and how this sharing will be managed;

1.3.8 apply to the activities of the Parties' personnel; and

1.3.9 describe how complaints relating to Personal Data sharing between the Parties will be investigated and resolved, and how the information sharing will be monitored and reviewed.

2. Purpose

2.1 The Specified Purpose of the data sharing is to facilitate the exercise of the ICB's Delegated Functions and NHS England's Reserved Functions as described in this Agreement.

2.2 ICBs must ensure that they have in place appropriate Data Sharing Agreements to enable data to be received by it from NHS Digital (or the successor to the relevant statutory functions of NHS Digital) and any other third party organisations from which the ICB must obtain data for the purpose of exercising the Delegated Functions. Specific and detailed purposes must be set out the Data sharing Agreement that complies with all relevant Legislation and Guidance.

3. Benefits of information sharing

3.1 The benefits of sharing information are the achievement of the Specified Purpose set out above, with benefits for service users and other stakeholders in terms of the improved delivery of the NHS services to which this Agreement relates.

4. Lawful basis for Sharing

4.1 Each Party shall comply with all relevant Information Law requirements and good practice in relation to the processing of Relevant Information shared further to this Agreement.

4.2 The ICB shall ensure that there is a Data Protection Impact Assessment ("DPIA") that covers all Delegated Functions. The ICB shall identify the lawful basis for sharing Relevant Information for each purpose and data flow, and where appropriate, enter into a Data Sharing Agreement.

5. Relevant Information to be shared

5.1 The Relevant Information to be shared shall be set out in a Data Sharing Agreement.

6. Restrictions on use of the Shared Information

6.1 Each Party shall only process the Relevant Information as is necessary to achieve the Specified Purpose, and, in particular, shall not use or process Relevant Information for any other purpose unless agreed in writing by the Data Controller that released the information to the other. There shall be no other use or onward transmission of the Relevant Information to any third party without a lawful basis first being determined, and the originating Data Controller being notified.

6.2 Access to, and processing of, the Relevant Information provided by a Party must be the minimum necessary to achieve the Specified Purpose. Information and Special Category Personal Data will be handled at all times on a restricted basis, in compliance with Information Law requirements, and the parties' personnel should only have access to Personal Data on a justifiable **Need to Know** basis.

6.3 Neither the provisions of this Schedule 4 *(Further Information Governance and Sharing Provisions)* nor any Data Sharing Agreements entered into in accordance with this Schedule should be taken to permit unrestricted access to data held by any Party. It lays the parameters for the safe and secure sharing and processing of information on a justifiable **Need to Know** basis.

6.4 Neither Party shall subcontract any processing of the Relevant Information without the prior written consent of the other Party. Where a Party subcontracts its obligations, it shall do so only by way of a written agreement with the sub-contractor which imposes the same obligations as are imposed on the Data Controllers under this Agreement.

6.5 Neither Party shall cause or allow Data to be transferred to any territory outside the United Kingdom without the prior written permission of the responsible Data Controller.

6.6 Any particular restrictions on use of certain Relevant Information are included in the Personal Data Agreement annexed to this Schedule.

7. Ensuring fairness to the Data Subject

7.1 In addition to having a lawful basis for sharing information, the UK GDPR generally requires that the sharing must be fair and transparent. In order to achieve fairness and transparency to the Data Subjects, the Parties will take the following measures:

7.1.1 amendment of internal guidance to improve awareness and understanding among personnel;

7.1.2 amendment of respective privacy notices and policies to reflect the processing of data carried out further to this Agreement, including covering the requirements of articles 13 and 14 UK GDPR and providing these (or making them available to) Data Subjects;

7.1.3 ensuring that information and communications relating to the processing of data is easily accessible and easy to understand, and that clear and plain language be used; and

7.1.4 giving consideration to carrying out activities to promote public understanding of how data is processed where appropriate.

7.2 Each Party shall procure that its notification to the Information Commissioner's Office and record of processing maintained for the purposes of Article 30 UK GDPR reflects the flows of information under this Agreement.

7.3 Each Party shall reasonably cooperate with the other in undertaking any Data Protection Impact Assessment associated with the processing of data further to this Agreement, and in doing so engage with their respective Data Protection Officers in the performance by them of their duties pursuant to Article 39 UK GDPR.

7.4 Further provision in relation to specific data flows should be included in Data Protection Agreements.

8. Governance: personnel

8.1 Each Party must take reasonable steps to ensure the suitability, reliability, training and competence, of any personnel who have access to the Personal Data (and Special Category Personal Data) including reasonable background checks and evidence of completeness should be available on request by each Party.

8.2 The Parties agree to treat all Relevant Information as confidential and imparted in confidence and must safeguard it accordingly. Where any of the Parties' personnel are not healthcare professionals (for the purposes of the Data Protection Act 2018) the employing Parties must procure that personnel operate under a duty of confidentiality which is equivalent to that which would arise if that person were a healthcare professional.

8.3 Each Party shall ensure that all personnel required to access the Personal Data (including Special Category Personal Data) are informed of the confidential nature of the Personal Data and each Party shall include appropriate confidentiality clauses in employment/service contracts of all personnel that have any access whatsoever to the Relevant Information, including details of sanctions for acting in a deliberate or reckless manner that may breach the confidentiality or the non-disclosure provisions of Information Law requirements, or causes damage to or loss of the Relevant Information.

8.4 Each Party shall provide evidence (further to any reasonable request) that all personnel that have any access to the Relevant Information whatsoever are adequately and appropriately trained to comply with their responsibilities under Information Law and this Agreement.

8.5 Each Party shall ensure that:

8.5.1 only those personnel involved in delivery of the Agreement use or have access to the Relevant Information; and

8.5.2 that such access is granted on a strict **Need to Know** basis and shall implement appropriate access controls to ensure this requirement is satisfied and audited. Evidence of audit should be made freely available on request by the originating Data Controller.; and

8.5.3 specific limitations on the personnel who may have access to the Information are set out in the relevant Data Sharing Agreement

9. Governance: Protection of Personal Data

9.1 At all times, the Parties shall have regard to the requirements of Information Law and the rights of Data Subjects.

9.2 Wherever possible (in descending order of preference), only anonymised information, or strongly or weakly pseudonymised information will be shared and processed by Parties, without the need to share easily identifiable Personal Data. The Parties shall cooperate in exploring alternative strategies to avoid the use of Personal Data in order to achieve the Specified Purpose. However, it is accepted that some Relevant Information shared further to this Agreement may be Personal Data/Special Category Personal Data.

9.3 Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a **Need to Know** basis. If either Party:

9.3.1 becomes aware of any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted or unusable; or

9.3.2 becomes aware of any security vulnerability or breach,

in respect of the Relevant Information it shall promptly (and within 48 hours) notify the other Party. The Parties shall fully cooperate with one another to remedy the issue as soon as reasonably practicable, and in making information about the incident available to the Information Commissioner and Data Subjects where required by Information Law.

9.4 In processing any Relevant Information further to this Agreement, each Party shall:

9.4.1 process the Personal Data (including Special Category Personal Data) only in accordance with the terms of this Agreement and otherwise (to the extent that it acts as a Data Processor for the purposes of Article 27-28 GDPR) only in accordance with written instructions from the originating Data Controller in respect of its Relevant Information;

9.4.2 process the Personal Data (including Special Category Personal Data) only to the extent as is necessary for the provision of the Specified Purpose or as is required by law or any regulatory body;

9.4.3 process the Personal Data (including Special Category Personal Data) only in accordance with Information Law requirements and shall not perform its obligations under this Agreement in such a way as to cause any other Data

Controller to breach any of their applicable obligations under Information Law; and

9.4.4 process the Personal Data in accordance with the requirements of Information Law and in particular the principles set out in Article 5(1) and accountability requirements set out in Article 5(2) UK GDPR.

9.5 Each Party shall act generally in accordance with Information Law requirements, and in particular shall implement, maintain and keep under review appropriate technical and organisational measures to ensure and to be able to demonstrate that the processing of Personal Data is undertaken in accordance with Information Law, and in particular to protect the Personal Data (and Special Category Personal Data) against unauthorised or unlawful processing and against accidental loss, destruction, damage, alteration or disclosure. These measures shall:

9.5.1 Take account of the nature, scope, context and purposes of processing as well as the risks of varying likelihood and severity for the rights and freedoms of Data Subjects; and

9.5.2 Be appropriate to the harm which might result from any unauthorised or unlawful processing, accidental loss, destruction or damage to the Personal Data (and Special Category Personal Data) and having regard to the nature of the Personal Data (and Special Category Personal Data) which is to be protected.

9.6 In particular, each Party shall:

9.6.1 ensure that only personnel authorised under this Agreement have access to the Personal Data (and Special Category Personal Data);

9.6.2 ensure that the Relevant Information is kept secure and in an encrypted form, and shall use all reasonable security practices and systems applicable to the use of the Relevant Information to prevent and to take prompt and proper remedial action against, unauthorised access, copying, modification, storage, reproduction, display or distribution, of the Relevant Information;

9.6.3 obtain prior written consent from the originating Party in order to transfer the Relevant Information to any third party;

9.6.4 permit the other Party or their representatives (subject to reasonable and appropriate confidentiality undertakings), to inspect and audit the data processing activities carried out further to this Agreement (and/or those of its agents, successors or assigns) and comply with all reasonable requests or directions to enable each Party to verify and/or procure that the other is in full compliance with its obligations under this Agreement; and

9.6.5 if requested, provide a written description of the technical and organisational methods and security measures employed in processing Personal Data.

9.7 Each Party shall adhere to the specific requirements as to information security set out in the Data Sharing Agreements.

9.8 Each Party shall use best endeavours to achieve and adhere to the requirements of the NHS Digital Data Security and Protection Toolkit.

9.9 The Parties' Single Points of Contact set out in paragraph 14 *(Governance: Single Points of Contact)* below will be the persons who, in the first instance, will have oversight of third party security measures.

10. Governance: Transmission of Information between the Parties

10.1 This paragraph supplements paragraph 9 *(Governance: Protection of Personal Data)* of this Schedule.

10.2 Transfer of Personal Data between the Parties shall be done through secure mechanisms including use of the N3 network, encryption, and approved secure (NHS.net / gcsx) email.

10.3 Wherever possible, Personal Data should be transmitted (and held) in pseudonymised form, with only reference to the NHS number in 'clear' transmissions. Where there are significant consequences for the care of the patient, then additional data items, such as the postcode, date of birth and/or other identifiers should also be transmitted, in accordance with good information governance and clinical safety practice, so as to ensure that the correct patient record/data is identified.

10.4 Any other special measures relating to security of transfer should be included in a Data Sharing Agreement.

10.5 Each Party shall keep an audit log of Relevant Information transmitted and received in the course of this Agreement.

10.6 The Parties' Single Point of Contact notified pursuant to paragraph 14 *(Governance: Single Points of Contact)* will be the persons who, in the first instance, will have oversight of the transmission of information between the Parties.

11. Governance: Quality of Information

11.1 The Parties will take steps to ensure the quality of the Relevant Information and to comply with the principles set out in Article 5 UK GDPR.

11.2 Special measures relating to ensuring quality are set out in the Personal Data Agreement annexed to this Schedule.

12. Governance: Retention and Disposal of Shared Information

12.1 The non-originating Party shall securely destroy or return the Relevant Information once the need to use it has passed or, if later, upon the termination of this Agreement, howsoever determined. Where Relevant Information is held electronically the Relevant Information will be deleted and formal notice of the deletion sent to the Party that shared the Relevant Information. Once paper information is no longer required, paper records will be securely destroyed or securely returned to the Party they came from.

12.2 Each Party shall provide an explanation of the processes used to securely destroy or return the information, or verify such destruction or return, if requested by the other Party and shall comply with any request of the Data Controllers to dispose of data in accordance with specified standards or criteria.

12.3 If either Party is required by any law, regulation, or government or regulatory body to retain any documents or materials that it would otherwise be required to return or destroy under this paragraph 12 *(Governance: Retention and Disposal of Shared Information)*, it shall notify the other Party in writing of that retention, giving details of the documents or materials that it must retain.

12.4 Retention of any data shall comply with the requirements of Article 5(1)(e) GDPR and with all good practice including the Records Management NHS Code of Practice, as updated or amended from time to time.

12.5 Any special retention periods should be set out in the Data Sharing Agreements.

12.6 Each Party shall ensure that Relevant Information held in paper form is held in secure files, and, when it is no-longer needed, destroyed using a cross cut shredder or

subcontracted to a confidential waste company that complies with European Standard EN15713.

12.7 Each Party shall ensure that, when no longer required, electronic storage media used to hold or process Personal Data are destroyed or overwritten to current policy requirements.

12.8 Electronic records will be considered for deletion once the relevant retention period has ended.

12.9 In the event of any bad or unusable sectors of electronic storage media that cannot be overwritten, the Party shall ensure complete and irretrievable destruction of the media itself in accordance with policy requirements.

13. Governance: Complaints and Access to Personal Data

13.1 Each Party shall assist the other in responding to any request made under Information Law made by persons who wish to access copies of information held about them ("**Subject Access Requests**"), as well as any other purported exercise of a Data Subject's rights under Information Law or complaint to or investigation undertaken by the Information Commissioner.

13.2 Complaints about information sharing shall be routed through each Party's own complaints procedure but reported to the Single Points of Contact set out in paragraph 14 *(Governance: Single Points of Contact)* below.

13.3 The Parties shall use all reasonable endeavours to work together to resolve any dispute or complaint arising under this Agreement or any data processing carried out further to it.

13.4 Basic details of the Agreement shall be included in the appropriate log under each Party's Publication Scheme.

14. Governance: Single Points of Contact

14.1 The Parties each shall appoint a Single Point of Contact to whom all queries relating to the particular information sharing should be directed in the first instance.

15. Monitoring and review

1. The Parties shall monitor and review on an ongoing basis the sharing of Relevant Information to ensure compliance with Information Law and best practice. Specific monitoring requirements must be set out in the relevant Data Sharing Agreement.

SCHEDULE 5

Financial Provisions and Decision Making Limits

Part 1 - Financial Limits and Approvals for Primary Care

1. The ICB shall ensure that any decisions in respect of the Delegated Functions and which exceed the financial limits set out below are only taken:

   1.1 by the following persons and/or individuals set out in column 2 of Table 1 below; and

   1.2 following the approval of NHS England (if any) as set out in column 3 of the Table 1 below.

2. NHS England may, from time to time, update Table 1 by sending a notice to the ICB of amendments to Table 1.

Table 1 – Financial Limits		
Decision	**Person/Individual**	**NHS England Approval**
General		
Taking any step or action in relation to the settlement of a Claim, where the value of the settlement exceeds £100,000	ICB Chief Executive Officer or Chief Finance Officer or Chair	NHS England Head of Legal Services and Local NHS England Team Director or Director of Finance
Any matter in relation to the Delegated Functions which is novel, contentious or repercussive	ICB Chief Executive Officer or Chief Finance Officer or Chair	Local NHS England Team Director or Director of Finance or NHS England Region Director or Director of Finance or NHS England Chief Executive or Chief Financial Officer
Revenue Contracts		
The entering into of any Primary Care Contract or Arrangement which has or is capable of having a term which exceeds five (5) years	ICB Chief Executive Officer or Chief Finance Officer or Chair	Local NHS England Team Director or Director of Finance
Capital Note: As at the date of this Agreement, the ICB will not have delegated or directed responsibility for decisions in relation to Capital expenditure (and these decisions are retained by NHS England) but the ICB may be required to carry out certain administrative services in relation to Capital expenditure under paragraph 13 *(Financial Provisions and Liability).*		

SCHEDULE 6

Mandated Assistance and Support

1. Primary Dental Services

1.1 NHS Business Services Authority has existing agreements with NHS England to support its delivery of the following services:

1.1.1 Contract management – end-to-end administration of contract variations and other regional team/ICB support activities;

1.1.2 Performance management - provide mid and end of year administration process to support regional teams and ICBs and undertake risk based assurance reviews - PPV can also be instigated by the ICS or Counter Fraud;

1.1.3 Clinical assurance reviews – provide clinical assurance of quality of dental services delivered, working in collaboration with regional teams/ICBs to identify and seek to address any concerns;

1.1.4 Provide data reports to teams defining quantity and service delivery at a contractor level.

2. Primary Ophthalmic Services

2.1 NHS Business Services Authority have existing agreements with NHS England to support its delivery of the following services:

2.1.1 Contract management. End-to-end administration of new contract applications, contract variations and contract terminations.

2.1.2 Contract assurance. Administration of the annual contractor assurance declaration and additional in-depth assurance declaration where appropriate. Provision of assurance reports at ICS and contractor level, supporting further assurance decisions.

2.1.3 GOS complaints. Administration of the annual GOS complaints survey.

2.1.4 Post-Payment Verification (PPV). End-to-end process for identifying and verifying GOS claims as part of the national PPV framework. This includes obtaining and reviewing claims and carrying out a financial recovery where appropriate. PPV can also be instigated by the ICS or Counter Fraud.

2.1.5 GOS 4 pre-authorisation of repair or replacement glasses.

3. Pharmaceutical Services and Local Pharmaceutical Services

3.1 NHS Business Services Authority has existing agreements with NHS England to support ICBs to discharge their assurance responsibilities by the delivery of the following services to ICBs:

3.1.1 Performance management – direct support to commissioners and community pharmacy contractors to implement corrective and preventative intervention;

3.1.2 Contract assurance – administration of the annual contractor assurance declaration and additional in-depth assurance declaration where

appropriate, provision of assurance reports at ICS and contractor level supporting further assurance decisions by the ICB;

3.1.3 Post-Payment Verification (PPV) – end-to-end process for identifying and verifying claims as part of the national PPV framework to support ICBs to play their part in ensuring compliance with contractual requirements and delivery of quality and value for money. This includes obtaining and reviewing claims, investigation of outliers and other potential inappropriate claims, along with referrals and investigatory reports to the ICB to consider and decide overpayment recoveries, and carrying out the financial recovery where appropriate. PPV can also be instigated by the ICS or Counter Fraud.

4. Support Services directed by DHSC

4.1 NHS Business Services Authority is directed by DHSC to undertake specific activities as well as having existing agreements with NHS England to support its delivery of primary care services. These include (without limitation):

4.1.1 The administration of national payment platforms for primary care services to dentists, pharmacy contractors, appliance contractors, oxygen contractors and special school eye care providers;

4.1.2 The calculation of payment for covid-19 and flu vaccinations to PCNs and GP practices as well as payments to Dispensing Doctors and prescribing only doctors for personal administration claims and sharing this information accurately and in a timely manner;

4.1.3 Clinical advisory support;

4.1.4 Administration functions;

4.1.5 Assurance services - performance and contract management of primary care providers;

4.1.6 The provision of information to primary care organisations for all contractor groups via standardised reporting (eg. ePACT2, eDEN and eOPS);

4.1.7 Working with NHS England and ICB Counter Fraud Teams to reduce loss across the system.

SCHEDULE 7

Local Terms

Primary Care staffing (incl. Finance)	The employment of the Primary Medical Care, Dental and Finance staff delivering contracting and commissioning functions will be transferred to Bedfordshire, Luton and Milton Keynes ICB with effect from 1st April 2023. The employment of the Pharmacy and Optometry team will transfer to Hertfordshire and West Essex ICB only, to support the hosting arrangement agreed between the six East of England ICBs.
Professional Networks (Dental, Eye, Pharmaceutical)	The professional networks will be retained by NHSE for a transitional year 2023/24, reporting to the Medical Directorate and direct links into the ICBs. During 2023/24 there will be a review of the structure and reporting lines of the professional networks.
Complaints	On 1st April 2023, the Complaints Team will align to ICBs to support the delegated responsibility for Primary Care complaints. Employment of the team is planned to transfer to ICBs on 1st July 2023.

SCHEDULE 8

Deployment of NHS England Staff to the ICB

Note: This schedule relates to the Deployment of Staff who are employed by NHS England only.

Deployment of NHS England Staff

1. NHS England may deploy Staff to the ICB for the purposes of carrying out the Delegated Functions.

2. The Parties have agreed that arrangements for the provision of NHS England Staff and the associated employment model envisaged by section 5.9 of the HR Framework **https://www.england.nhs.uk/wp-content/uploads/2021/06/B1427-Human-resources-framework-for-developing-integrated-care-boards-version-2-March-2022.pdf**) will be determined by the National Moderation Panel convened for this purpose and endorsed by NHS England's Executive Group.

3. The Parties agree and acknowledge that the Staffing Models will be developed in conjunction with the ICB and are subject to the decision of the National Moderation Panel and cannot be varied without the express agreement of NHS England.

4. A proposal for a variation to any Staffing Model must be made by means of a formal submission to the National Moderation Panel which will determine the proposal, following which the proposal if approved, will be endorsed by NHS England's Executive Group.

5. Subject to any variation made in accordance with paragraphs 3 and 4 above, a Staffing Model determined in accordance with paragraph 2 will apply for the duration of this Agreement.

Availability of NHS England Staff

6. In addition to any Staff deployed in any communicated Staffing Model arrangement, NHS England may deploy additional Staff to the ICB to perform administrative and management support services together with such other services specified in SCHEDULE 7 (Local Terms) (the "Services") so as to facilitate the ICB in undertaking the Delegated Functions pursuant to the terms of this Agreement.

7. NHS England will take all reasonable steps to ensure that the NHS England Staff deployed for the purposes of carrying out the Delegated Functions shall:

    a. faithfully and diligently perform duties and exercise such powers as may from time to time be reasonably assigned to or vested in them; and

    b. perform all duties assigned to them pursuant to this Schedule 8.

8. The ICB shall notify NHS England if the ICB becomes aware of any act or omission by any NHS England Staff which may have a material adverse impact on the provision of the Services or constitute a material breach of the terms and conditions of employment of the NHS England Staff.

9. NHS England shall use all reasonable efforts to make its Staff available for the purposes of this Schedule 8 whilst the NHS England Staff are absent:

    a. by reason of industrial action;

    b. as a result of the suspension or exclusion of employment or secondment of any Staff by NHS England;

c. in accordance with the NHS England Staff's respective terms and conditions of employment and policies, including, but not limited to, by reason of training, holidays, sickness, injury, trade union duties, paternity leave or maternity or where absence is permitted or required by Law;

d. if making the NHS England Staff available would breach or contravene any Law;

e. as a result of the cessation of employment of any individual NHS England Staff; and/or

f. at such other times as may be agreed between NHS England and the ICB.

Employment of the NHS England Deployed Staff

10. NHS England shall employ their Staff and shall be responsible for the employment of their Staff at all times on whatever terms and conditions as NHS England and their Staff may agree from time to time.

11. NHS England shall pay their Staff their salaries and benefits and make any deductions for income tax liability and national insurance or similar contributions it is required to make from the Staff's salaries and other payments.

12. NHS England shall not, and shall procure that the NHS England Staff shall not, hold themselves out as employees of the ICB.

Management of NHS England staff

13. NHS England where appropriate, shall in consultation with the ICB, make arrangements to ensure the day-to-day control of the activities of their Staff is shared with the ICB and deal with any relevant management issues concerning their Staff including, without limitation, performance appraisal, discipline and leave requests.

14. The ICB agrees to provide all such assistance and co-operation that NHS England may reasonably request from time to time to resolve grievances raised by NHS England Staff and to deal with any disciplinary allegations made against NHS England Staff arising out of or in connection with the provision of the Services which shall include, without limitation, supplying NHS England with all information and the provision of access to all documentation and NHS England Staff as NHS England requires for the purposes of considering and dealing with such issues and participating promptly in any action which may be necessary.

Conduct of Claims

15. If the ICB becomes aware of any matter that may give rise to a claim by or against a member of NHS England Staff, notice of that fact shall be given as soon as possible to NHS England. NHS England and the ICB shall co-operate in relation to the investigation and resolution of any such claims or potential claims.

16. No admission of liability shall be made by or on behalf of the ICB and any such claim shall not be compromised, disposed of or settled without the consent of NHS England.

Confidential Information and Property

17. For the avoidance of doubt, this paragraph 17 (Confidential Information and Property) is without prejudice to any other provision of this Agreement in relation to confidential information.

18. It is acknowledged that to enable the NHS England Staff to provide the Services, the Parties may share Confidential Information.

19. The Parties agree to adopt all such procedures as the other party may reasonably require and to keep confidential all Confidential Information.

Intellectual Property

20. All IPR made, written, designed, discovered or originated by Staff (People Resources) deployed by NHS England, shall be the property of NHS England to the fullest extent permitted by Law and NHS England shall be the absolute beneficial owner of the copyright in any such IPR.

SCHEDULE 9

Mandated Guidance

Primary Medical Care

- Primary Medical Care Policy and Guidance Manual.
- The 'Principles of Best Practice' and any other guidance relating to *the Premises Cost Directions 2013.*
- Guidance relating to the Minimum Practice Income Guarantee.
- Guidance relating to Primary Medical Care discretionary payments.
- Guidance for Commissioners: Interpreting and Translation Services in Primary Care.
- Framework for Patient and Public Participation in Primary Care Commissioning.
- NHS England National Primary Care Occupational Health Service Specification.
- Guidance relating to list cleansing in relation to Primary Medical Care providers.
- Guidance relating to mergers and closures of GP practices and/or Primary Medical Care providers.
- Guidance relating to Primary Medical Care and POD contract reviews.
- Guidance relating to the escalation of complaints from a named 'performer'.
    - Including: *Framework for Managing Performer Concerns.*

Pharmaceutical Services and Local Pharmaceutical Services

- Pharmacy Manual.
- NHS England National Primary Care Occupational Health Service Specification.
- The NHS Pharmacy Regulations Guidance 2020[1].
- Guidance for ICSs and STPs on transformation and improvement opportunities to benefit patients through integrated pharmacy and medicines optimisation.

Primary Ophthalmic Services

- Policy Book for Eye Health.
- NHS England National Primary Care Occupational Health Service Specification.

Primary and Prescribed Dental Services

- Policy Book for Primary Dental Services.
- Securing Excellence in Commissioning NHS Dental Services.
- Securing Excellence in Commissioning NHS Dental Services: Key facts.
- Securing Excellence in Commissioning NHS Dental Services: FAQs.
- Quick Guide: Best use of unscheduled dental care services.
- How to update NHS Choices for Dental Practices.
- Flowchart for managing patients with a dental problem/pain.
- Guidance on NHS 111 Directory of Services for dental providers.
- Definitions – Unscheduled Dental Care.
- Introductory Guide for Commissioning Dental Specialties.
- Guide for Commissioning Dental Specialties: Orthodontics.
- Guide for Commissioning Dental Specialties: Oral Surgery and Oral Medicine.
- Guide for Commissioning Dental Specialties: Special Care Dentistry.
- Guide for Commissioning Service Standards: Conscious Sedation in a Primary Care Setting.
- Commissioning Standard for Dental Specialties: Paediatric Dentistry.
- Commissioning Standard for Urgent Dental Care.
- Commissioning Standard for Restorative Dentistry.

[1] https://www.england.nhs.uk/primary-care/pharmacy/pharmacy-manual/nhs-pharmacy-regulations-guidance-2020/

- Commissioning Standard for Dental Care for People with Diabetes.
- Accreditation of Performers and Providers of Level 2 Complexity Care.
- NHS England National Primary Care Occupational Health Service Specification.
- Dental Access Controls.

Finance

- Guidance on NHS System Capital Envelopes.
- Finance and Payments Guidance for Community Pharmacy, Dental and Primary Care Ophthalmology Services Delegated to ICBs from 2022.
- Managing Public Money (HM Treasury).
- Guidance relating to Personal Service Medical Reviews.
    - Including: *Implementing Personal Medical Services Reviews.*
- Dental Commissioning and Financial Management Guidance.

Workforce

- Guidance on the Employment Commitment.

Other Guidance

- National Guidance on System Quality Groups.
- Managing Conflicts of Interest in the NHS.
- Arrangements for Delegation and Joint Exercise of Statutory Functions.
- Guidance relating to procurement and provider selection.
- IG Guidance relating to serious incidents.
- All other applicable IG and Data Protection Guidance.
- Any applicable Freedom of Information protocols.
- Any applicable guidance on Counter Fraud, including from The NHS Counter Fraud Authority.
- Any applicable guidance relating to the use of data and data sets for reporting.
- Any applicable guidance relating to the commissioning and management of clinical waste in primary care e.g.
    - Including: Management and disposal of healthcare waste.

SCHEDULE 10

Administrative and Management Services

1. The ICB shall provide the following administrative and management services to NHS England:

    1.1 the administrative and management services in relation to the Capital Expenditure Functions and the Capital Expenditure Funds as more particularly set out in this Part 1 of this Schedule 10 (*Administrative and Management Services*); and

    1.2 the administrative and management services in relation to the Section 7A Functions and Section 7A Funds as more particularly set out in Part 2 of this Schedule 10.

    1.3 the administrative and management services in relation to other Reserved Functions as more particularly set out in Part 3 of this Schedule 10 (*Administrative and Management Services*).

Part 1: Administrative and/or Management Services and Funds in relation to the Capital Expenditure Functions

1. The Parties acknowledge that the Capital Expenditure Functions are a Reserved Function.

2. The Parties further acknowledge that:

    2.1 accordingly, the Delegated Funds do not include any funds in respect of amounts payable in relation to the Capital Expenditure Functions (**"Capital Expenditure Funds"**); and

    2.2 NHS England remains responsible and accountable for the discharge of the Capital Expenditure Functions and nothing in Part 1 of this Schedule 10 (*Administrative and Management Services*) shall be construed as a divestment or delegation of NHS England's Capital Expenditure Functions.

3. Without prejudice to paragraph 3 above, the ICB will comply with any Mandated Guidance issued in relation to the Capital Expenditure Functions and shall (on request from NHS England) provide the following administrative services to NHS England in respect of the Capital Expenditure Funds:

    3.1 the administration and payment of sums that NHS England has approved as payable in relation to the Capital Expenditure Functions;

    3.2 if requested by NHS England and taking into account (i) any other support or services provided to NHS England by NHS Property Services Limited or otherwise and (ii) any Mandated Guidance issued in respect of the Capital Expenditure Functions, the provision of advice and/or recommendations to NHS England in respect of expenditure to be made under the Capital Expenditure Functions; and

    3.3 such other support or administrative assistance to NHS England that NHS England may reasonably request in order to facilitate the discharge by NHS England of its responsibilities under or in respect of the Capital Expenditure Functions.

4. NHS England may, at the same time as it allocates the Delegated Funds to the ICB under Clause 9.11, transfer to the ICB such amounts as are necessary to enable the discharge of the ICB's obligations under this Part 1 of Schedule 10 (*Administrative and Management Services*) in respect of the Capital Expenditure Functions.

Part 2 - Administrative and/or Management Services and Funds in relation to Section 7A Functions

1. The Parties acknowledge that the Section 7A Functions are part of the Reserved Functions.

2. The Parties further acknowledge that:

   2.1 accordingly, the Delegated Funds do not include any funds in respect of amounts payable in relation to the Section 7A Functions (whether such arrangements are included in or under Primary Care Contracts or Arrangements or not) (**"Section 7A Funds"**); and

   2.2 NHS England remains responsible and accountable for the discharge of the Section 7A Functions and nothing in this Schedule 10 Part 2 shall be construed as a divestment or delegation of the Section 7A Functions.

3. The ICB will provide the following services to NHS England in respect of the Section 7A Funds:

4. the administration and payment of sums that NHS England has approved as payable under or in respect of arrangements for the Section 7A Functions; and

5. such other support or administrative assistance to NHS England that NHS England may reasonably request in order to facilitate the discharge by NHS England of its responsibilities under or in respect of the Section 7A Funds.

6. NHS England shall, at the same time as it allocates the Delegated Funds to the ICB under Clause 9.11, allocate to the ICB such amounts as are necessary to enable the discharge of the ICB's obligations under this Schedule 10 Part 2 in respect of the Section 7A Funds.

Part 3: Administrative and/or Management Services and Funds in relation to other Reserved Functions

1. NHS England may ask the ICB to provide certain management and/or administrative services to NHS England (from a date to be notified by NHS England to the ICB) in relation to the carrying out of any of the Reserved Functions.

2. If NHS England makes such a request to the ICB, then the ICB will, but only if the ICB agrees to provide such services, from the date requested by NHS England, comply with:

3. provisions equivalent to those set out above in relation to the Capital Expenditure Functions (Part 1 of this Schedule 10) and the Section 7A Functions (Part 2 of this Schedule 10) including in relation to the administration of any funds for such functions but only to the extent that such provisions are relevant to the management or administrative services to be provided; and

4. such other provisions in respect of the carrying out of such management and administrative services as agreed between NHS England and the ICB.

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Integrated Care Board

Report to the Primary Care Commissioning Committee 17 March 2023
8. BLMK Fuller Programme – Progress Update

Vision: "For everyone in our towns, villages and communities to live a longer, healthier life"	
Please state which strategic priority and / or enabler this report relates to	
Strategic priorities	
☒	**Start Well:** Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
☒	**Live Well:** People are supported to engage with and manage their health and wellbeing.
☒	**Age Well:** People age well, with proactive interventions to stay healthy, independent and active as long as possible.
☐	**Growth:** We work together to help build the economy and support sustainable growth.
☒	**Reducing Inequalities:** In everything we do we promote equalities in the health and wellbeing of our population.

Enablers			
Data and Digital ☒	Workforce ☒	Ways of working ☒	Estates ☒
Communications ☐	Finance ☒	Operational and Clinical Excellence ☒	Governance and Compliance ☐
Other ☐(please advise):			

Report Authors	Amanda Flower, Associate Director Primary Care Commissioning & Transformation BLMK ICB
Date to which the information this report is based on was accurate	7th March 2023
Senior Responsible Owner	Nicky Poulain, Chief Primary Care Officer.

The following individuals were consulted and involved in the development of this report:
BLMK ICB Board. 4 Place Boards. PCN Clinical Directors.
This report has been presented to the following board/committee/group:
As above.

Purpose of this report - what are members being asked to do?

The members are asked to:

- To **note** the feedback from the ICB Board workshop and the priority for each place to define their neighbourhoods and the importance of the Place Boards to drive local implementation.

1. Brief background / introduction:

The BLMK Fuller Programme is a system programme with the aim of anchoring transformation at place to deliver the vision for integrated neighbourhood teams.

2. Summary of key points:

The programme is supported by the ICB Primary Care team and the ICB PMO Team and framed using the following 4 pillars:

1. The development of neighbourhood teams aligned to local communities
2. The provision of streamlined and flexible access for people who require same day primary care
3. The provision of proactive personalised care and support for people with complex needs and co-morbidities
4. An ambitious and joined up approach to prevention.

The BLMK Fuller Programme is accountable to the Primary Care Commissioning and Assurance Committee and is also coordinated by the ICB Fuller Programme Working Group and the BLMK Fuller Stakeholder Collaborative Group.

The ICB Fuller Programme Working Group (meeting fortnightly) will track progress, resolve escalated issues, and ensure system connectivity including workforce, digital technology.

The BLMK Fuller Stakeholder Collaborative Group will ensure the programme is 'Place' and neighbourhood sensitive, adopting the principle of subsidiarity and meeting the needs of local people to enabling and embed place-based transformation. The stakeholder group met for the first time in December 2022 and will resume monthly meetings from the 23rd of March 2023.

3. Are there any options?

These will be identified during the development of the local implementation plans.

4. Key Risks and Issues

These will be identified through implementation. Early risks and issues are identified in the programme highlight reports.

Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☐	No ☒

5. Are there any financial implications or other resourcing implications, including workforce?

These will be identified during the development of the local implementation plans.

6. How will / does this work help to address the Green Plan Commitments?

Click to view Green Plan

The implementation will work on digital first where appropriate and any estates will be built in line with the Green Plan.

7. How will / does this work help to address inequalities?
Implementation will provide continuity of care for those in Core20plus5.
8. Next steps:
Continue to develop the BLMK Fuller Programme Plan with system partners.
9. Appendices
Appendix A – DRAFT BLMK Fuller Roadmap Appendix B – BLMK Fuller Framework for Shared Action
10. Background reading
NHS England » Next steps for integrating primary care: Fuller stocktake report

BLMK Fuller Programme – Progress Update

7th March 2023

1. Background

The Fuller stocktake report outlines a new vision for primary care that reorientates the health and care system to a local population health approach through the development of neighbourhood teams that will streamline access, provide proactive and personalised care, and help people to stay healthy.

The report makes clear that primary care is the foundation, and an integral part of local systems around which system co-operation and collaboration needs to be built to meet local population health need.

Work continues to collaboratively design the BLMK Fuller ambition and programme for delivery through wide ranging discussions across a range of forums. The Fuller ambition will be consistent across BLMK but with customised delivery at place to support local neighbourhoods.

2. Progress

Since the last update, we have continued our work to define with partners our ambition across BLMK that will be delivered at place.

A draft roadmap for delivery of integrated primary care in BLMK – BLMK ICB Board 24 February 2023.

On the 24th of February 2023, in a session led by Professor Claire Fuller, members of the Bedfordshire, Luton and Milton Keynes Integrated Care Board, supported by wider partners, discussed the Fuller Report and the application of the Fuller Framework in BLMK.

Members present at the session worked in place-based groups to consider 6 key questions/focus areas as follows:

- Feedback on the BLMK Fuller Roadmap? – is it agreed? any changes needed?
- What will Fuller neighbourhoods look and feel like in 5 years' time in our place? What's our vision/ambition?
- Agree the next steps and the timescales for your place to develop Fuller Neighbourhoods in 23/24 (and beyond?)?
- Identify any support needed from the ICB / the collaboratives (Mental Health, Learning Disabilities and Neurodiversity & Bedfordshire Care Alliance) / wider partners?

- ❖ Agree any place based collaborative actions on workforce and estates needed to enable Fuller neighbourhoods? How can we use our estates and workforce assets differently?
- ❖ Who do we need to take on this journey with us (key partners, stakeholders and decision-makers)? How will we do that, who will do that?

The important place-based discussions and actions were not intended to form the agreed plan of action to implement the Fuller Programme – collaborative work continues to develop this - but instead to establish and reflect the 'buy in' that each place and place leaders committed There is wide recognition that general practice is not sustainable in its current form and there is an urgent need to codesign a diverse, modern, and effective primary care offer for place and neighbourhood that meets residents' needs.

From all the place-based discussion there were consistent themes which emerged:

- There was agreement that the draft roadmap captures the ambition – place needs to define the *what* and the *how*
- Neighbourhoods should be well defined, understood and recognised by residents and stakeholders
- PCNs will 'lean-in', with a range of other stakeholders/providers, to support neighbourhoods but Integrated (Health and Care) Neighbourhood Teams may be supported by more than 1 PCN
- We should develop a clear and shared understanding of community and neighbourhood assets
- Engaging with front line staff and local leaders early and often is essential
- Working with VCSE and Healthwatch partners is key to developing well-functioning and diverse Integrated Neighbourhood Teams that meet residents' needs
- Piloting our approach to delivering the Fuller Roadmap will mean we learn important lessons that we can share across BLMK

The outputs from the ICB Board session on the 24th February are being considered and developed further at future Place Boards, the Fuller Collaborative Stakeholder Group and reported to the Board via the PCCAC.

The BLMK Fuller Framework for Shared Action is attached as Appendix B to this report to provide committee members full sight of the breadth and depth of the programme. Future reports to the committee will provide more detailed progress reports and evidence against each of the key requirements.

Item 8 Appendix A

Delivering the Fuller Vision in BLMK

Bedfordshire, Luton and Milton Keynes
Integrated Care Board

A *DRAFT* roadmap for Integrated Primary Care

Trust

Respect

Integrity

Accountability

Care and Compassion

The Vision

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The ‘Next Steps for Integrating Primary Care: Fuller Stocktake Report’ – Dr Claire Fuller, May 2022’ provided the mandate for BLMK to develop a detailed vision for integrating primary care, improving access, and improving the experience and outcomes for our residents. This draft Roadmap sets out, at a high-level, the proposed vision, the suggested work needed to achieve the vision, timescales for delivery and what Integrated Primary Care in BLMK will look like going forward.

We are committed to the principle of subsidiarity and supporting each of our four places, (Bedford, Central Bedfordshire, Luton, and Milton Keynes) to improve the health and wellbeing of the population (all age) by creating a safe and sustainable health and care system that is fit for the future.

Delivering effective Primary Care requires close working between partners across health and care, including (not exhaustive) Public Health, Local Authorities, community and mental health services, acute hospitals and the voluntary sector. At the heart of this collaborative approach is co-production – working with residents, local communities, general practice teams, community pharmacies, dental and optometry teams, and all health and care partners - to design services which meet the needs of people in the places that they live and the neighborhoods they call home.

In BLMK, we see this being achieved through an operating model that draws inspiration from the Fuller Stocktake Report for Integrated Primary Care. In essence this means our work to transform primary care will be anchored firmly at “place” with Primary Care Networks and stakeholders owning and driving the plans.

Our goal is clear: more responsive and accessible primary care services, delivered by those best able to understand – and meet – the health and wellbeing needs of the local communities they are proud to serve

What does this mean?

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Neighbourhood teams - a virtual team that is connected around the residents and the community and is bound together by their understanding of and commitment to the population.

Offer to the population made obvious and available through a single directory – MiDOS.

A neighbourhood team will provide the collaborative framework from which to deliver same day primary care, continuity of care and prevention to the population.

Same Day Primary Care – many of our population don't get ill very often but when they do, for many reasons, its important that they can access primary care in a timely way – on the same day.

We need to streamline too - we know that sometimes our population cant get through to their practice team or cant get an appointment that day and we currently have multiple access points which can be confusing.

The BLMK Fuller Vision for Integrated Primary Care

Proactive and personalised care for the population with co-morbidities - our residents with the most complex needs require a coordinated – through one named professional - multi agency, multi disciplinary team that supports their health and care. This will provide the continuity of care and reduced duplication that will improve outcomes and increase our residents experience.

Develop and embed an ambitious, joined up approach to prevention – using a data driven approach we will take a more active role in creating healthy communities and reducing the incidence of ill health.

We will work with communities, the local authorities and the voluntary sector to support and engage our residents in taking a preventative approach.

Plan on a Page

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The Four BLMK Fuller Programme Objectives

Develop neighbourhood teams aligned to local communities

Scope

- Use current progress to champion new ways of working for communities
- Establishment of expanded PCN Teams to fully integrated neighbourhood teams (INTs) which would comprise a range of staff such as GPs, pharmacists, nurses, community geriatricians, social prescribers and AHPs such as physiotherapists and podiatrists/ chiropodists, joined by social care and the voluntary sector
- Support and develop Place Leadership including PCN Clinical Leadership
- Anchor the transformation at Place through the Place Based Boards

Streamlined and flexible access for people who require same day urgent care

Scope

- Provide bespoke support to the practices with the most significant access challenge
- Take a place based approach to communicating with the population and stakeholders
- Facilitate PCNs to work with Places to collaborate offering a scaled same day primary care offer
- Working with urgent community response teams, including LA/ UCR/UTC and ambulance providers
- Continue our work to improve integrated and integrated telephony
- Review same day and urgent health and care flows and plan future provision at Place level – via future procurements – for the population need

Proactive personalised care and support for people with complex needs and comorbidities

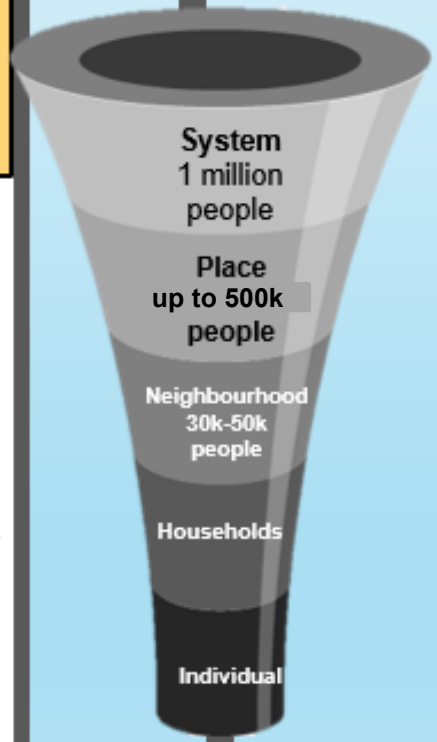
Scope

- Design and deliver proactive personalised health and care at neighbourhood and place level
- Learn from best practice (including CVSE) to implement more multi-disciplinary team working to priority cohorts
- Continue to innovate and deliver capacity to support recovery and transformation of long term conditions - for example the implementation of protocols for the management of hypertension and the implementation of the community lipid services
- Provide bespoke support to cohorts of the population informed by PHM, by Place working

An ambitious and joined up approach to prevention

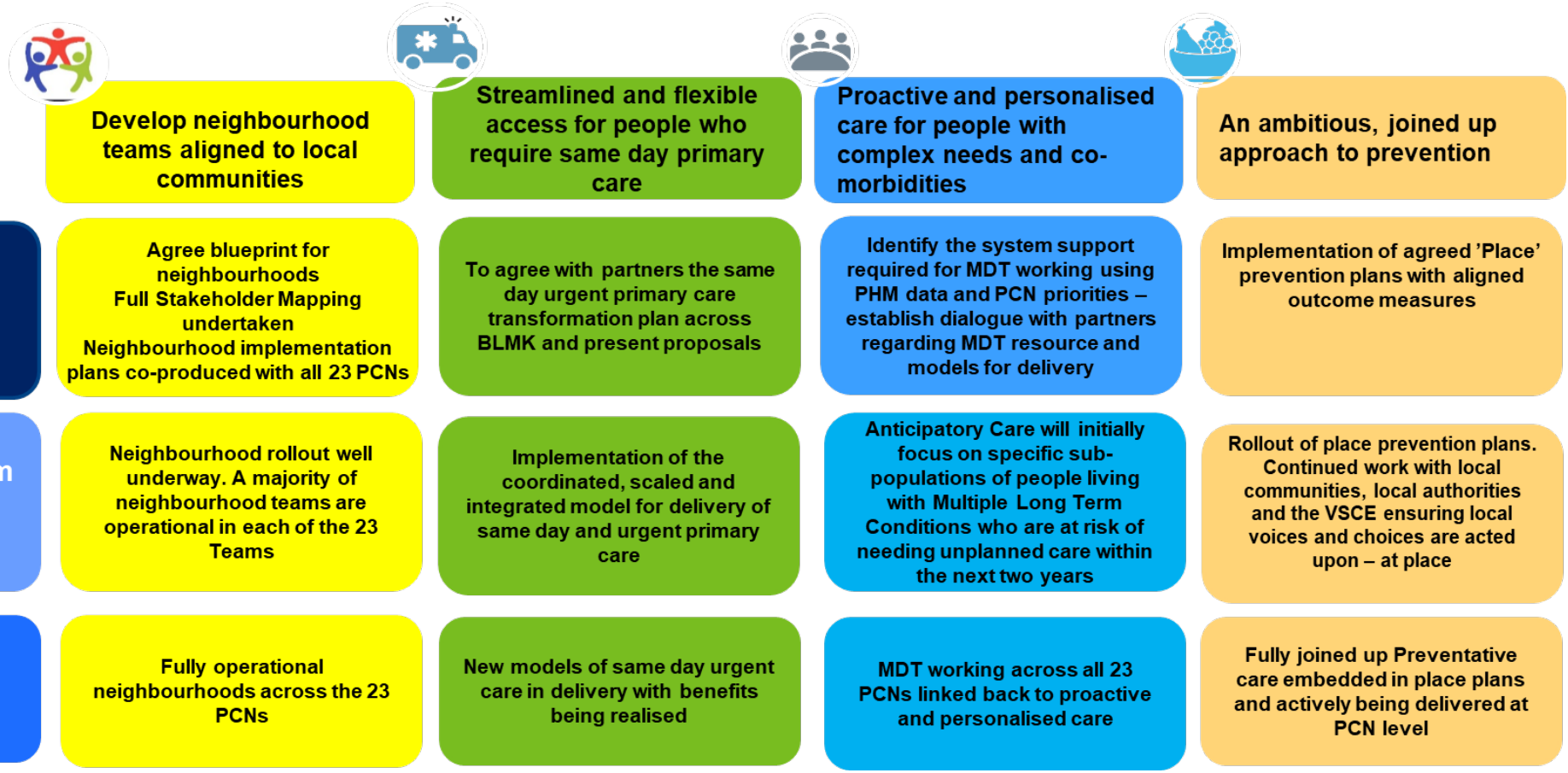
Scope

- Improve take up of cancer screening
- Improve access to the weight management programme
- Strengthen the Diabetes Prevention Programme
- LD & SMI Health Checks
- Establish partnership Implementation of agreed 'Place' prevention plans with aligned outcome measures
- Maximise offer and take up of vaccinations / immunisations (COVID, Flu, MMR)



Timeline

Bedfordshire, Luton and Milton Keynes Integrated Care Board



	Develop neighbourhood teams aligned to local communities	Streamlined and flexible access for people who require same day primary care	Proactive and personalised care for people with complex needs and co-morbidities	An ambitious, joined up approach to prevention
Short Term 12 Months	Agree blueprint for neighbourhoods Full Stakeholder Mapping undertaken Neighbourhood implementation plans co-produced with all 23 PCNs	To agree with partners the same day urgent primary care transformation plan across BLMK and present proposals	Identify the system support required for MDT working using PHM data and PCN priorities – establish dialogue with partners regarding MDT resource and models for delivery	Implementation of agreed 'Place' prevention plans with aligned outcome measures
Medium Term 3 years	Neighbourhood rollout well underway. A majority of neighbourhood teams are operational in each of the 23 Teams	Implementation of the coordinated, scaled and integrated model for delivery of same day and urgent primary care	Anticipatory Care will initially focus on specific sub-populations of people living with Multiple Long Term Conditions who are at risk of needing unplanned care within the next two years	Rollout of place prevention plans. Continued work with local communities, local authorities and the VSCE ensuring local voices and choices are acted upon – at place
Long Term 5 years	Fully operational neighbourhoods across the 23 PCNs	New models of same day urgent care in delivery with benefits being realised	MDT working across all 23 PCNs linked back to proactive and personalised care	Fully joined up Preventative care embedded in place plans and actively being delivered at PCN level

Principles and Enablers

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Utilise population health management data	Use Core20plus5 approach to address inequalities	Low bureaucracy based high trust model	Embed digital innovation
Foster an improvement culture	Embed clinical leadership	Co-design neighbourhoods with residents	Remove professional & organisational barriers

BLMK Fuller Programme – Collaboration & Connectivity

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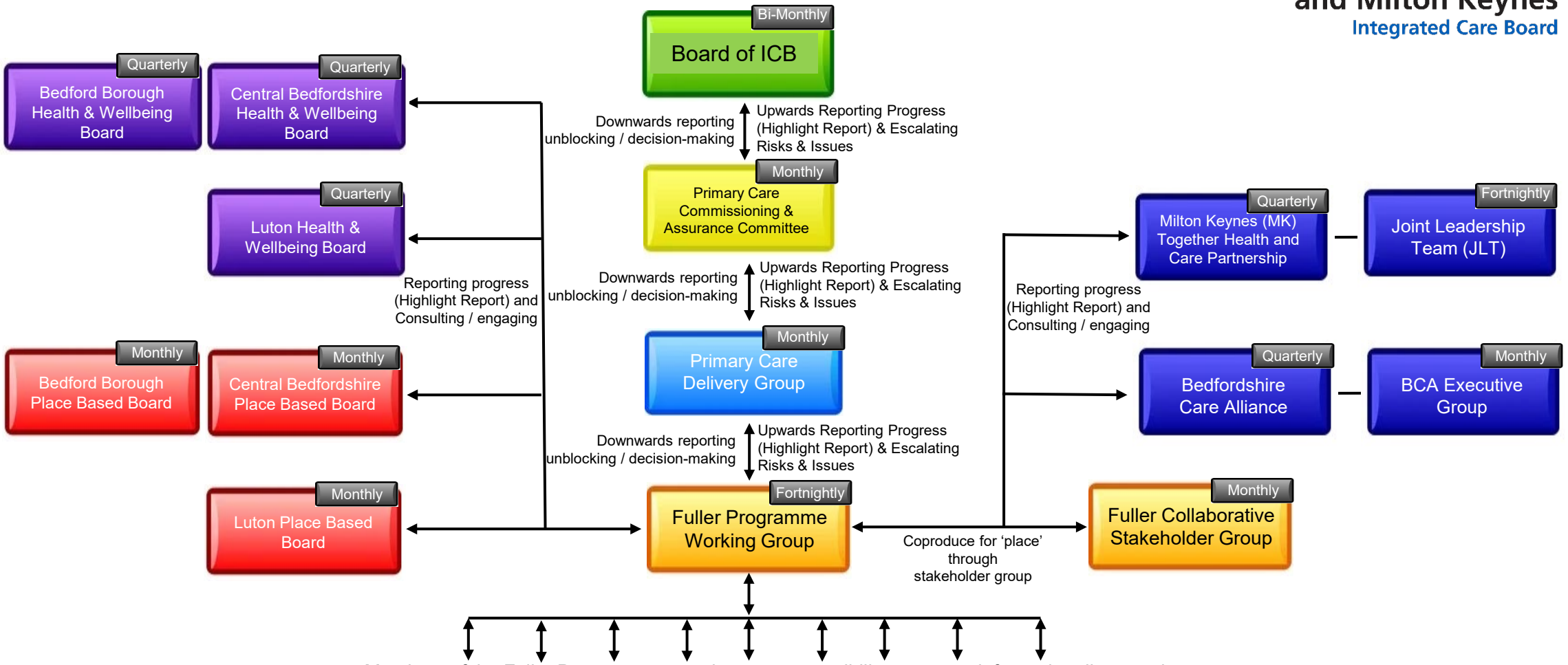

Members of the Fuller Programme team have a responsibility to ensure information discussed within the team is appropriately disseminated to interested or influential stakeholders/groups. Equally members also have a duty to feed information back into the Fuller Programme Team from any interested or influential stakeholders/groups, for example the Primary Care Access Group

Glossary of Terms

Health Inequalities	Unfair and avoidable differences in health across the population, and between different groups in society. This could include how long people are expected to live, the ill health they may experience, and the services that are available to them.
General Practice	A multi-disciplinary healthcare team, led by a general practitioner (doctor), in the community providing a range of services and continuity of care to a registered population.
Neighbourhood Team	A team of multi disciplinary professionals typically drawn from primary care, community services, fire and rescue, local authorities, education, police, mental health services, and the voluntary community and social enterprise sector. Delivering a range of coordinated and joined up services and health and care to the residents of that community (usually a population of 30,000 - 50,000).
Population Health Management	A data driven approach to bring together health & care related information to identify specific populations that should be prioritised for services/interventions.
Prevention	A set of interventions aimed at keeping people healthy and avoiding the risks associated with poor health and illness. This can include secondary prevention.
Primary Care	Includes general practice (GPs) optometry, dentists, community pharmacy, 111, urgent treatment centres, and urgent GP clinics. These are usually the first step for the population in accessing health services.
Primary Care Networks	Groups of practices working together to deliver a scaled primary care offer – where it is efficient & effective to do so - to the population
Proactive care	A joint approach between the resident and the health and care professional to help meet patient goals, increase wellness and wellbeing, support confidence to self manage, prevent deterioration, and reduce the risk of unplanned episodes of ill-health. The care plan is usually monitored in partnership.
Same day primary care	Provision of services/appointments, to meet patient need, in the community delivered by the range of primary care professionals.

Framework for shared action

ICS Actions Taken from the Framework for shared action	Status
Develop a single system-wide approach to managing integrated urgent care to guarantee same-day care for patients and a more sustainable model for	
Same-day access for urgent care would involve care from the most clinically appropriate local service and professional and the most appropriate modality, whether a remote consultation or face to face	
Enable all PCNs to evolve into integrated neighbourhood teams supporting better continuity and preventive healthcare as well as access with a blended generalist and specialist workforce drawn	
Secondary care consultants – including, for example, geriatricians, respiratory consultants, paediatricians and psychiatrists – should be aligned to neighbourhood teams with commitments reflected in job plans, along with members of community and mental health teams	
Teams should be co-located within neighbourhoods where possible, to extend models of personalised care, embed enhanced health in care homes and develop a consistent set of diagnostic tests.	
Bring together teams on admissions avoidance, discharge and flow – including urgent community response, virtual wards and community mental health crisis teams	
Focus on community engagement and outreach, across the life	
Focus on community engagement and outreach	
Proactively identify and target individuals who can benefit from interventions in neighbourhoods, committing to delivering neighbourhood teams first for Core20PLUS5 populations	
Co-ordinate vaccinations, screening and health checks at place level, in accordance with national standards.	
Co-design and put in place the appropriate infrastructure and support for all neighbourhood teams - digital, data, intelligence, quality improvement, HR, finance, workforce plans and models, and estates	
Specifically put in place sufficient support for all PCN clinical directors and multiprofessional leadership development, and protected time for team development.	
Baseline the existing organisational capacity and capacity for primary care, across system, place and neighbourhood levels, to ensure systems can undertake their core operational and transformation function	
Develop a primary care forum or network at system level with suitable credibility and breadth of views, including professional representation and ensure primary care is represented on all place based boards.	
Embed primary care workforce as an integral part of system thinking, planning and delivery	
Improve workforce data	
Support innovative employment models and adoption of NHS terms and conditions.	
Support the development of training and supervision, recruitment and retention and increased participation of the workforce, including GPs	
Develop a system-wide estates plan to support fit-for-purpose buildings for neighbourhood and place teams delivering integrated primary care a 'one public estate' approach and maximising the use of community assets and spaces	
Create a clear development plan to support the sustainability of primary care and translate the framework provided by Next steps for integrated primary care into reality, across all neighbourhoods.	
Ensure a particular focus on unwarranted variation in access, experience and outcomes.	
Ensure understanding of current spending distribution across primary care, compared with the system allocation and health inequalities.	
Support primary care where it wants to work with other providers at scale, by establishing or joining provider collaboratives, GP federations, supra-PCNs or working with or as part of community mental health and acute providers.	
Tackle gaps in provision, including where appropriate, commissioning new providers in particular for the least well-served communities.	
Work alongside local people and communities in the planning and implementation process of the actions set out above, ensuring that these plans are appropriately tailored to local needs and preferences, taking into account demographic and cultural factors	

Key:

- ***In progress***
- ***Not yet started***
- ***Complete***

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Integrated Care Board

Report to the Primary Care Commissioning & Assurance Committee 17 March 2023
8.1 Primary Care Workforce Programme – Highlight Report

Vision: "For everyone in our towns, villages and communities to live a longer, healthier life"	
Please state which strategic priority and / or enabler this report relates to	
Strategic priorities	
☒	**Start Well:** Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
☒	**Live Well:** People are supported to engage with and manage their health and wellbeing.
☒	**Age Well:** People age well, with proactive interventions to stay healthy, independent and active as long as possible.
☒	**Growth:** We work together to help build the economy and support sustainable growth.
☒	**Reducing Inequalities:** In everything we do we promote equalities in the health and wellbeing of our population.

Enablers			
Data and Digital ☐	Workforce ☒	Ways of working ☒	Estates ☐
Communications ☐	Finance ☐	Operational and Clinical Excellence ☐	Governance and Compliance ☐
Other ☐(please advise):			

Report Author	Susi Clarke, Primary Care Workforce Programme Lead
Date to which the information this report is based on was accurate	07/03/23
Senior Responsible Owner	Nicky Poulain, Chief Primary Care Officer

The following individuals were consulted and involved in the development of this report:
N/A
This report has been presented to the following board/committee/group:
BLMK ICB People Board.

Purpose of this report - what are members being asked to do?
The members are asked to **note** the following: A) Progress outlined in the Primary Care Workforce Programme highlight report.

Executive Summary Report

1. Brief background / introduction:

This paper includes an update on the Primary Care Workforce Programme via the highlight illustrating progress against the programme's strategic workstreams;

- Wellbeing, Education, Training & Development
- Retention, Career Development & Equality, Diversity & Inclusion
- Leadership & Organisational Development
- Attraction, recruitment, planning & supply.

In addition to a progress update, the report provides financial allocations, a RAG rating and highlights the critical success factors and risks or challenges for each of the projects / workstreams.

2. Summary of key points:

- PCN Training Teams established in 12 / 23 PCNs. Comprehensive action plans agreed and Training Teams recruited to. Quarterly progress reviews in place and Best Practice event planned September 23
- Launch of regional Leadership programme for Community Pharmacy leads working on PCN Integrated Care project. Collaborative project with 4 EOE ICBs
- Quality & Expansion programme recognised regionally as performing to a high standard
- Nursing Associate programme successfully embedded and ongoing recruitment to support nursing workforce
- 3 x Legacy GPN in post to support newly qualified & retention of experienced nurses
- Nurse leadership development programme launching March 23.

3. Are there any options?

N/A

4. Key Risks and Issues

- Insufficient capacity & resource within the current team to deliver against all NHS E/I & HEE priorities in addition to local priorities and need
- Primary Care staff workload and potential burnout impacting on ability / capacity to engage with training & development initiatives
- Primary Care staff workload & potential burnout impacting on retention
- Estates constraints impacting ability to grow workforce, embed new ARRS roles and increase student placement capacity
- POD contract responsibility, capacity & resource to support with training & development requirements.

Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☒	No ☐

Recorded on the Primary Care directorate risk register

5. Are there any financial implications or other resourcing implications, including workforce?
All financial detail for initiatives is included in the Primary Care Highlight Report.
6. How will / does this work help to address the Green Plan Commitments? Click to view Green Plan
Supporting innovative new ways of working and new models of care Embedding sustainability into workforce Green wellbeing offers e.g. Allotment project & BLMK Walking Group Digital innovation e.g. Shine Mind App and digital prescriptions via Shine Project Virtual delivery of training & development reducing travel.
7. How will / does this work help to address inequalities?
All initiatives and activities within the Primary Care Workforce Programme consider how they can address inequalities within their delivery.
8. Next steps:
• Development of strategy to progress Fuller Report workforce recommendations • Preparation for workforce, education & training implications of POD contracts moving to the ICB from April 2023.
9. Appendices
Appendix 1. Highlight report.
10. Background reading
N/A

Item 8.1 Appendix 1 Primary Care Workforce Programme - Highlight Report **Mar-23**

SRO: Nicky Poulain

Programme Lead: Susi Clarke

		Project Overview							Progress Update - August 2022			
People Plan Priorities	**Strategic Workstream**	**Deliverable**	**Project/s**	**Responsible Person**	**Potential Allocation / Investment**	**Metrics**	**Status**	**Critical Success Factors**	**Key Progress This Month**	**Risks / Challenges / Comments**	**Key Activities Planned for Next Month**	**Last Updated**
A - Looking after our People	**Wellbeing, Education, Training & Development**	**1. Continuing Professional Development**	**CPD Programme**	Jay Willett	139K	All places & funding fully utilised		- Full utilisation of HEE CPD programme budget - Rollout of programme positive uptake of training places offered L6	-Wave one, two and three of programme launched and 90% of courses fully booked. -New Training & Development Manager in post to support implementation. -Final 10k being used to fund further cohorts of training that were over subscribed and had large waiting lists.	-Capacity in general practice to release time for staff to attend training -Challenge with staff attending / committing to longer courses e.g. diplomas -Covering enough subjects to meet the needs of nurse and AHP staff.	-Ongoing promotion of funded places -Consideration for priorities for next year's funding. -Review and feedback from delegates to be collected to support with next years training needs. -Follow up on DNAs and non-attendance	Mar-23
			ACP development & scoping	Jo Finney	Funding for 1 ICS ACP strategic Lead & 2 x AP Supervision Leads	All places & funding fully utilised		Full utilisation of training places offered by HEE	Strategic ACP in post & scoping need Priority area for support identified as Primary Care Funding received from HEE for ACP qualifications	Capacity/appetite for practices to set up digital apprenticeship account to access levy fees to pay for ACP MSc course fees. Access to apprenticeship levy to fund ACP places Limited interest for PG GPN Diploma - entry criteria broadened and to also include as part of N2P programme offer	- Support practices with setting up a digital apprenticeship account and facilitating levy transfer with HEE and HEIs for ACP MSc - Support practices with ACP requirements for CQC - Support practices & PCNs with training & development requirements for ACP - Development of ACP Forum - Recruit to 2 x ACP supervisors	Mar-23
			HCA Training Programme	Jay Willett / Kirsty Shanley	18k	All places & funding fully utilised		Engagement with staff & full utilisation of training places	Programme Plan in place T&D Manager in post All funding used to fund 5 different courses from phlebotomy to Imms and Vaccs. - All courses fully booked and most courses have waiting lists	Engagement / release of staff to attend training Capacity within team to facilitate programme delivery Limited places on courses	Ongoing provision & roll out -Feedback from delegates - Follow up DNAs and non attendance. - Understand budget for next year and complete TNA	Mar-23
			PCN Pilot Project	Hannah Baker		Number of PCNs approved		Approval of Pilot sites as PCN Learning Environments and transfer of responsibility from HEE to the TH	x1 PCN Learning Environment approved x1 PCN Learning Environment approved for wider workforce and currently expanding to include GP Trainees x2 PCN Learning Environment applications in progress Discussions with PCN Training Teams ongoing to work towards approval HEE have simplified approval process for PCNs with multiple existing Training Practices	Different processes continue to be in place for EOE and Thames Valley Primary Care Schools so variation between MK and Bedfordshire (incl Luton)	Progress the x3 applications currently in progress Work with the PCN Training teams with ambition for PCN Learning Environment approval	Mar-23
		2. PCN Learning Environment Development	**Student Pharmacist & Physician Associate Summer Placement Programme**	Rajiv Nandha / Lydia Jacks	55k	Number of Student Pharmacists placed & retained in BLMK		Uptake from students and practices. Students increased ambition to work in Primary Care and more practices/PCNs wishing to take on students and PAs/Pharmacists	2023 - working with 3 other areas in EoE to roll out programme. Beginning to recruit student advisors to help facilitate the programme. 2022 cohort complete with excellent feedback and engagement. 2 students offered jobs in MK. Programme so successful Clinical Pharmacist Lead is supporting 2 other systems in EOE to roll out.	Ensuring recurrent funding in place to maintain programme	Recruitment of advisors & students. Reach out to practices to confirm placements. Continue work with other ICB areas with their programmes.	Mar-23
			PCN Training Teams	Susi Clarke / Jay Willett	570k	50% of PCNs establish a training team		Take up from all 50% of PCNs Capacity within PCN to maximise opportunity	EOI out to all PCNs deadline 9th December 14 EOI received and review panel have agreed funding for 12 PCNs Meetings with each PCN held to confirm next steps and look at KPIs MOUs completed and sent to PCN Training Teams for signature	PCN capacity to maximise opportunity and if engaged maintain engagement Sustainability if non-recurrent funding Allocating funding before March 31st	-PCNs to establish baselines - Organise invoices and release funding -3,6 &12 month review meetings booked in with PCN TT -Each PCN TT to recruit to posts -Event in September to be organised for all PCN TT to come together and share best practice -Ongoing support to PCNs from Training Hub team	Mar-23

3. Student Education, Supervision & Placement	**Expanding Supervisory Capacity**	Hannah Baker / Justine Platt		Increase supervisory capacity & support to PCNs from baseline		Sufficient supervisory capacity to support all professions in Primary Care with a key focus on support to FCPs and ACPs through their verification of competencies.	Number of FCP Supervisors increased to 20 of which 13 have accessed backfill support funding. Training backfil offer closed however replaced with a one-off £3,000 grant for each PCN to claim. 13/23 PCNs have claimed a £3,000 FCP Development Grant to support development and supervision of FCPs. Advertising and support payment of £300 for ACPs undertaking Tier 3 Educator training	Capacity in Primary Care to support additional roles with Supervision and to create capacity where Supervision may not already be active Capacity in team to progress at pace Uptake of ACP Tier 3 Training Pathway	Restart work on supervision requirements guide. Encourage remaining PCNs to claim £3,000 grant Continue to offer and promote peer clinical supervision training to increase number of clinical supervisors.	Mar-23
	Expanding Student Placement Capacity	Hannah Baker	£26k	22 additional GP student placements in 22/23 27 in 23/24 and 27 in 24/25 Increase of 30 GP Educators and 10 Learning Organisations by Aug 22		Engagement from practices, PCNs & wider system to increase placements Retention of existing placements & Educators	x2 rounds of GP Educator training support funding. First round - 25 Educators and 4 Training Practices to be ready by Aug 23. 2nd round a further 17 Educators and 2 practices to be ready by Feb-24. Backfill for Educators to attend ARCP days and maintain requirements Educator & GP trainee development days Working with UoB and MKUH on Paramedic and Therapy placement models	Capacity in Primary Care to increase the number of students in placement. Estates challenges. Capacity of Primary Care staff to take on additional Education roles / responsibilities.	Delivering SSSA training in conjunction with UoB to increase Nurse Assessor & Supervisory capacity Delivering clinical supervision training to increase number of clinical supervisors. Recruit B7 Project Manager to help progress expansion models and support PCN Training Teams.	Mar-23
4. AHP Roadmap Development	**Support to FCPs & PCNs with Roadmap navigation**	Hannah Baker / Tom McNally / Matt Cooper	£60k			All PCNs / Practices / FCPs aware of requirements. Each FCP access to a supervisor and plans in place to support through the requirements.	Ongoing support from AHP leads to FCPs HEE funding to provide 11 grants to enable FCP supervisors to support trainees Additional funding allocated to increase AHP Lead hours / appoint further support 13/23 PCNs have claimed a £3,000 FCP Development Grant to support development and supervision of FCPs.	Capacity of Practices / PCNs to provide the required supervision. No additional funding currently to support supervision. Awareness of the FCP role. Response from NHSE on ARRS requirements.	Encourage remaining PCNs to claim £3,000 grant	Mar-23
5. Wellbeing, coaching & mentoring support	**Health & Wellbeing Pilot**	Lydia Jacks / Rajiv Nandha / Janet Thornley	175k	Increased uptake of Shiny Mind App (2k) All wellbeing resources and webinar places fully booked and utilised		Effective and far-reaching communication. Engagement with entirety of workforce Capacity to engage	RISE programme well embedded with excellent take up of virtual health & wellbeing sessions. Began CARE lunchtime sessions throughout Feb-Mar each session has had 35-50 attendees with positive initial feedback. Continuation of targeted H&W Being sessions in-house with practices on mindfulness, meditation & teambuilding - 8 sessions run throughout end of 2022 & start of 2023. BLMK Book Club great success with high attendance & plans to roll out the framework to other groups.	Workforce burnout & overloaded not accessing support when needed Resources and offers not shared to the right people at the right time - continued issue of communication	Ongoing roll out of resources and offers available to all throughout BLMK. Begin enrolling HWB Champions throughout BLMK - including POD. 5 in-person sessions in pipeline for the upcoming months - finalise agendas & dates.	Mar-23
	Shiny Mind App rollout	Janet Thornley / Nora Donohoe		Uptake measured monthly		All members of the BLMK Primary Care Workforce to download and utilise the Shiny Mind App to support in their health and wellbeing.	Currently there are 1857 users from the BLMK Primary Care Workforce utilising the app. App has been offered to all CCG staff & Bedford Hospital Nurses & AHPs undertaking App development project GPN Strategic Lead offering sessions on utilisation of the App	Challenges with comms with the workforce.	Ongoing promotion via all staff meetings & ongoing provision of Shiny Mind Live programme	Mar-23
	Coaching & Mentorship Training	Helen Worthington-Smith		No. coaches & mentors trained per annum		Retention of experienced Medical and Clinical professionals through coaching and mentoring training opportunities including Coaching ILM7 Certificate and Diploma and ILM5 Certificate and Diploma, Coaching by AKESO and Mentoring support by the LMC	Ongoing provision of Coaching via Akeso with good uptake GPN legacy nurses appointed to support primary care staff	Challenges with individuals dropping out of the programme due to work demands as a result of COVID	Review of all current mentors/coaches being trained to ascertain if their completion dates are still accurate. Discussion at Steering Group regarding next steps for those coaches due to complete their courses	Mar-23
	Peer support network development	Janet Thornley / Kirsty Shanley / Tom McNally / Matt Cooper / Mehreen Shafiq / Rajiv Nandha		No of staff supported via TH clinical leads		Engagement with networks	Networks established and consistently expanding	Ensuring comms are effective and streamlined Capacity to respond to all requests for support	Further development of networks & joint activities planned	Mar-23

B. Belonging in BLMK	**Retention, Career Development, Equality, Diversity & Inclusion**	**1. Multi-professional retention strategy**	**BLMK Local Fellowships**	Helen Worthington-Smith	45k	Uptake & retention of GPs		Recruitment & retention to posts	GP Educator Fellow in post and planning GP Educator & VTS away days	Workload balance	Support to Beds & Luton VTS	Mar-23
			Flexible Pool Scheme	Susi Clarke	120k	Utilisation of platform x no of practices X no of locums signed up		System-wide engagement & agreement on BLMK solution Sustainability of funding	Contract extended to August 23 46 practices signed up, 90 GPs signed up to platform Urgent Care Providers signed up	Encouraging more practices to sign up & utilise platform Increasing multi-professional sign up & practices to post multi-professional shifts 'poaching' clause other agencies	Targeted engagement with areas e.g. MK that have less use of the platform Encouraging sign up from all staff cohorts	Mar-23
			International Medical Graduates	Hannah Baker				Retention of IMGs graduating in BLMK. Sufficient Tier 2 practices to employment opportunity. IMGs supported as needed through visa and reimbursement processes.	Requirements now more understood.	Access to data on the IMGs in our area. Out of date national resources advising on processes and guidance.	Ongoing recruitment support to IMGs and Tier 2 practices when IMGs qualify. Ongoing support to practices to become Tier 2 sponsors	Mar-23
			GP Retention Scheme (Retainer)	Helen Worthington-Smith	Draw down	Increased uptake of scheme		Awareness & engagement with the scheme	Budget & internal process for approval identified and established Closer working relationship with Thames Valley scheme 1 further Retainer approved	Lack of awareness at practice level of scheme	System-wide promotion of scheme as part of GP retention strategy	Mar-23
			Supporting Mentors Scheme	Helen Worthington-Smith	133k	No GPs receiving mentoring/number mentoring sessions delivered No. mid to late career GPs training to become mentors		Attraction of mid-late career GPs wanting to take on mentoring. Completion of ILM5 qualification and retention of Mentors beyond first 12 months.	We now have 11 GP mentors completing the ILM5 training. 4 mentors will be completing their first year on the programme in April 23 and review meetings have been completed with three of them to ascertain if they would like to remain on the scheme for another year. All 3 have accepted the offer to remain on the scheme. The fourth is having a separate meeting with the programme lead.	Insufficient number of New to Practice and Early Career GPs interested in mentoring support to ensure that Mentors time is utilised effectively	Interview cohort 2 new applications	Mar-23
			International GPs	Hannah Baker		Retention of all IRGPs		Retention of IGPR pilot GPs on Programme until signed off independently, increasing the number of GPs in BLMK.	5/6 IGPs complete and on performers list	Ongoing support & retention	Ongoing pastoral support to IGPs and tracking progress through the programme.	Mar-23
			Portfolio Career Opportunities	Helen Worthington-Smith		No of individuals & PCNs engaged		Retention of experienced members of the workforce. Projects to collaborate and work across a PCN to introduce improvement to population health management	On pause subject to available budget	Insufficient number of applications received from the workforce due to current work demands.	On pause subject to available budget	Mar-23
		2, Career Development, Work Experience & Legacy opportunities	**Mid-late career package**	Nina Pearson	45k	Retention of Vital Third GPs		Retention of mid-late career workforce	GP Retention strategy & principles devised Commissioning Phoenix Leadership development programme (due to start Mar-23)	Engagement Capacity within team to facilitate	Launch Phoenix Leadership programme GP Lead networking within existing forums to promote offers	Mar-23
			Coaching Faculty Development	Helen Worthington-Smith		No of professionals in BLMK Faculty		This opportunity will bring together individuals that have had coaching training to build a faculty to support, share learning and build resilience in Primary Care	8 Coaches due to have completed their training by Mar-23	Retention of coaches trained, engagement from workforce to access coaching	Plan to make contact with all coaches completing ILM5/7 training to ascertain if their completion dates are still accurate and to encourage them to sign up to AKESO	Mar-23
			Quality & Differential Attainment programme	Hannah Baker / Kirsty Shanley / Sadaf Javed / Justine Platt / Janet Thornley		No of trainees supported to complete training Effective management of Educator, Practice and PCN approvals and reapprovals. Ongoing quality monitoring of Education in Primary Care		Improved attainment for those at risk of Differential Attainment. Support programmes available to all those that need it. Transfer of responsibility from HEE to the TH for the remaining areas of quality including management of student placements and associated tariffs.	QDA roles well embedded and working with PC School to support trainees in need	Capacity in team to manage the volume of approvals and reapprovals	Recruit to B7 Project Manager to take on expansion approvals Continue monthly reviews and submission to Quality & Oversight Panel (HEE) Continue to align practice and educator reapprovals by PCN Continue working through wider workforce approval	Mar-23
			Clinical Pharmacist Network development	Rajiv Nandha / Lydia Jacks		No of clinical pharmacists engaged		Retention of Clinical Pharmacists within Primary Care	Peer support networks successfully established - virtual thinking round groups every 2 months. Clinical Pharmacist Lead providing 121 support to newly appointed CPs in practice	Adequate supervision & induction in place to retain Clinical Pharmacists	Ongoing development of training & networking opportunities	Mar-23

C. New Ways of Working	Leadership & Organisational Development	3. Equality, Diversity & Inclusion	Primary Care EDI Strategy	Shankari Maha / Lydia Jacks		Number of practices engaged in agenda Number of people booking onto webinars & grouping groups		Engagement & ongoing participation	Wellbeing & EDIB Board established & group are engaged. Tolerance in the workplace: Islamophobia webinar - 44 attendees. 2x International Women's Day Webinars - Felicity Cox & Tanya Carter. Focus on gender discrimination & Digital support for women.	Capacity within team to progress Capacity within general practice to take on board actions required	Upcoming EDIB & Wellbeing Board. Allyship training - particularly for general practice roles running throughout April - both in person & virtual. Introduction of a BAME, Women's, Disability network throughout ICB.	Mar-23
		1. Leadership Development	CARE Leadership Programme	Janet Thornley / Nina Pearson	£50k	Number of staff engaged with programme		Engagement & ongoing participation	Further two cohorts of CARE Leadership programme in planning for Autumn 22 - multi-professional & specifically focussed on supporting newly qualified & experienced nurses	Capacity for staff to fully engage & participate	Ongoing planning	Nov-22
			RCGP Practice Manager Accreditation	Hannah Baker	£27k	Uptake and completion		Engagement & uptake	Advertised offer to fund all practices to put their PM forward to undertake the accreditation	Capacity for PM to take up offer Very low take up	Ongoing promotion	Mar-23
		2. Culture & Change Management	Personalised Care	Helen Worthington-Smith	30K	Personalised care roles fully supported via peer networks and opportunities for development		Engagement and staff released to attend training	Personalised Care Lead appointed who has been meeting with the personalised care roles staff to ascertain what support they require.	It has been identified that H&WB coaches require supervision from a trained H&WB coach supervisor. The training to become a supervisor is difficult to access and expensive and there are very few H&WB coach supervisors in the system. There is a risk that many H&WB coaches are not receiving the supervision they require.	Commissioning of H&WB coach training for new H&WB coaches coming into post. Working with NHS England and two trainee H&WB coach supervisors from BLMK to arrange group supervision for H&WB coaches. However, this will only be available until May 2023.	Mar-23
			Video Group Consultations	Helen Worthington-Smith / Janet Thornley	29K	Number of PCNs taking up the intensive support package		Utilisation of 150 training places and intensive support offer for 6 PCNs.	5 PCNs signed up for the intensive support package but 2 have withdrawn and the third has not yet started their support package. The other two have both successfully completed the programme and are starting to set up video group clinics in their PCNs. A meeting was due to take place with Redmoor Health to discuss how to progress this project but had to be cancelled at the last minute due to staff sickness.	Capacity of PCNs to participate in programmes.	Meeting to be arranged with the Redmoor Health team to decide how to move forward with supporting PCNs to access the VGC training or whether to utilise the underspent budget with Redmoor Health to provide support in a different way.	Mar-23
D. Growing for an integrated workforce	Attraction, recruitment, planning & supply	3. Digital Workforce Strategy	Support to PCNs with Workforce Plans & data analysis	Susi Clarke / Place-based leads				PCNs review workforce plans in relation to population health needs Supply to enable recruitment to plans	All PCN workforce plans submitted on time. Analysis undertaken	Workforce supply Capacity within PCN to successfully recruit and retain	Targeted support to PCNs in relation to roles recruiting	Mar-23
		1. PCN Workforce Data & Planning	New to Practice Programme	Helen Worthington-Smith / Shankari Maha / Bethany Buddery	290K	No. new GPs signed up, no. new GPNs signed up		Increase the uptake of GPs and GPNs accessing the programme and are retained and engaged for a future career in Primary Care. Increase in practices seeing the benefit of the programme in their recruitment and retention of early career GPs and GPNs.	Large increase in the number of GPs and GPNs currently on the N2PFP. 2 GPs and 2 GPNs have now completed the full 2 years of the programme. The GPNs have both gone on to take up leadership roles as a result of the support they have received on the programme.	There is still a less than 100% takeup of the programme amongst newly qualified GPs and some more work needs to be done to reach this cohort. There is also a low number of GPNs who are newly qualified and therefore, additional work to be completed to speak with nursing students to raise the profile of primary care as a first career opportunity. Another risk is team capacity to continue running the programme as it gets bigger. However, we have just recruited a project support officer to support the N2PFP project manager	Plans to match each GP fellow with one of the Supporting Mentors Scheme GPs to further align the Supporting Mentors Scheme to the N2PFP. Plans to further review the programme and identify the learning activities that will be arranged for 2023/24	Mar-23
			In reach schools & HEIs	Janet Thornley / Kirsty Shanley / Mehreen Shafiq				Ongoing connectivity with schools & HEIs Visible supply of students into Primary Care settings	Ongoing engagement with schools New GPN lead recruited to support Central Beds	Practice capacity to engage Ensuring appropriate supervision & retention of students	Plan resources to support understanding of General Practice Working with national website team to include detail on Primary Care careers for 16-18 year olds Linking with Beds Health & Care Academy to promote careers in Primary Care	Mar-23
			Roll out PC Apprenticeships - In scoping	TBC				Gifting of Apprenticeship Levy from partner organisations	SNAs supported to undertake Nursing Associate programme, levy gifted by CNWL and supported by TH	Reliant on gifting of levy not sustainable	Linking with ICS Apprenticeship group to understand further support for Primary Care Regional events promoting apprenticeships in Primary Care	Mar-23
			Digital Student Nurse Placements	Kirsty Shanley / Hannah Baker	£30k	Increased number of digital student nurse placements		Adequate support provided for students during placements	Pilot took place in February 23	Recruiting to placements Ensuring adequate support	Evaluation and feedback	Mar-23

2. Support to recruitment, induction & embedding	**Pipeline into Nursing**	Kirsty Shanley / Janet Thornley		Increase pipeline of nurses into Primary Care		Engagement & uptake	KS working with Horizon to support interactive functional skills assessments KS now trained admin of platform Developing access course for HCAs before joining Nurse Associate Apprenticeship	Engagement, uptake and retention	3 X Legacy nurses in post supporting new recruits, Nursing Associates & HCAs	Mar-23
	Student Nurse Associate Project	Kirsty Shanley / Helen Worthington-Smith		No. NA apprentices currently completing a course, no. new NA apprentices recruited in 2022/23		Practices/PCNs are supported to understand the apprenticeship pathway and the benefits of training their own Nursing Associates rather than recruiting from the existing limited pool. Current NA apprentices are supported on their programmes	We currently have 8 NA apprentices who will complete the course in 2023. In 2022, we supported 14 NA apprentices to access the course and have already have 1 apprentice start the course in 2023 with plans for further cohorts to run through the year. We therefore currently have a total of 23 NA apprentices in primary care in BLMK.	There is currently a risk that we will be a low uptake of the NA apprenticeship as those currently employed staff members wanting to access the course have already accessed it. There are also issues with estate capacity limiting the amount of new staff who can be recruited into primary care.	Ongoing advertising of the opportunity, take expressions of interest, deliver practice engagement events, support.	Mar-23
3. Flexible & rotational opportunities	**ACP development & scoping**	Hannah Baker / Jo Finney	£6,000 per student			Commissioned placements taken up with full supervision support provided by employer. All current ACPs supported through the recognition process.	22-23 Placement round now concluded. Demand scope for 23-24 places submitted First ACP Forum took place in October.	Capacity in Primary Care to provide Clinical Supervision. Access to Apprenticeship Levy to support new ACP students. Duplication of pathways for AHPs alongside the Roadmap requirements. Current awareness in Primary Care of the requirements. ACP Clinical Lead not in place.	Await confirmation of places Continue to support career conversations Plan next ACP Forum	Mar-23

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Primary Care Commissioning & Assurance Committee (PCCAC) 17 March 2023
9. Primary Care (Medical Services) Contracting Assurance Update

Vision: "For everyone in our towns, villages and communities to live a longer, healthier life"	
Please state which strategic priority and / or enabler this report relates to	
Strategic priorities	
☒	**Start Well:** Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
☒	**Live Well:** People are supported to engage with and manage their health and wellbeing.
☒	**Age Well:** People age well, with proactive interventions to stay healthy, independent and active as long as possible.
☐	**Growth:** We work together to help build the economy and support sustainable growth.
☒	**Reducing Inequalities:** In everything we do we promote equalities in the health and wellbeing of our population.

Enablers			
Data and Digital ☒	Workforce ☒	Ways of working ☒	Estates ☒
Communications ☒	Finance ☒	Operational and Clinical Excellence ☒	Governance and Compliance ☒
Other ☐(please advise):			

Report Author	Lauren Sibbons Senior Contract Manager – NHSE Aligned Team
Date to which the information this report is based on was accurate	07 March 2023
Senior Responsible Owner	Nicky Poulain, Chief Primary Care Officer

The following individuals were consulted and involved in the development of this report:
Lynn Dalton – Associate Director of Primary Care Development Pamela Lewin – NHSE Contract Manager Nina Hannagan – NHSE Contract Support Officer Beth Collins – Head of Primary Care Transformation

This report has been presented to the following board/committee/group:
This report has not been presented elsewhere although does contain updates and outcomes (***highlighted in blue type***) from previous contracting papers presented to the Primary Care Delivery Group (PCDG).

Purpose of this report - what are members being asked to do?
Note the updates and take assurance that required contractual, governance patient and practice considerations and actions have been followed and applied.

Executive Summary Report

This report is a standing agenda item to provide members of the Primary Care Commissioning & Assurance Committee (PCCAC) with assurances that the correct processes required contractually, to fulfil our statutory responsibilities have been made available to PCDG to enable a fair and equitable decision to be made in compliance with contractual regulations and considering patient and practice circumstances.

For ease of reading to recap items that are still in progress, updates will be shown in blue text if it is a follow up position being reported.

New and existing items will be in black text, this is for ease of reading and interpretation and identification of in progress items and new items.

1. Brief background / introduction:

Bedford Luton and Milton Keynes ICB is the responsible commissioner for primary medical care (GP) Contracts. This fully delegated role for the **93 GP contracts** transitioned to BLMK ICB from 1July 2022 on the passing of the Health and Care Act 2022. Health and Care Act 2022 (legislation.gov.uk)

It is to be noted that the Health and Care Act 2022 means that NHSE is required to transfer all primary care contracts to ICBs. From 1 April 2023, BLMK ICB anticipate having delegated commissioning responsibility for Community Pharmacy, Optometry and Dental contracts in addition to those already held for General Practice.

Total Portfolio of Contracts from 1 April 2023 for BLMK ICB is as follows:

Discipline	Contract Numbers
General Practice	93
Community Pharmacy	162
Optometry	86
Dental*	148
Total portfolio	**489**

Includes two acute trust services and two specialist community dental providers

Considerable amounts of work are being undertaken with NHSE and HR teams within BLMK and NHSE on the transfer of contracts and workforce ready for the 1 April 2023 transfer date.

2. Summary of key points:

2.0	Applications for list closure(s)
2.1	Caretaking arrangements – The Village Medical Centre: actions being taken and contingency arrangements – Update and actions taken since previous PCDG
2.2	Contract Extensions – Cauldwell Medical Centre
2.3	Novation Application(s) - Malzeard Road Medical Centre update and actions taken since previous PCGD
2.4	Remedial Notices - Ashcroft Surgery: update and actions taken since previous PCDG
2.5	Refugees, Evacuees and Asylum Seekers. update on current position across BLMK
2.6	Succession planning – Ashburnham Road update and actions.
2.7	Annual E-dec report BLMK results issued (contractual requirement to submit)
2.8	Annual PCAR – reinstatement following Covid

3. Are there any options?

As set out in body of paper for each item.

4. Key Risks and Issues

As set out in body of paper for each item.

Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☐	No ☒

There are no new risks to add.

5. Are there any financial implications or other resourcing implications, including workforce?

No

6. How will / does this work help to address the Green Plan Commitments?

Click to view Green Plan

Care closer to home and the use of telehealth through remote consultations supports the reduction in carbon emissions.

7. How will / does this work help to address inequalities?

By ensuring continuity of primary care services, particularly in areas which may be underserved or experiencing deprivation. Consideration has been given to all protected groups and characteristics to ensure that our statutory requirements have been effectively discharged and that patients are not inadvertently discriminated against by any decisions that we make. Any changes to service delivery will have both a Quality Impact Assessment (QIA) and an Inequalities Health Impact Assessment (IQIA) undertaken.

8. Next steps:

The Primary Care Contract team will continue to provide assurance to PCCAC that due process has been followed or flag any issues and proposed solutions with PCCAC.

9. Appendices

None.

10. Background reading

All primary care contracts are underpinned by both Primary and Secondary legislation, it is this, that informs Regulations and then the Contract.

In addition, Primary Medical Care Contracts need to be assessed against the criteria that is set out within the Policy Guidance Manual (PGM) to ensure that all contractors nationally are treated equitably by following due process.

Policy Guidance Manual

BLMK ICB in addition take into consideration the sustainability of practices, taking a supportive approach to ensure continuity of and support to the primary care workforce and consider the impact on patient care. This is through our Primary Care Strategy.

2. Practices with closed lists and further applications for list Closures

2.1 The table below was shared with the PCDG and shows an overview of practices that currently have closed lists within the ICB along with dates and or actions to support reopening.

Figure 1 – Approved List Closures

Practice	Date Approved	Actions Required	Conditions	Date to re-open
Cobbs Gardens	21/12/2022	1. To work with the training hub for workforce support 2. To work with the place team for patient communication due to the rurality aspect of the practice	Whilst your list is closed, you may only accept an application for inclusions on your list from a person who is an immediate family member of a registered patient.	5th June 2023 This will be subject to a 3-month progress review meeting TBC in March 2023
Greensands (Ampthill)	21/12/2022	1. To work with the training hub 2. To work with the place team for support 3. To work with the Estates team.	Whilst your list is closed, you may only accept an application for inclusions on your list from a person who is an immediate family member of a registered patient.	3rd April 2023

The Contracts team have received requests from a further three practices requesting application forms to apply for list closure, these have been sent and we are waiting receipt of them, and the supporting information required to enable reports to PCDG for consideration.

Figure 2 – Requests for List Closure Application Forms – In progress

Practice	Date Sent	Comments
Leagrave Surgery	06.12.2022	Further work required from practice as they need to carry out engagement on impact to neighbouring practices. Reasons sighted for request is inability to recruit. Update: Place team are working with the practice on engagement with neighbouring practices to assess impact.

Update: No further applications have been received in February 2023. Assurance is given that timeframes will be met. The Terms of Refence for the PCDG and PCCAC are shortly due to be reviewed and a consideration will be given on the approach to ensure that the ICB can meet the national timeline set of 21-day timeframe can be met.

2.1 Caretaking Arrangements – Queens Park on behalf of the Village Medical Centre

The Village Medical Centre, Great Denham was originally a "Type Two Practice" with a subsidy to provide infrastructure for a new village development. Type two funding is no longer available. The previous contractor resigned their contract and the ICB had to put alternative arrangements in place to ensure continuity of patient care.

The practice is currently being managed by the Queens Park Group Surgery which was appointed following an emergency expression of interest for a one-year GMS which ended on 31 October 2022. The planning intention was to merge the two lists on the 31 October 2022. As this was not achieved the ICB has entered into an Alterative Provider of Medical Services (APMS) contract which is the only contractual option available to the ICB following the one-year GMS contract.

Over the last year the Queens Park Group Surgery has stabilised the service and improved quality and the number of patient complaints has reduced. However, recruitment issues, turnaround workload and associated costs have been considerably greater than anticipated.

Queens Park Group has been provided with an APMS contract, once this is signed by the partners the ICB finance and contracting team will work with Queens Park Group during March 2023 to review the global sum payments and any adjustments that may have to be made as a result of the one year GMS contract to ensure that the practice is not destabilized as a result of taking of emergency contract award of a 1 year GMS contract. There is a commitment by Queens Park and the ICB to transfer the patients to Queens Park through a managed list dispersal whilst retaining TVMC premises.

Update: There is now a fully signed contract in place between Queens Park Group and the ICB.

2.2 Cauldwell Medical Centre - contract extension

The ICB received a whistleblowing complaint against Cauldwell Medical Centre. As a result of the concerns raised, it was mutually agreed at Executive Director level that these should be fully investigated, a deep dive visit was undertaken to ensure patient continuity of patient care and delivery of safe services.

The deep dive visit took place on 20 January 2023 and the outcome and findings at the visit were incredibly positive. The ICB was provided with full assurance the allegations were not substantiated or mitigations were in place to address some of these.

Due to the confidential and sensitive nature of the whistle blowing allegations a report has been presented to the private section of the PCCAC to provide assurance the allegations were taken seriously and have been thoroughly investigated.

Contract Extension:

Cauldwell Medical Centre contract is due to be extended for a further two years from April 2023 to March 2023. PCCAC is being asked to support the recommendation to extend the current contract. Noting that the contract is an APMS contract and in line with the terms of this type of contract the practice will be subject to regular joint service review and monitoring meetings.

2.3 Novation Application(s) - Malzeard Road Medical Centre

At the PCDG of 8 November 2022, the Group was asked to note that the ICB had received an application for incorporation and a novation at Malzeard Road contract. The contract holder subsequently asked the ICB to confirm its support to them moving to the next stage of the process due to the costs and efforts required in submitting a formal application.

Update: Assurance is given to the PCCAC that the ICB will apply the national Commissioner Assessment Framework (CAF) process with the contractor and this will entail working with the contracting, quality and finance team to ensure that due diligence is undertaken prior to a formal submission for incorporation is made by the contractor in May 2023 seeking the ICBs approval.

2.4 Remedial Notices - Ashcroft Surgery:

Dr Bath's practice, Ashcroft Practice, had a CQC inspection on 21 July 2022. Overall, the practice was rated as "Inadequate." This follows a previous inspection on 18 May 2016 when the practice was rated "Good" overall. Overall domain ratings to note: -

Safe -inadequate
Effective – requires improvement
Well led – requires improvement

https://www.cqc.org.uk/location/1-497037814/reports

In addition to working with CQC, the Quality team and the LMC, the practice was issued with a contractual remedial breach notice on 1 December 2022 with a 28-day turnaround to supply evidence that the identified remedial breaches had been remedied.

Unfortunately, the ICB did not receive this information from the practice and had to be followed up; documentation has been received by the place team in a readable format on 24 January 2023 and is being matched to ensure that this meets the requirements as set out.

It needs to be noted that as the information was not received as requested, the ICB does have the option to serve a breach notice.

It does however need to be noted that the practice has been working hard to turn the practice around and CQC appear to be pleased with their progress.

A follow up visit with the ICB contract, quality and place team representatives is taking place on 6 February 2023.

Update: following the visit to the practice on 6 February, work is taking place and improvement can be seen, PCDG noted in February that a further remedial or breach notice could be issued however PCDG have decided against this as we wish to support the practice and recognise the progress that they have made to date. Assurance has been given, this practice will now move to BAU contractual monitoring and visits.

2.5 Refugees, Evacuees and Asylum Seekers

This is to update on the current position across BLMK of the Asylum Seekers and Refugees that we currently have in our system.

1. **Ukrainian refugees and Afghan Guests**

   There has been no change to the position of either of these groups since the last update.

2. **Asylum Seekers**

   There has been no change in numbers or services for the established sites for Asylum Seekers in BLMK. There have been 91 new arrivals in the ICB since the 23rd of January.

   With the exception of one overnight site, all accommodation sites in Luton are now Initial Accommodation Contingency. This means those living at those sites can and are registered with
   two local practices.

   The spot booked accommodation site in Luton has now been decanted and closed.
   For the overnight site in Luton for 24/48-hour stays, healthcare is managed on site by the Home Office unless there is an emergency which is dealt with via A&E/999.

   The new Initial Accommodation Contingency Hotel that opened in BLMK in January is now occupied with Asylum Seekers who have been relocated from another area where they were registered with a local practice and screening was undertaken. We are working with the ICB and practice in that area to ensure that records are transferred, and any follow-up referrals or screening is undertaken here. As these individuals have previously registered in the UK there is no additional funding available, and the practice are registering them in the same way as any other new patient.

   An Initial Accommodation Contingency Hotel opened in BLMK in February and a local practice has been appointed to register those living there. As of 21st February, there had been no arrivals. When there are and it is clear whether they have been relocated from another area or if they are new to the country the appropriate screening will be put into place.

   The PCCAC can take assurance that the Primary Care Delivery Group have reviewed the primary care place and contracting team's processes in responding and supporting refugees and evacuees placed in BLMK in a timely manner, often with minimal notice.

2.6 Succession planning – Ashburnham Road

As part of succession planning, Dr Basra, the single-handed provider at Ashburnham Road, approached the ICB to help facilitate a merger with a suitable practice to enable him to retire and provide continuity of care for his patients and retain his GMS contract in perpetuity. A discussion took place with the LMC who were supportive of the approach requested by Dr Basra. An "Expression of Interest" was circulated to all GP practices in BLMK on Dr Basra's request. Three expressions of interest were received, and Dr Basra is currently in discussion with one of the practices and undertaking due diligence prior to making a final decision to merge or include new partners on his current contract.

Risk Assessment

Should the GP-led merger or inclusion of a new partners process not proceed the Primary Care Delivery Group needs to be alerted to a potential three-month contract notice period which would require the usual option appraisal of caretaking, dispersal, advertising the contract or other solution.

Update: Active dialogue has been taking place between Dr Basra and the other contractor, they have completed their due diligence and the ICB has been requested to provide a contract variation to enable both parties to sign confirming the contractual change. The ICB is currently waiting for the contract variation to be returned. On receipt of the signed variation notice this will enable continuity of care for patients and retains a GMS contract in perpetuity.

2.7 - Annual e-DEC report BLMK results

The electronic practice self-declaration (eDEC) is a mandatory data collection which all GP practices in England must complete every year. The eDEC covers eight areas:

- practice details (such as name and address)
- practice staff
- practice premises and equipment
- practice services
- information about the practice and its procedures
- governance
- compliance with Care Quality Commission (CQC) registration requirements
- general practice (GP) information technology (IT)

CQC use this information to check that GP practices meet the CQC registration requirements, including complying with the law and in particular the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) (as amended). The answers to the questions relating to CQC's regulatory requirements will form part of their pre-inspection documentation, to reduce practice workload in line with our commitments in the General Practice Forward View.

Results have just been shared with the ICB and headlines for BLMK are as in the table below:

Number of questions flagged due to Practices' non-compliant responses

High priority	43
Medium priority	96
Low priority	29
Null responses	6

PCCAC can take assurance that the contracts team are analysing the responses and will work with place teams and practices where issues have been highlighted.

2.8 - Primary Care Activity Report (PCAR) - reinstatement following Covid

The PCAR was introduced in 2016/17 to support greater assurance and oversight of NHS England's primary care commissioning responsibilities. It replaced what had often been variable and ad hoc requests for information with a more systematic approach.

The primary care commissioning report collects information on local commissioning activity regardless of the commissioning route, for example, NHS England or CCGs with delegated authority.

The main areas of interest for reporting include:

- management of contractual performance
- financial assistance to providers
- procurement and expiry of contracts
- availability of services, including closed lists
- assurance of policy compliance and implementation

The collection of PCAR data was suspended in response to the pandemic to alleviate burden on the NHS that was part of the Covid-19 response. It has now been agreed that the PCAR data collection will resume April 2023.

The link to the PCAR web page is below for further information (this will be updated with more information closer to launch) https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/primary-care-commissioning-activity-report-pcar

The contracts team will continue to follow the progress and release of the PCAR to ensure that practices submit the data that is required. Gateway and the GP bulletin will be utilised to communicate with practices to ensure that submissions are made within the submission timeframe.

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Report to the Primary Care Commissioning & Assurance Committee 17 March 2023
9.1 Ivel Medical Centre contract resignation

Vision: "For everyone in our towns, villages and communities to live a longer, healthier life"	
Please state which strategic priority and / or enabler this report relates to	
Strategic priorities	
☒	**Start Well:** Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
☒	**Live Well:** People are supported to engage with and manage their health and wellbeing.
☒	**Age Well:** People age well, with proactive interventions to stay healthy, independent and active as long as possible.
☐	**Growth:** We work together to help build the economy and support sustainable growth.
☒	**Reducing Inequalities:** In everything we do we promote equalities in the health and wellbeing of our population.

Enablers			
Data and Digital ☒	Workforce ☒	Ways of working ☒	Estates ☒
Communications ☒	Finance ☒	Operational and Clinical Excellence ☒	Governance and Compliance ☒
Other ☐(please advise):			

Report Author	Lynn Dalton Associate Director of Primary Care Development
Date to which the information this report is based on was accurate	5 March 2023
Senior Responsible Owner	Nicky Poulain, Chief Primary Care Officer

The following individuals were consulted and involved in the development of this report:
Nicky Poulain Chief Primary Care Officer
This report has been presented to the following group:
Primary Care Delivery Group (PCDG) February 2023 and update provided in March 2023

Purpose of this report - what are members being asked to do?

Members are being asked to **note** the content of this paper and decision by the partners of Ivel Medical Centre, Biggleswade, Bedfordshire to resign their GMS contract effective from 1 December 2022.

To note the steps being taken to secure a new provider from 1 June 2023 and ensure continuity of the service and patient care.

Due to the timeline for this contract the ICB intends to be able to recommend the preferred provider in early April 2023 to move to contract award giving 6-week mobilisation. Consideration is required in view of the tight timeline for this urgent/emergency procurement. The Committee is asked to consider agreeing a Chairs Action Group (of the PCC&AC) to be convened to approve the recommended provider.

Members are also advised of the closure in Biggleswade of Lloyds Pharmacy based in Sainsbury's which is currently a 100-hour pharmacy. NHS England gave approval at the Pharmaceutical Services Regulatory Committee (PSRC) in February 2023 to accept the closure of the pharmacy. As a result of this decision the ICB has a meeting with the Public Health Consultant at Central Bedfordshire Council to request that a new or refreshed Pharmaceutical Needs Assessment (PNA) is undertaken to identify if additional pharmacy provision is required in Biggleswade.

Executive Summary Report

1. Brief background / introduction:

Ivel Medical Centre (IMC) is a five partner GP practice located in Biggleswade, Bedfordshire. The partners hold a General Medical Services (GMS) contract and have a practice list in January 2023 of 13,620 actual patients. This is a reduction of 392 patients for the same period in 2022. Ivel Medical Centre is one of two practices in Biggleswade, the other being Saffron Group Partnership with a list of 21,403 registered patients in January 2023; this is an increase of 590 patients for the same period last year.

One of the partners resigned from the partnership giving notice to leave effective from 31 March 2023. The decision by the partner to leave resulted in the four remaining partners reviewing their position following difficulties trying to recruit a new partner and or salaried GPs. The ICB has supported the practice over the last year through its commissioning arrangements with the Local Medical Committee (LMC) to provide support to the partners, protected time to review their contractual options and sustainability. In addition, the partners commissioned an external agency to review their options and they have also had on-going support with the ICB place team.

On the 30 November 2022 the partners requested a meeting with the ICB to advise of their decision to resign their GMS contract the following day 1 December 2022, giving the required 6 months' notice period. The partners requested that their decision to resign their contract remained confidential over the Christmas and New Year period to reduce any stress their decision may place on their staff. This request was supported by the ICB with a date agreed to meet and inform the practice staff set for 16 January 2023.

The partners did not want to consider the option of a merger with another practice, however following the meeting with the ICB they agreed to explore a merger with a known interested practice. The two practices worked together to review the opportunity during December and early January. The ICB advised both parties that a request to rescind the termination notice would be accepted until midnight on Sunday 15 January. The rational for this timeline was to enable the GMS contract to be retained in perpetuity and if that was not feasible to provide the ICB with sufficient time to commission a new provider with effect from 1 June 2023, thus ensuring continuity of the service and patient care.

In January 2023 the IMC partners advised the ICB that they had made their decision not to merge with the interested practice. Three of the four partners advised the ICB their current intention is not to continue to work at the practice as salaried GPs under the employment of the new provider, but to seek alternative

employment or partnership arrangements. Support is being offered to the partners to consider their options and retain their clinical knowledge and expertise within the local system.

Another point to note is that the partners opted out of the Primary Care Network (PCN) Directed Enhanced Service (DES) in April 2022. This was a result of a breakdown in the relationships of the practices within their previous PCN. They are one of four practices that opted out of the PCN DES resulting in the ICB commissioning a single PCN (Lea Vale Group) to provide PCN managed services on behalf of the four practices to ensure patients continued to receive PCN services. The partners have confirmed they welcomed the support and leadership provided by Lea Vale Group and expressed a view to continue with the same approach in 2023.

On 16 January 2023 the ICB joined the partners when they informed the practice team of their decision to resign their contract. The ICB supported the partners to respond to questions and provided assurance to their employed staff that they will be for Transfer Undertakings Protected Employment (TUPE) to the new provider from 1 June and the partners will provide them with HR support.

The ICB training hub has been asked to support with a well-being offer and support from the professional nurse leads and paramedic leads to support the practice team. The ICB has given a commitment to meet with the partners and practice staff monthly to update them and also respond to any questions or concerns they may have; these meetings are diarised in advance and the next meeting will take place on 6 March.

Following the staff meeting the partners and ICB met with the Chair of the Patient Participation Group (PPG). This was followed by a meeting with the wider PPG on 19 January to inform them of the partners decision, provide assurance on the ICB's responsibility to secure a new provider to take over the service and that staff will transfer to the new provider to ensure their employment and continuity of care by the practice team. They were made aware of the situation regarding the partners continuing to work at the practice will be a personal decision. The ICB has agreed to meet with the PPG once a contract has been awarded to a new provider in mid-April.

Communications have been released which includes letters to patients, stakeholders and a media briefing. The ICB has met with one local councillor and further meetings and briefings will be prepared as required. The ICB has informed the senior partner of the neighbouring Saffron Medical Practice, who whilst supportive of the partners decision has some anxieties this will impact on their practice through patients seeking to register at the practice. Saffron Group will seek approval from the ICB to register new patients who are new to the area, until a new provider takes over the Ivel Medical Centre contract.

The ICB is taking Option A as the approach to secure a new provider. This is following advice, discussion and agreement with the ICB specialist procurement advisor NHS Arden & Gem. The following set out the risks of each option.

- Option A - Prior Information Notice (PIN) was released to the market seeking expressions of interest to appoint a short-term caretaker provider for 18-24 months from 1 June -31 October 2023 to stabilise the service before going out to a full commercial procurement for a longer-term APMS provider. The notice advised the market that the caretaker will need to use their knowledge of delivery of primary care medical services within BLMK to mobilise quickly and bring stability to the practice's staff, and patients whilst building resilience and providing reassurance to the local community. The PIN notice was shared with BLMK GP providers (GMS & APMS). This approach of a restricted procurement is not without risk of challenge, should that occur the ICB will apply option B.

- Option B - Access NHS England Pseudo-Dynamic Purchasing Scheme (PDPS) framework, a list of NHSE pre-approved providers able to bid for an APMS contract this route reduces the procurement timescale and risk of a challenge to the ICB. The ICB has identified that there are 5/6 local providers on the PDPS framework. If this route is not successful, the ICB will apply option C.

- Option C - If the ICB is unsuccessful in securing a provider using the PDPS, it can apply Public Contracts Regulations - regulation 32 and award an emergency APMS contract, in doing so issue a 30-day VEET notice to the market to reduce a challenge. The earliest that this approach can reasonably take place is the end of April and mobilise in May.

2. Summary of key points:

2.1 Partners at Ivel Medical Centres decision to resign their GMS contract.
2.2 Work being undertaken to secure a new short-term caretaker contract from within BLMK for a period of 18-24 months from 1 June 2023.
2.3 The procurement approach being taken to secure a new provider and the associated risks.
2.4 To note there is a financial implication in awarding an APMS contract with a premium of between 10-15% above global sum.
2.5 Action being taken to request the Public Health Consultant at CBC reviews or refreshes the PNA in view of the closure of Lloyds Pharmacy in Sainsburys – further update will be provided at the meeting.
2.6 Approve the request to convene an urgent Chairs Action Group to approve the recommended provider in early April to enable the ICB to go to contract award as set out in appendix A.

3. Are there any options?

The ICB is required to secure a new provider to provide primary medical services to the patients registered with Ivel Medial Centre from 1 June 2023 or alternatively close the practice and disperse the list which is not an option.

4. Key Risks and Issues

Procurement risks and mitigations are highlighted in this report, the actions being taken in view of the timeline to appoint and mobilise a new provider. The approach taken by the ICB to offer this contract as a short-term caretaker contract to practices (GMS & APMS) within BLMK boundary is essentially a stabilise and turn around position prior to going out to the open market procurement for a longer-term contract of circa 9 years. The ICB has been transparent in its approach when it issued a PIN notice on the procurement portal. There has been no challenge to the ICBs approach at the time of writing this paper.

Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☒	No ☐

The risk is on the primary care risk register.

5. Are there any financial implications or other resourcing implications, including workforce?

Yes, there is a financial implication for awarding an APMS contract. APMS contracts have a premium applied, this can be in the range of 10-15% higher than the current annual GMS global sum of £1.265m. In addition, there will be contract mobilisation and procurement costs.

6. How will / does this work help to address the Green Plan Commitments?

Click to view Green Plan

7. How will / does this work help to address inequalities?

The priority is to ensure continuity of care for patients and for the new provider to continue to work with patients and key stakeholders to deliver services within the local community that support delivery of the health inequality agenda.

8. Next steps:

Due to the timeline of receipt of the termination notice over the Christmas and New Year period and the requirement to provide the partnership the opportunity to rescind their notice of resignation on the 15 January, the Chief Primary Care Officer briefed the Chief Executive and Executive Team whilst progressing this urgent/emergency programme of work. A paper was presented to the Executive Team and the Primary Care Delivery Group (PCDG) in January 2023 and approval was given to commence the urgent procurement in January 2023.

Due to the urgency and timeline the ICB has commenced the procurement process on 19 January 2023. The tender was issued on 21 February and the deadline for submission of bids is noon on 10 March 2023. This will be followed by evaluation and moderation of bids with the aim to recommend preferred provider by early April 2023.

The PIN notice and advert for this contract was circulated to all BLMK GP practices. Practices were also sent the links to the procurement portal when the tender was released. The ICB is anticipating receiving bids based on the information we have received from our specialist procurement advisors as a result of expressions of interest and questions being raised by potential bidders.

9. Appendices

Appendix A – anticipated procurement timeline (may be subject to change if the other options are required.).

10. Background reading

Procurement Timeline for Ivel Medical Centre contract

Commence Procurement – anticipated dates may be subject to slight change		
19 January 2023	The ICB will commence procurement to secure a new contractor to take over running of IMC. Release a PIN notice.	Pin notice will be issued for a period of 2 weeks to seek Expressions of Interest (EOI) and or identify risk of a legal challenge.
30 January 2023	Procurement EOI closes.	ICB reviews the position with its specialist procurement advisors and assesses procurement risk and proceeds with option A or applies option B.
21 February 2023	ICB either issue the procurement tenders to the BLMK practices or uses NHSE PDPS Framework.	
3 March 2023	Submission of tenders/bids.	For evaluation.
6 March – 31 March 2023	Evaluation and moderation of tenders/bids.	ICB governance and appropriate committee to approve contract award to recommended bidder.
3 April 2023	Inform bidders successful and unsuccessful.	Enter mandatory 10 day stand still period.
14 April	Contract award.	ICB will work with the successful bidder to prepare contractual documents and commence mobilisation.
14 April	ICB releases communications confirming contract award and confirms the successful bidder.	Communications to patients, staff, and key stakeholders.
17 April – 31 May 2023	Contract mobilisation.	
1 June 2023	Contract commences.	

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Report to the Primary Care Commissioning & Assurance Committee 17 March 2023
10. Acute Respiratory Infection Hubs 2022/23

Vision: "For everyone in our towns, villages and communities to live a longer, healthier life"	
Please state which strategic priority and / or enabler this report relates to	
Strategic priorities	
☒	**Start Well:** Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
☒	**Live Well:** People are supported to engage with and manage their health and wellbeing.
☒	**Age Well:** People age well, with proactive interventions to stay healthy, independent and active as long as possible.
☐	**Growth:** We work together to help build the economy and support sustainable growth.
☒	**Reducing Inequalities:** In everything we do we promote equalities in the health and wellbeing of our population.

Enablers			
Data and Digital ☒	Workforce ☒	Ways of working ☒	Estates ☒
Communications ☒	Finance ☒	Operational and Clinical Excellence ☒	Governance and Compliance ☐
Other ☐(please advise):			

Report Author	Amanda Flower, Associate Director, Primary Care Commissioning & Transformation BLMK ICB
Date to which the information this report is based on was accurate	7TH March 2023
Senior Responsible Owner	Nicky Poulain, Chief Primary Care Officer BLMK ICB

The following individuals were consulted and involved in the development of this report:
PCN Clinical Directors Primary Care Providers BLMK General Practice Teams NHSE/I
This report has been presented to the following board/committee/group:
N/A

Purpose of this report - what are members being asked to do?

The members are asked to **note** the following:

A) Progress Update and next steps - Acute Respiratory Infection (ARI) Hubs

Acute Respiratory Infection (ARI) Hubs

Background

To support access for the population during winter 22/23 additional funding (£658,000) was confirmed on the 8th of December 2022 from NHSE/I to the ICB. The funding was to provide additional capacity across 7 days for 15 weeks to support the increased incidence of respiratory illness in the paediatric and adult population. A national specification determined that ICBs should set up Acute Respiratory Infection Hubs and BLMK developed a Standard Operational Procedure to ensure standardisation, with providers given the flexibility to modify at place with practices/PCNs.

The model for ARI Hubs was to be locally designed but should build on the vision presented in the Fuller Stocktake report for the integration of primary care – provision of a same day response in primary care & creating time for continuity of care through a residents usual registered GP.

Progress update

BEDOC mobilised a 5-day service from 4/1/23 to Bedford Borough. The service is delivered from Shortstown Surgery.

Evexia launched a 7-day model for Luton from 3/1/23. The service is delivered from Gardenia and Marsh Farm Practices.

MKUCS launched a 5-day model for Milton Keynes on 9/1/23 and scaled to a 6-day model. The service is delivered from the MK Urgent Treatment Centre.

In Central Bedfordshire a 5-day model is being delivered by the following PCNs to their population.

- Chiltern Hills went live from 28/12/22
- Leighton Buzzard went live from 9/1/23
- Titan went live from 9/1/23

Bedoc & Evexia have supported Hillton, Ivel Valley South and Sandhills and the 4 managed practices and all of CB at the weekends.

From mobilisation (phased as described above) to the 5th March 2023 the ARI Hubs have delivered an additional 4,809 face to face appointments.

Next steps

Funding is only available to 31st March 2023 only and Hubs will cease after this date. The Hub model will be evaluated fully and will form an integral part of the BLMK Winter planning for 2023/24. Feedback to date from patients and professionals has been extremely positive and the intention would be to mobilise this earlier (subject to funding) next Winter to ensure the best impact for our system.

1. Summary of key points:		
2.1 Note the update on Acute Respiratory Infection Hubs		
2. Are there any options?		
N/A		
3. Key Risks and Issues		
N/A		
Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☐	No ☒
'Winter' is not specifically recorded on the primary care risk register however risks pertaining to primary care access generally are included.		
4. Are there any financial implications or other resourcing implications, including workforce?		
N/A		
5. How will / does this work help to address the Green Plan Commitments? Click to view Green Plan		
Ensuring reduced patient travel burden and that patients are seen first time in the right place by the right professional.		
6. How will / does this work help to address inequalities?		
Supporting access across our system for the population.		
7. Next steps:		
To fully evaluate the ARI Hubs and include in 23/24 Winter Planning for rapid mobilisation.		
8. Appendices		
N/A		
9. Background reading		
N/A		

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Report to the Primary Care Commissioning & Assurance Committee 17 March 2023
11. Universal Offer Update ***Personal Medical Services (PMS) reinvestment proposal and principles for 2022 -2024/2025***

Vision: "For everyone in our towns, villages and communities to live a longer, healthier life"	
Please state which strategic priority and / or enabler this report relates to	
Strategic priorities	
☐	**Start Well:** Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
☒	**Live Well:** People are supported to engage with and manage their health and wellbeing.
☒	**Age Well:** People age well, with proactive interventions to stay healthy, independent and active as long as possible.
☒	**Growth:** We work together to help build the economy and support sustainable growth.
☒	**Reducing Inequalities:** In everything we do we promote equalities in the health and wellbeing of our population.

Enablers			
Data and Digital ☒	Workforce ☒	Ways of working ☒	Estates ☒
Communications ☒	Finance ☒	Operational and Clinical Excellence ☒	Governance and Compliance ☒
Other ☐ (please advise):			

Report Author	Cerys Gravener Primary Care Commissioning Manager
Date to which the information this report is based on was accurate	02.03.2022
Senior Responsible Owner	Amanda Flower Associate Director Primary Care Commissioning & Transformation Lynn Dalton Associate Director of Primary Care Development

The following individuals were consulted and involved in the development of this report:
Amanda Flower, Associate Director of Primary Care Commissioning & Transformation Lynn Dalton, Associate Director of Primary Care Development Edna Muraya, Senior Finance Manager
This report has been presented to the following board/committee/group:
Primary Care Delivery Group verbal update on 7th March 2023.
Purpose of this report - what are members being asked to do?
The members are asked the following: 1) **Note** the status update of the programme of work 2) **Provide support** to proceed with services for inclusion at the price proposed within financial schedule (Appendix A). 3) **Note** the next steps to achieve delivery of the Universal Offer.

1. Brief background / introduction:

The Personal Medical Services (PMS) re-investment proposal has been reviewed by the ICB Primary Care Delivery Group (PCDG) in October 2022 and the Primary Care Commissioning & Assurance Committee (PCCAC) in November 2022.

The PMS reinvestment budget is £5,367,572 which is being utilised to develop a range of services for inclusion in a new BLMK wide Universal Offer.

As we approach the new financial year we continue to work with stakeholders to finalise the service schedules, the proposed approach to mobilisation, and outline the remaining steps to achieve delivery and coverage of the Universal Offer. The universal offer is an important enabler for the delivery of the BLMK Fuller Programme. Stakeholders from across the ICB have contributed to the planning and design of the Universal Offer as shown in illustration 1 below.

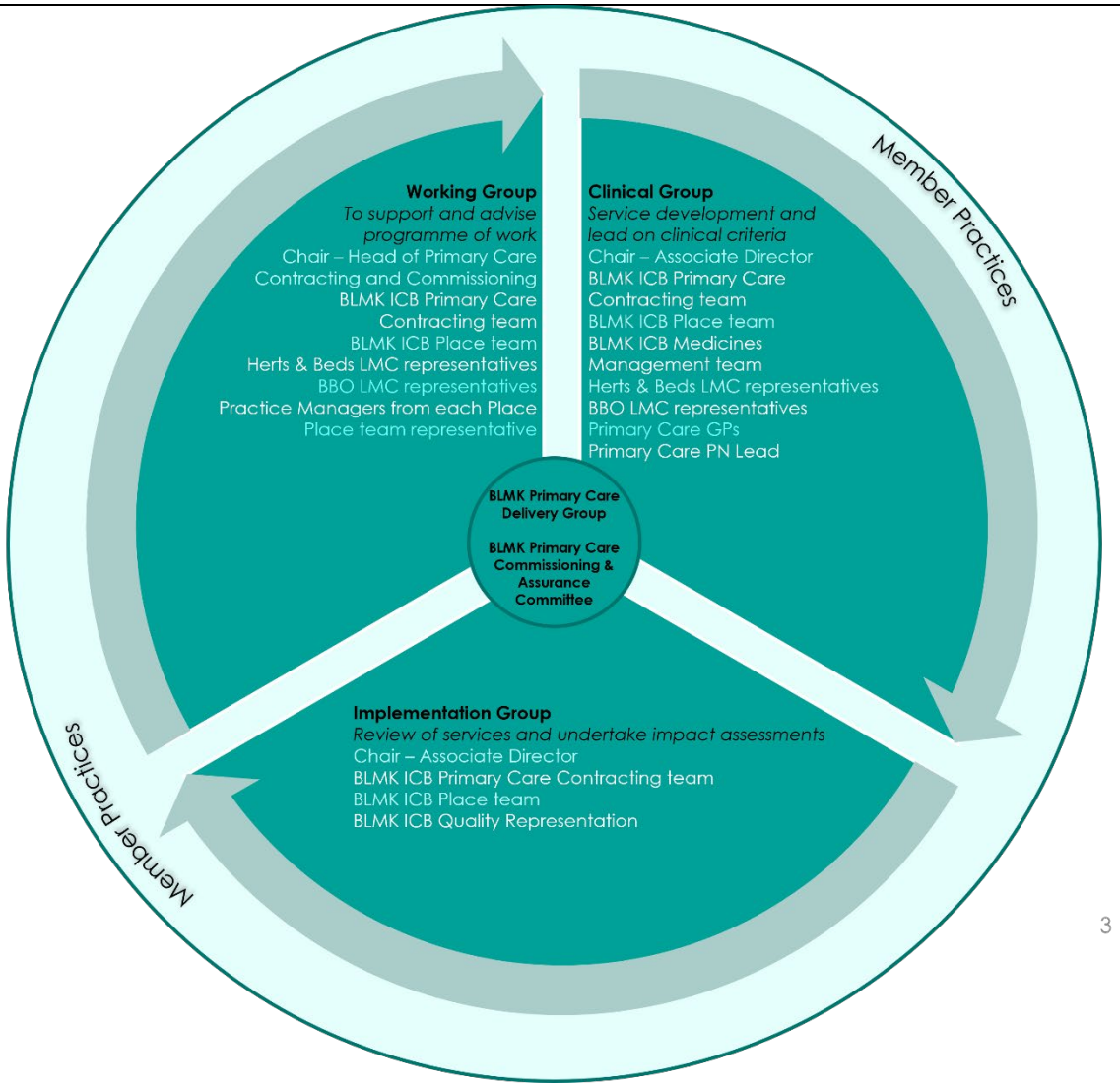

Illustration 1

The schedule of services (Appendix A) has been developed, through dialogue, and adjusted to meet identified clinical priorities across BLMK. The included services will support an equitable level of care delivery and support a reduction of health inequalities. The schedule has been discussed throughout with LMC colleagues to understand and mitigate any immediate concerns.

In summary the Universal Offer has 4 components covering a number of offers for the population:

Component 1 – Treatment Room Services

- Wound dressings
- Ulcer dressing incl. doppler
- Sutures and Staples
- 12 Lead ECGs
- Fuller Proactive Care for LTCs

Component 2 - Long Term Condition Recovery and Transformation

- Diabetes Structured Education
- Gestational Diabetes
- Diabetes 8 Care Process Completion

- Hypertension Monitoring
- Asthma Management

Component 3

- Phlebotomy

Component 4 – Facilitating primary Care Services (that may benefit from at scale delivery)

- Spirometry Hubs
- Ear Wax Removal

In the last year considerable planning and evaluating of both PMS reinvestment and Locally Commissioned Services has taken place which has enabled the formation of the Universal Offer scheme that is consistent for our patient population, of added value to practices, and clinically relevant.

In previous updates we have noted the importance of a phased approach in implementing the Universal Offer, to support practices to mobilise safely and efficiently. This approach is to be maintained; therefore the schedule of services has been divided into 4 separate components that can be introduced gradually as shown in the schedule at Appendix A.

The ICB has maintained communication with practices throughout and they have been advised that there will be no change to the current PMS reinvestment funding and practice income will remain protected for the delivery of the existing PMS reinvestment programme. As we now reach the end of the design and planning stage, the aim would be to enter a period practice engagement. The intention is to host webinars in each place to describe the Universal Offer in more detail, socialise the schedule of services and provide an extensive list of FAQ's. Once these have taken place it will enable a confirmed schedule for mobilisation.

The Quality Impact Assessment (QIA) process has commenced through the implementation group who will oversee the QIA process, review the outcome and recommendations on next steps. This will ensure we have a robust view of services which should move from the scope of the (PMS) Universal Offer to a Locally Enhanced Service or those that are no longer required.

2. Summary of key points:

The members are asked the following:

1) **Note** the status update of the programme of work
2) **Agreement to proceed** with services for inclusion at price proposed within financial schedule (Appendix A)
3) **Outline the next steps** to achieve delivery of the Universal Offer.

3. Are there any options?

The ICBs expectation is to commission the majority of new universal offer directly from GP practices. Practices will have the option to sign up to deliver at practice level or where services lend better to a scaled delivery – such as spirometry – this will be facilitated.

4. Key Risks and Issues

- GP Engagement – requires on-going intensive joint working – utilising clinical leadership to design schemes with discussion through clinical and stakeholder group and planned webinars.
- Capacity and complexity – requiring a phased approach over two years.
- Patient expectation – requires communication and engagement including with MP's and other patient advocates / groups.
- Differing historical budgets in each of the previous (CCG) areas - Working with PMs within working group to assess and mange impact on practices of any changes.
- Ensuring engagement with the LMCs.
- Timeframe for delivery - mitigation - a phased approach.

Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☐	No ☒

PMS reinvestment to be considered for inclusion on the primary care risk register.

5. Are there any financial implications or other resourcing implications, including workforce?

[please outline sources and applications of funds and people resources required to deliver the work**]**

The PMS re-investment budget of £5.37million is now included in the baseline delegated budget. There is a commitment to spend the PMS budget, to support a universal offer

- Total budget £5,367,572 million.

6. How will / does this work help to address the Green Plan Commitments?

Click to view Green Plan

Support delivery of right care, right place, right time.

7. How will / does this work help to address inequalities?

- Focusing PMS reinvestment on supporting primary care access to vulnerable groups to address inequalities
- By being evidence based to provide better outcomes for population and improve the health & wellbeing of the population.
- To enhance patient experience, quality, and access to care particularly for more vulnerable patients and those with chronic and long-term health conditions.

8. Next steps:

- Full agreement of the schedule of services including financial modelling through governance and with all stakeholders
- Finalising of the Universal Offer Specification
- Implement a series of place webinars for practice engagement to support mobilisation of universal offer
- QIA to be undertaken for services currently outside of scope of the Universal Offer and review the outcome through the implementation group and with stakeholders.

9. Appendices

Appendix A - Schedule of services and financial proposal.

10. Background reading

N/A

UNIVERSAL OFFER REMUNERATION PROPOSAL- FEBRUARY 2023

Component 1-Treatment Room Services				
Service name	**Service requirements**	**Evidence submission**	**Period**	**Avg cost per 1,000 pop**
Wound Dressings	Delivery of direct evidence-based wound care assessment and treatment by competent/skilled primary care staff- • Treatment for post operative wound care, new application of dressing and re application of bandages • Practice maintenance of internal protocols, patient records, stock	Year 1 on capitation until baseline established, thereafter practice claim to be made on activity	April 23-Mar 24	£657.58
Ulcer dressings including doppler	Practices will care for patients with ulcers; initial and ongoing management- • Patient assessment and triage of leg ulcers including doppler where necessary • Initial management of venous leg ulcers before referral to Tissue Viability Service (TVS)			£589.27
Sutures and Staples	Practices will carry out the removal of sutures and staples related to third party procedures on request			£91.07
12 Lead ECGs	Practices will provide 12-lead ECGs to their patients for all purposes, including for memory clinic referrals, when requested by local hospitals and for the purposes of primary care diagnostics.			£357.38
Fuller Proactive Care- Long term conditions – pro-active care to those with greatest clinical need and complex patients	Identification of people with unmet clinical need and requiring support for further optimisation and risk reduction- • Undertake 6 monthly running of reports to highlight missed diagnoses • Undertake 6 monthly running of reports to identify patients with LTC at high risk of adverse outcomes • Routine LTC reviews to occur for all people living with LTCs • Practices to develop (and build upon existing arrangements) to establish multi agency, multi-disciplinary team reviews to support management of the most complex patients (these can be face to face or virtual) to support management of the most complex patients	Review of reporting		£400.00
Total (component 1 only)				**£2095.30**
Component 2-Long Term Conditions (LTC) recovery and transformation				
Diabetes Structured Education	Improve and engagement with the diabetes structured education programme- • Undertake a backdated running of report to review how many / what proportion of people first diagnosed with type 2 diabetes in 22/23 have a record of attending diabetes structured education in 21/22.	Performance based payment for recorded attendance pp (no upper or lower threshold)	April 23-Mar 24	£40.00
Gestational Diabetes	Practices to keep a register of patients with previous gestational diabetes (who have not subsequently developed type 2 diabetes) and to offer follow-up in line with NICE guidance • Practice to hold a register of patients with previous gestational diabetes (and who do not have type 2 diabetes) • Post-natal glycaemic check in line with NICE guidance • Practice to offer annual HbA1c for this patient cohort with appropriate subsequent care provided • Discussion of results after a glycaemic check • Practice to offer eligible patients referral to NHS Diabetes Prevention Programme	Performance-pay pp (no upper or lower threshold)		£70.00
Diabetes 8 Care Process Completion	To encourage all 8 care processes to be completed for all patients living with diabetes, reward good practice ensuring that missed opportunities are avoided. Practice to endeavour for every person with diabetes to receive- • Blood tests: (no need for fasting sample) 1. HbA1c 2. Creatinine 3. Cholesterol • Urine test: (no need for morning sample) 4. Urine albumin/creatinine ratio • Physical checks: 5. Blood pressure recording 6. Weight / BMI recording 7. Foot examination • Verbal enquiry: Smoking status recording	Performance with threshold target Lower threshold: 20% Upper threshold: 90% Min payment: £5 pp Actual dependent on achievement:£10 pp		£270.00

UNIVERSAL OFFER REMUNERATION PROPOSAL- FEBRUARY 2023

Hypertension Monitoring	To support recording of blood pressure in people with hypertension- • Practice must have reached 65% of patients with hypertension having had a BP recorded this financial year • After the 65% threshold has been passed, the practice will receive a payment for each additional patient with hypertension who has a BP recorded this financial year, until they have reached 90% achievement. • Any activity between the 65% and 90% thresholds will qualify for payment. • Clinic BP readings as well as average home readings are suitable and qualify for this scheme/payment. • For clarity, only activity within the 65% and 90% thresholds will count for payment. After the 90% threshold has been reached by a practice, no further incentive payments can be gained under this scheme this financial year	Performance with threshold target Lower threshold: 65% Upper threshold: 95% Min payment: £3 pp Actual dependent on achievement:£4 pp		140.00
Asthma management	• Reduce the proportion of people with asthma and potential SABA overuse	Performance with threshold target Lower threshold: 75% Upper threshold: 95% Min payment: £10.50 pp Actual dependent on achievement:£15 pp		140.00
Total (component 2 only)				**£660.00**
Proposed cost per 1000 population (Component 1+2)				**2755.30**
Total (Population 1097000 accurate as of 1st Jan 2023) (Component 1+2)				**£3022565.72**
Component 3				
Service	Service description	Evidence submission	Period	Total budget
Phlebotomy	This service will support practices to provide a phlebotomy service in their practice premises, encompassing all blood sampling for investigations and follow up arising from the management of patients in primary care (including routine housebound patients)- • Take blood samples as required based on medical need • Record blood test results on the clinical system and ensure that this data is auditable. • Maintain patient record and provide communication on the process	Activity	April 23-Mar 24	1483308
Total (component 3 only)				**1483308**
Component 4-Primary care services at scale				
Spirometry Hubs	• To undertake spirometry/FeNO testing as per published quality standards for suitable adults and children to enable accurate diagnosis and optimise future therapy (Activity payments of £43 for Spiro and £18 for FeNO) • Patients will be referred into the Primary Care Respiratory Diagnostic Hub for assessment • The appropriate clinician from the patient's practice will contact the patient to discuss the results and any therapy required	Activity	April 23-Mar 24	527000
Ear Wax Removal	• Assessment of patient • Attempt to remove was using appropriate equipment	Activity	July 23-Mar 24	330000
Total (component 4 only)				**857000**
Summary				
PMS budget				5367572
Contingency				4698.28
Total spend				5367572
Balance				0

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Primary Care Commissioning & Assurance Committee 17 March 2023
12. Primary Care Directorate Risk Register

Vision: "For everyone in our towns, villages and communities to live a longer, healthier life"	
Please state which strategic priority and / or enabler this report relates to	
Strategic priorities	
☒	**Start Well:** Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
☒	**Live Well:** People are supported to engage with and manage their health and wellbeing.
☒	**Age Well:** People age well, with proactive interventions to stay healthy, independent and active as long as possible.
☒	**Growth:** We work together to help build the economy and support sustainable growth.
☒	**Reducing Inequalities:** In everything we do we promote equalities in the health and wellbeing of our population.

Enablers			
Data and Digital ☒	Workforce ☒	Ways of working ☒	Estates ☒
Communications ☒	Finance ☒	Operational and Clinical Excellence ☒	Governance and Compliance ☒

Report Author	Jill White Senior Primary Care Contracting Manager
Date to which the information this report is based on was accurate	03/03/23
Senior Responsible Owner	Nicky Poulain Chief Primary Care Officer

The following individuals were consulted and involved in the development of this report:
Risk leads as named on the risk registers.
This report has been presented to the following board/committee/group:
None.
Purpose of this report - what are members being asked to do?
The members are asked to **note** that risks relating to the primary care directorate are being identified and managed appropriately. All risks continue to be logged and monitored in the 4Risk system.

Executive Summary Report

The primary care directorate and digital risk registers are attached for information and assurance that risks have been correctly identified and are being suitably managed.

1. Brief background / introduction:		
The primary care directorate risk register is reviewed at regular intervals by risk leads and monthly at the Primary Care Interconnectivity Meeting to ensure risks are highlighted to and owned by all relevant stakeholders. It is also reviewed bi-monthly at the Primary Care Delivery Group. The risks associated with the transition work for community pharmacy, optometry, and dental (POD) delegated commissioning is included. The primary care digital risk register is maintained by the digital team and reviewed on a regular basis, either monthly or when programmes are updated or closed.		
2. Summary of key points:		
All risks are outlined on the attached registers and managed as part of the relevant programmes of work.		
3. Are there any options?		
NA		
4. Key Risks and Issues		
See risk register attachments.		
Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☒	No ☐
Risk refs as given on the registers.		
5. Are there any financial implications or other resourcing implications, including workforce?		
As outlined on the risk registers.		
6. How will / does this work help to address the Green Plan Commitments? Click to view Green Plan		
Managing risks well will ensure greater long term sustainability.		
7. How will / does this work help to address inequalities?		
Managing risks well will help to address inequalities in delivery of services.		
8. Next steps:		
To continue to manage and monitor risks as part of each programme of work.		
9. Appendices		
Appendix A – Primary care directorate risk register Appendix B – Primary care digital risk register.		
10. Background reading		
NA		

Risk Area	Risk Ref	Created Date	Risk Owner	Risk Lead	Risk title	Risk Description	Escalate to Corporate RR	Initial Score	Risk Control	Current Score	Action Required	Target Score
Corporate Risk Register	CRR 76	23/07/2021	Nicky Poulain	Amanda Flower	111 capacity and resilience	As a result of increasing patient reliance and demand within the BLMK system there is a risk that: - 111 call volumes will remain higher than those able to be commissioned - staff capacity will not meet patient match demand due to high staff attrition rates as a result of pay grades in a competitive market and in an increasingly stressful working conditions. This could result in an increase in abandoned calls which would lead to inappropriate use of urgent and emergency service or patients failing to seek help at all.	Yes	I = 4 L = 4 16	• Fuller programme - Urgent same-day care workstream in BLMK - monthly highlight report • National integrated urgent care (IUC) modelling work ahead of winter to support demand profiling • Local IUC modelling and forecasting • Co-production of pan-HUC recovery plan • Transformation work as part of contract negotiations with HUC and DHU • Monthly provider/commissioner meetings with national IUC team Control Owner: Amanda Flower	I = 3 L = 4 12	Planning assumptions to be challenged with providers focusing on finding efficiencies and reviewing investment - contract review meeting taking place with HUC on 30/9 to discuss these issues. Implementation of 111 single virtual call centre (regional call management) - planned go live anticipated -pending April 22 Providers to continue to recruit call handlers to increase capacity Person Responsible: Steve Gutteridge To be implemented by: 1st May 23	I = 3 L = 2 6
Primary Care	R 1	06/03/2021	Nicky Poulain	Lynn Dalton	GP practice resilience	As a result of the multiple factors impacting on BLMK general practices (including fuel bills, national contract negotiations, the increased needs of patients and other demands), there is a risk that practices will become increasingly more vulnerable and less resilient, which may result in access issues, referral variation, reduced morale, reduced workforce, restriction of services delivered, impacted CQC ratings, an increase in acute care access with its resulting financial impact to the CCG, as well as an inability to transform in line with ICS priorities.	No	I = 4 L = 4 16	•Workforce Development Programme •ARRS recruitment and retention initiatives •Releasing Time for Care programme •Estates and technology development •working with the national team for offers of phone system to practices/PCNs •Further primary care network development •GP Resilience Programme •Place-based teams •RCGP support •Digital development with supported training schemes for staff and patients •Facilitating practice merger support •Pre/post-CQC support •PC Quality Dashboard to monitor individual practices which are struggling •Focussed access clinical leadership to embed practices/PCNs engagement to drive the access Task Group's work •Working with PPGs/Health Watch and ward & town councillors to improve understanding and support for practices who are struggling to meeting patient demand Control Owner: Lynn Dalton	I = 3 L = 3 9	Ongoing use of controls to support general practice across BLMK. Person Responsible: Lynn Dalton To be implemented by: 1st June 2023	I = 2 L = 2 4
Primary Care	R 2	13/03/2021	Nicky Poulain	Lynn Dalton	Practices' capacity to host students	As a result of the current resilience issues facing multiple BLMK practices, there is a risk that some practices will not have the resource and capacity to maintain or expand their training / mentorship provision, which may result in a reduction in the number of students training in general practice and impact on the development of the future workforce and the capacity of general practice to innovate and transform in line with ICS strategy.	No	I = 3 L = 4 12	•BLMK Training Hub schemes and leads •Continued assessment of capacity/support needed •Technology has been implemented with ongoing training opportunities •Clinical leads in post to support with PC development •Training hub placement expansion workstream in partnership with the primary care school Control Owner: Susi Clarke	I = 2 L = 3 6	Continued assessment of situation and use of controls as listed. Ongoing review with primary care school and programme directors Cross reference with estates programme regarding premises capacity Person Responsible: Susi Clarke To be implemented by: 31 Mar 2023	I = 2 L = 1 2
Primary Care	PCN 1	13/03/2021	Nicky Poulain	Nicky Poulain	Variations in services across PCNs	As a result of the varying ambitions beyond services and characteristics explicit in the PCN DES, there is a risk that services, access and patient experience may vary between PCNs across BLMK resulting in inequitable services for patients, inequalities in patient population, variations in outcomes and variations in work backlogs.	No	I = 3 L = 3 9	•Place based team support •PCN DES •Maturity Matrix/BLMK dashboard assessment •Clinical leadership support and development training •Population Health Management/Business Intelligence outputs •Primary Care Strategy •ICP, ICS, Partnership Board Control Owner: Nicky Poulain	I = 2 L = 2 4	Continue to provide consistent offers of support across BLMK: - Continued work with Quality Team - BLMK Access Group - Maturity Matrix reviews - DES assurance reporting - PCN plans for enhanced access provision from 1 Oct Re-engagement with Primary Care Home model Person Responsible: Lynn Dalton To be implemented by: 31 March 2023	I = 1 L = 1 1
Primary Care	PCN 2	13/03/2021	Nicky Poulain	Lynn Dalton	Recruitment to ARRS roles	As a result of system-wide workforce challenges and complications around employment there is a risk that PCNs may struggle to recruit to PCN DES reimbursable roles resulting in patients not benefitting from the additional capacity and PCNs having less capacity to deliver the PCN DES specifications.	No	I = 3 L = 4 12	• Support and relationship management from PC team including resources (materials/ skills/ expertise) available from training hub • Continued work with wider provider partners to offer scaled and resilient solutions • Support from CCG to work up PCN workforce plans • Primary Care Careers commissioned to support all PCNs with recruitment processes • Encourage PCNs to diversify workforce profile • PC training hub supporting onboarding, CPD and FCP roadmap • Increasing supply chain eg nursing associates, student clinical pharmacists Control Owner: Lynn Dalton	I = 3 L = 3 9	Continued support provided as per controls Work with regional team to review trust rotational models Month on month place WTE reporting Person Responsible: Susi Clarke To be implemented by: 31 Mar 2023	I = 2 L = 2 4
Primary Care	R 3	11/05/2021	Nicky Poulain	Lynn Dalton	Potential GP staff staff burnout	As a result of the increasing asks of general practice across BLMK and post-lockdown backlogs to be addressed there is a risk that there will be an increasing level of staff 'burnout' resulting in increasing resilience issues with practices, low morale and a rising level of vacancies	No	I = 4 L = 3 12	•BLMK Primary Care Team support and representation at system level •Primary care involvement in system transformation •Training Hub engagement and support •Communications campaign •CCG/LMC meetings •Access Group •Acute Trust Clinical Forums supported by Clinical Transformation Directors •Primary care health and wellbeing project well embedded Control Owner: Susi Clarke	I = 3 L = 3 9	Continued implementation of controls Support from place based teams and senior team to address avoidable asks of primary care on an ongoing basis Person Responsible: Susi Clarke To be implemented by: 1st June 2023	I = 2 L = 2 4

Primary Care	PCN 3	02/07/2021	Nicky Poulain	Nikki Barnes	Accommodation for ARRS roles	As a result of there not yet being any formally agreed national policy on the funding stream for space to accommodate staff recruited into the PCN ARRS, there is a risk that the CCG will enter into agreements to lease accommodation to alleviate this premises issue, which may result in an impact on the revenue budget, or PCNs may experience operational issues including recruitment & retention challenges relating to inadequate premises capacity which could reduce the value of the ARRS investment funding. **UPDATE Oct 2022** Announcement of national capital funding has been made but does not include recurrent revenue funding so does not alleviate this risk	No	I = 4 L = 3 12	BLMK estates workstream to identify possible solutions for addressing individual PCN needs Prioritisation panel took place during Nov 2022 confirming which schemes ICB can afford to support, including quantification of risks associated with not progressing projects identified as being required, and decisions were ratified by chair's action group Dec 2022 Ongoing discussions within ICB around management of this risk, including Board seminar 24/02/23 Control Owner: Nikki Barnes	I = 3 L = 3 9	Continue to progress work plan following outcome of prioritisation panel Work closely with place teams to support PCNs to manage operational pressures and explore innovative solutions to constraints Person Responsible: Nikki Barnes To be implemented by: 31 Mar 2023	I = 1 L = 1 1
Primary Care	R 4	06/09/2021	Nicky Poulain	Amanda Flower	Access to primary care - rising patient demand	As a result of increasing patient demand within primary care there is a risk that practices will struggle to meet patient need which could result in high staff turnover, reluctance to fill overtime shifts and issues with recruitment. **Update November 22** Demand for general practice remains high. There are resilience challenges in some practices due to staff recruitment and retention. • Activity levels in primary care are higher than pre pandemic levels and continue to rise. • BLMK is ranked highest for face-to-face appointments. • The GP Survey published in July 22 indicates BLMK at 64% are below the national figure of 72% for 'Good' experience at their GP practice and BLMK has a higher percentage of people having difficulty getting through on the phone than the national average. • On 24th Nov GP access data was published by the govt. This included total number of appts, number of appts face-to-face, number of appts with a GP/other professionals & number of same day appts provided. Locally this information is being collated and benchmarked.	No	I = 4 L = 4 16	Collaborative approach with population and system partners to develop and deliver the Fuller Programme to support development and transformation of integrated primary care, organised around 4 pillars: 1. Development of neighbourhood teams 2. Provision of same day (urgent) primary care 3. An integrated approach to prevention 4. Providing continuity of care through a coordinated MDT approach to the population most at risk of adverse health outcomes. Using a data driven approach our specific access areas of focus are: • Workforce • Digital/telephony • Community Pharmacy GP Referral Scheme • Facilitating a 'learn and share' approach through the provision of webinars; and the development of a 'top tips' to support practices in delivering access • Communications campaign (placed based comms to explain current primary care offer launched in Nov 22) • Bespoke support for practices with the most significant access challenge, including access to the NHSE/I acceleratory programme • Work to support the primary/secondary care interface Control Owner: Amanda Flower	I = 3 L = 3 9	Take a transparent data driven approach Continued development and implementation of support/access improvement projects via BLMK Access Group and sub-groups (as described in risk controls) Facilitate discussions with practice/PCN/place stakeholders to support system programme approach to access Launch and develop new monthly place based communications campaign/approach explaining primary care/general practice Develop a learn and share approach through regular webinars and sharing top tips with practices Provide bespoke support to practices with most significant challenge Person Responsible: Amanda Flower To be implemented by: 31 March 2023	I = 3 L = 2 6
Primary Care	POD 1	22/04/2022	Nicky Poulain	Lynn Dalton	PC team capacity to take on POD commissioning	As a result of the delegation of primary care pharmacy, optometry and dentistry to CCGs, there is a risk that capability and capacity of the primary care team will be inadequate resulting in a failure to properly manage and monitor the contracts and a possible overspend on the CCG's running cost allowance	No	I = 3 L = 4 12	• AD of Primary Care Development working closely with NHSEI regional team through the transition period • ICB Chief Exec has signed off national delegation agreement for GP contracts from end of year; POD agreement to be signed later this year. • First draft of ICB pharmacy strategy has been developed and circulated to system partners for comment • Optom & pharmacy contract teams to be kept together and hosted by H&WE ICB on behalf of all system ICBs. All remain employed by NHSE at this time. • Dedicated programme management support now in place through regional funding provided to all ICBs • Allocation of dental commissioning staff now confirmed Control Owner: Lynn Dalton	I = 3 L = 3 9	Refresh of primary care strategy to encompass commissioning of POD - awaiting ICB clinical strategy Once we are able to link directly with the dental commissioning team transferring to the ICB: • Mapping of primary care team members' previous knowledge and experience to understand who may already have some relevant skills and knowledge • Review current running cost allowance to ensure adequate capacity within team for this new workstream Collaborative working & reporting MOU to be finalised for pharmacy & optom to underpin commissioning team arrangements from April 2023. Person Responsible: Liz Eckert To be implemented by: 31 Mar 2023	I = 2 L = 2 4
Primary Care	R 11	21/07/2022	Nicky Poulain	Nikki Barnes	GP premises constraints	As a result of population growth and increased demand for services, along with budget constraints for the ICB, there is a risk that some practices across BLMK will not have sufficient premises capacity to support delivery of the full range of face-to-face services and to enable them to keep their patient lists open to new registrations. This could result in an inability for practices to participate in workforce development schemes and an a negative impact on the reputation of primary care amongst our partners. **UPDATE Oct 2022** Announcement of national capital funding has been made but does not include recurrent revenue funding so does not alleviate this risk	No	I = 3 L = 4 12	Primary Care Estates Strategy identifies projects likely to be required to ensure adequate primary care premises capacity across BLMK Number of premises projects underway at various stages (delivered / under construction / at planning stage / not yet started) Heads of PC at place maintain good working relationships with local authority partners and provide assurance to overview & scrutiny committees. Prioritisation panel took place during Nov 2022 confirming which schemes ICB can afford to support, including quantification of risks associated with not progressing projects identified as being required, and decisions were ratified by chair's action group Dec 2022. Ongoing discussions within ICB around management of this risk, including Board seminar 24/02/23 Control Owner: Nikki Barnes	I = 3 L = 3 9	Continue to progress work plan following outcome of prioritisation panel Work closely with place teams to support practices with operational pressures, and support them to explore innovative solutions to constraints Person Responsible: Nikki Barnes To be implemented by: 30 Apr 2023	I = 3 L = 3 9
Primary Care	R 6	22/06/2022	Nicky Poulain	Lynn Dalton	Supervision of new non-medical staff in practices & PCNs	As a result of the increased number of new staff requiring supervision there is a risk that practices & PCNs do not have the adequate capacity & capability to provide the necessary support which may result in a negative impact on staff retention and patient care	No	I = 3 L = 3 9	Workforce development programme Control Owner: Susi Clarke	I = 3 L = 3 9	Support to practices to increase supervisory capacity & capability Support to new staff with mentorship, peer support & road map navigation Person Responsible: Susi Clarke Deadline: 31 March 2023	I = 3 L = 2 6

Primary Care	R 7	22/06/2022	Nicky Poulain	Amanda Flower	Resilience of out of hours services in Luton & Beds	As a result of the out of hours provider in Beds and Luton struggling to find enough GPs to fill shifts, there is a risk of inadequate out of hours provision to meet patient need, which could result in inappropriate use of urgent and emergency services or patients failing to seek help at all.	No	I = 4 L = 3 12	HUC have been working to improve relationships with GPs and build trust so there is an increased willingness to work for them A programme of additional actions is underway to address root causes of the problem including safety concerns amongst GPs regarding working at the Luton town centre GP out of hours base Control Owner: Amanda Flower	I = 3 L = 3 9	• Examine staffing mix in clinical assessment services to take a more multi-disciplinary approach & free up GP capacity • Assess 111 pathways to safely reduce reliance on clinical assessment. • Look to agree consistent rate escalation processes and rate caps between providers • Use ICB comms channels to raise awareness of OoH opportunities with local GPs • Develop training & mentorship, through PC Training Hub with OoH providers, for interested GPs who may not be confident in OoH work • Increase opportunities for GP trainees to receive their OoH training with local OoH services to improve recruitment and retention • Facilitate closer collaboration between providers to reduce system risk of inequitable access to urgent & same day care • Encourage transparency with OoH pay rates and escalation processes • Use ICB People Directorate experience and resource to build trust between providers and implement plans • HUC to implement GP out of hours modernisation plan across the HUC footprint (rationalisation of workforce and estate) Person responsible: Steve Gutteridge Deadline: 31 March 23	I = 3 L = 2 6
Primary Care	POD 2	18/11/2022	Nicky Poulain	Lynn Dalton	Quality of POD contracts and processes	As a result of a lack of visibility of the quality of the POD contracts and processes that support the contract management and a lack of contemporaneous contracts, there is a risk that there is more work to remedy the position than the current team transferring can undertake which could result in additional resourcing needs in the short term to rectify, but potentially a greater long term resourcing requirement to manage the contracts in line with the standards of the ICB.	No	I = 3 L = 4 12	AD of Primary Care Development working closely with NHSEI regional team through the transition period Discussions to ascertain the quality of contracts and processes are underway and looking for assurance from NHSE that the issue around contemporaneous contracts will be resolved before the responsibility transfers. Control Owner: Lynn Dalton	I = 3 L = 3 9	Develop a detailed understanding of the quality and process of POD contract management. Ensure that the risk of this is reflected in the MOU for the P&O contracting team so that the risk to the ICB is understood. Understand whether the gap in expectation is as a result of capacity or capability and consider how this might be addressed through training. Person Responsible: Liz Eckert To be implemented by: 31 Mar 2023	I = 2 L = 2 4
Primary Care	R 9	01/12/2022	Nicky Poulain	Lynn Dalton	Industrial action	As a result of the RCN decision to call their nurses out on strike, there is a risk that primary care services will be put under additional pressure, which could lead to an inability to meet patients' needs. To note: nurses are direct employees of GP practices, and under the terms of the GMS contract practices are not obliged to offer Agenda For Change terms pay and conditions. The national position is that the GMS global sum does not provide the funding to employ on this basis.	No	I = 3 L = 3 9	The majority of nurses who will be on strike are not employed by GP practices as only 2 practices offer AfC to their employees. EPRR teams are working at a regional level to manage the response Control owner: Lynn Dalton	I = 3 L = 3 9	Continue to link in with the regional response and monitor potential impact on our area Person Responsible: Lynn Dalton To be implemented by: 31 March 2023	I = 2 L = 2 4
Primary Care	R 10	16/01/2023	Nicky Poulain	Lynn Dalton	Ivel Medical Centre contract resignation	As a result of the notice to terminate their contract by the current GP partners, there is a risk that it will not be possible to find a new provider in the current timescales (by 1 June 2023). This could result in the 13,500 patients currently registered with the practice not having access to primary medical services.	No	I = 4 L = 3 12	Procurement plans have been put in place and PIN notice published asking for EOIs for caretaker provider - 4 responses Contingency plans also made Wellbeing and workforce support offered to practice from PC Training Hub ITT published 21/2/23 Control owner: Lynn Dalton	I = 3 L = 3 9	Work through procurement project plan and continue to adapt as needed to respond to any new developments Training hub to put paramedic lead in touch with practice ECPs Person Responsible: Jill White To be implemented by: 31 May 2023	I = 2 L = 2 4

Risk Ref	Risk Title	Risk Description	Initial Score	Risk Control	Current Score	Action Required	Person Responsible	To be implemented by	Target Score
661	Frontline Digitisation Fund - EPR leveling up Risk Owner: Helen Haumann Risk Lead: Mark Peedle Last Updated: 02 Feb 2023 Latest Review Date: 02 Feb 2023 Latest Review By: Joyce Baskerville Last Review Comments: reviewed	Central funding being made available too late for planned delivery (current) through the Frontline Digitisation Fund. Resulting in delays in delivery of national minimum data standards with regards to clinical patient record, also delays for clinical information to be available for shared health and care record - impacting patient direct care	I = 4 L = 3 12	Awareness raised at relevant levels with the Acute providers and in the ICB	I = 4 L = 1 4	National funding to come through - continue monitoring	Helen Haumann	28/02/2023	I = 3 L = 1 3
				Created local mitigation plans being developed for Bedfordshire Hospitals and progressing with processes needed for funding release		National business case and funding decision is now expected before end Dec	Helen Haumann	30/12/2022	
				Letter of intent and supporting evidence submitted to NHS England for approval by end Jan to facilitate funding release		Letter of intent and supporting evidence to be submitted to NHS England for approval by end Jan to facilitate funding release	Helen Haumann	31/01/2023	
				National business case and funding decision approved and signed off					
ICT 1	Cyber Risk Owner: Helen Haumann Risk Lead: Mark Peedle Last Updated: 08 Nov 2022 Latest Review Date: 25 Jan 2023 Latest Review By: Mark Peedle Last Review Comments: Risk remains open	There is a risk that a Cyber Attack, unpatched devices or user introduced malware (from for example a phishing email link being clicked) could take individual, multiple, departmental or organisational wide system offline.	I = 4 L = 3 12	All Anti-virus and malware patching is complete and up to date	I = 4 L = 2 8	All staff to complete the 202H upgrade, all staff to complete the Office 365 update	Mark Peedle	30/09/2021	I = 4 L = 2 8
				All desktop and laptop devices are upgraded to Windows 10 (from legacy operating systems)		Risk assess implications of energy/fuel disruption on services	Abimbola Hill	04/03/2022	
				All operating systems are regularly updated to the latest version, the latest windows 10 version on 202h and the upgrade is in progress at this time, all staff need to manually update at a time suitable for them. If this is not performed an automatic (mandatory) update will be initiated.		Risk assess implications of supply chain disruption as a result of attack on critical cyber infrastructure	Abimbola Hill	04/03/2022	
						Review cyber security and IT disaster recovery plans	Mark Peedle	04/03/2022	
						Agree Command & Control Structure in the event of incident	Mark Meekins	04/03/2022	
				HBL have Geolocation enabled on the firewalls, RU Ukraine and Chinese domains and IP addresses are blocked, proactive monitoring of the geopolitical landscape is undertaken and threats triaged and handled appropriately.		Review and agree proactive mitigations	Mark Peedle	04/03/2022	
				HBL ICT ensure all perimeter controls (firewalls on HSCN connections) are in place, fully operational and compliant.					
ICT 3	ICS Development - Additional Service responsibility for BLMK Risk Owner: Helen Haumann Risk Lead: Mark Peedle Last Updated: 08 Nov 2022 Latest Review Date: 08 Nov 2022 Latest Review By: Mark Peedle Last Review Comments: Risk remains - to keep on brief regarding POD transfer to the ICB, Risk Lead liaising with the Primary Care team.	As the ICS develops service contracts currently supported by NHS England, such as Dentists, Optoms and Pharmacies, may be transferred to the CCG/ICS - the funding to do this must follow the service.	I = 3 L = 3 9	New equipment ordered but is not yet in due to national supply issues. HBL have sourced 20 laptops to see us through until delivery of new stock but supplies are short.	I = 1 L = 2 2	Provide new equipment as required, ensure that current equipment is recycled appropriately, impress on all staff the duty of care they have for CCG equipment to ensure longevity and reduce waste	Mark Peedle	31/03/2022	I = 1 L = 2 2

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Primary Care Commissioning & Assurance Committee 17 March 2023
13. Report from Estates Working Group

Vision: "For everyone in our towns, villages and communities to live a longer, healthier life"	
Please state which strategic priority and / or enabler this report relates to	
Strategic priorities	
☐	**Start Well:** Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
☐	**Live Well:** People are supported to engage with and manage their health and wellbeing.
☐	**Age Well:** People age well, with proactive interventions to stay healthy, independent and active as long as possible.
☐	**Growth:** We work together to help build the economy and support sustainable growth.
☐	**Reducing Inequalities:** In everything we do we promote equalities in the health and wellbeing of our population.

Enablers			
Data and Digital ☐	Workforce ☐	Ways of working ☐	Estates ☒
Communications ☐	Finance ☐	Operational and Clinical Excellence ☐	Governance and Compliance ☐
Other ☐(please advise):			

Report Author	Nikki Barnes, Head of System & ICB Estates
Date to which the information this report is based on was accurate	3rd March 2023
Senior Responsible Owner	Dean Westcott, Chief Finance Officer Nicky Poulain, Chief Primary Care Officer

The following individuals were consulted and involved in the development of this report:
N/A
This report has been presented to the following board/committee/group:
Project updates reported to Estates Working Group and Primary Care Delivery Group.

Purpose of this report - what are members being asked to do?
The members are asked to **note** the updates provided for Estates schemes underway.

Executive Summary Report

1. Brief background / introduction:

Following completion of the Primary Medical Services (PMS) Estates Prioritisation Process, the focus of the Estates work within the ICB has been on continuing/mobilising delivery of the supported schemes within a phased programme.

This report provides an update for fourteen of the twenty-three prioritised schemes.

2. Summary of key points:

2.1 Following completion of the PMS Estates Prioritisation Process, the focus of the Estates work within the ICB has been on continuing/mobilising delivery of the supported schemes within a phased programme.

2.2 In the context of the available funding, the ICB has confirmed support for twenty-three primary care estates schemes across BLMK, these schemes are at various stages of delivery. This report provides updates on fourteen of these projects.

2.3 There are risks associated with some of the larger schemes, due to factors outside of the control of the ICB. Action is being taken to mitigate these risks as far as possible, and as swiftly as possible, to support delivery.

3. Are there any options?

N/A

4. Key Risks and Issues

The key risks associated with the schemes in the report are:

- North Bedford Hub – risks as a result of national delays to business case approval, and rising construction costs
- Biddenham New Surgery – viability challenges
- Grove View Integrated Health & Care Hub – risk relating to increased service charge costs, and issue around furniture delivery delays
- Ampthill Health Centre – increased service charge costs may affect affordability of the scheme for the practices involved
- Cost pressures for continuation of two PCN Estates schemes
- Timescales for using the financial allocation for inspecting primary care premises for Reinforced Autoclave Aerated Concrete (RAAC).

Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☒	No ☐

Estates Risk Register.

5. Are there any financial implications or other resourcing implications, including workforce?

Most schemes progressing within the budgets allocated via the Primary Care Estates Prioritisation Process.

Cost pressures identified for continuation of two of the PCN Estates Schemes as a result of increased service charge costs for 2023/24. Partially off-set by reduced costs for two other PCN Estates Schemes.

6. How will / does this work help to address the Green Plan Commitments?

Click to view Green Plan

Pilot scheme for Energy Assessments across GP Premises in BLMK Primary Care Settings is expected to improve premises Energy Ratings in line with The Government's mandated Carbon Emission plans and the NHS Net Zero by 2040 targets.

Replacement of poor-quality old buildings with modern compliant premises, which will result in improved energy efficiency.

Travel planning for each scheme, with a focus on sustainable transport modes as far as possible.

7. How will / does this work help to address inequalities?

Supports delivery of the primary care strategy, which includes greater focus on prevention, targeting reductions in inequalities, targeted Population Health Management approaches.

8. Next steps:

Continued delivery of prioritised primary care estates schemes.

Report from: Estates Working Group

To: Primary Care Commissioning & Assurance Committee

Date of Meeting: 17th March 2023

1.0 Introduction

Following completion of the Primary Medical Services Estates Prioritisation Process, the focus of the Estates work within the ICB has been on continuing/mobilising delivery of the supported schemes within a phased programme.

In the meantime, discussions have continued with partners to explore further opportunities for progressing some of the schemes not able to be supported at this stage.

2.0 Progress Update

The updates below describe the status of current Estates projects underway.

2.1 North Bedford Project (Reprovision of The De Parys Group)

The De Parys Group is the largest GP practice in BLMK with a list size of nearly 40,000 patients, and is coterminous with North Bedford Primary Care Network. The practice/PCN operates from six premises across Bedford Borough.

A Full Business Case for the relocation of patient services from four of The De Parys Group premises into the Enhanced Services Centre on Kimbolton Road was submitted to NHS England in September 2022. Funding to support the project was secured in principle from NHS England in 2018, subject to the Full Business Case.

As at the 1st March 2023, approval of the business case is still awaited from NHS England and the Department for Health & Social Care (DHSC). As a result of the delays, it has been necessary to pause aspects of the programme to avoid exposing the system to unaffordable levels of financial risk. The next steps for the project are dependent on the timing of approval of the Full Business Case at a national level.

2.2 Biddenham New Surgery

A business case to deliver a new primary care facility in Biddenham was approved by the former Clinical Commissioning Group in 2020. The scheme will provide new accommodation for the two small branch surgeries in Bromham, providing fit for purpose premises and with sufficient capacity to accommodate housing growth in and around the Biddenham area. It is expected to prevent many rural residents needing to travel into the town centre to access primary care services. The scheme is expected to serve a total of 15,500 patients living in the North-West of Bedford Borough.

Agreement for Leases were signed between the two practices and the developer in May 2022. Planning permission for the scheme and a revised S106 Agreement were finalised and issued in June 2022. Construction was scheduled to start on site in January 2023.

In November 2022, the developer notified the ICB that due to a steep increase in borrowing rates and construction costs, there are challenges to the financial viability of the scheme.

The ICB is working with the District Valuer, the developer, and other regional and national partners to reach an agreeable solution that delivers value for money and supports access to services for residents.

2.3 East MK Expansion Scheme

Designs have been developed for the multi-purpose community hub in the East MK Expansion Area, being funded by Housing Infrastructure Funding. During the summer of 2022 work the ICB supported work with MK Council, CNWL, The Bridge Primary Care Network and a healthcare planner to create a schedule of accommodation and design brief for the planned facility.

The vision is for an integrated community and health facility, which will include a Children's Centre, Library Service, Adult Education Service and an Activity Hall for community use, as well as a kitchen. There will be a range of consultation and treatment rooms for Primary Care, Community Mental and Physical Health Services and some shared office space for the Primary Care Network.

The Primary Care space has been sized to accommodate a list size of up to 10,000 as a branch surgery. Although the new housing development will eventually have more than 10,000 residents, it is expected that a proportion of these residents will already be resident in MK and will remain registered with their existing practice. It is anticipated that this facility will be a branch surgery and an expression of interest process will take place to identify a provider to operate from the premises.

CNWL plan to provide both paediatric and adult physical community health services from the building as well as mental health services spanning from IAPT to consultant led clinics, addressing the needs of the local population.

Planning permission has been applied for and is expected to be approved by the end of March 2023. The target date for contract award is early May, with work expected to start on site in late June. The hub is scheduled to open in Autumn 2024. It will be the first part of the development to be completed, in order to create the community infrastructure prior to the housing construction which is expected to take place from 2024 onwards.

Due to inflation and the current market conditions, the construction cost is expected to be greater than the HIF funding available. MK Council are considering bridging the funding gap by some forward funding in advance of future Tariff receipts likely to be generated by the development. They have confirmed to the ICB that it remains the intention of the Council to provide access to the new facilities to NHS providers at a nominal or peppercorn rent. As expected, occupiers will have to contribute to the shared costs of running the building and this may entail, for a short period, a contribution to the financing costs of any borrowing made by the Council in advance of Tariff receipts. It is envisaged that this will be around £20 per annum per square metre of Net Internal Floor Area and for a period of not more than 10 years.

2.4 Reprovision of King Street Surgery Premises, Kempston

King Street Surgery in Kempston, as part of the Caritas PCN, has a long-standing ambition to relocate into more fit-for-purpose accommodation. King Street Surgery is responsible for the services delivered from King Street Surgery, Cater Street Surgery and St John's Surgery in Kempston. They have a registered list size of 21,821 patients (June 2022).

As the first step in the journey towards new facilities, Bedford Borough Council and the former Bedfordshire CCG commissioned a Strategic Outline Case (SOC), completed in 2019, for the reprovision of the GP practice premises in Kempston into a single consolidated facility. A Strategic Outline Case is a high-level scoping exercise to confirm the feasibility of a project. This piece of work explored the range of services which might be offered from a single facility to enable more joined-up care in the local community, and a number of potential sites in Kempston were identified and appraised.

Based on this work, the former CCG supported the proposed next step of developing a more detailed Outline Business Case, but this was dependent on the ability to secure external enabling funding to

cover the costs of this work. External NHS funding was secured in 2022, and is being held by the Council to support the continuation of the partnership approach to this project.

BLMK ICB (Bedfordshire, Luton & Milton Keynes Integrated Care Board) has recently been through an exercise to prioritise the current revenue budget available for primary care estates for the next few years, and this project has been re-stated by the ICB as a priority. The ICB and Council have therefore commenced planning for establishing appropriate governance arrangements and for the procurement of additional resource to support the delivery of this piece of work. The programme timeline for completion of the business case will be agreed as part of this process.

This next stage of work will include the development of a Clinical/Service Strategy for primary care services in Kempston, based on King Street Surgery's intentions to continue to develop and improve access for patients and their service offer. It will reflect how service delivery has changed over the last few years since the SOC was completed, including digital developments that have offered new ways for patients to speak to their clinician. It will embrace the development of the multi-disciplinary team across the wider Primary Care Network and ambitions for more integrated working arrangements with community health, mental health and wider wellbeing services, potentially including the voluntary and community sector. The programme plan will include a Communications and Engagement Strategy, to ensure that plans are co-designed with the patients of the Surgery.

The business case will set out how delivery of the Service Strategy can best be achieved. This will include a more detailed review of the potential site options to confirm the preferred location, the development of a design and Cost Plan, and an appraisal of the options for funding and delivering the facility.

Delivering new healthcare facilities is an involved process and can take time. In the meantime, there are a number of activities underway to support King Street Surgery (which operates the three surgeries in the town) with their current premises situation, including planning which is underway to convert part of Kempston Health Centre into space for the practice to deliver services from (subject to final business case). Designs and costings for this work are in development.

2.5 London Road Surgery and East Bedford PCN

East London Foundation Trust (ELFT) vacated an area of London Road Health Centre last year, leaving void space in the building. It has been agreed that this space can be made available to both London Road Surgery (who are also based in the building) and to East Bedford Primary Care Network – enabling their multidisciplinary team working across the Network to have additional space for seeing patients.

Some minor refurbishment works are expected to be carried out early in 2023/24, and legal occupation arrangements will be finalised, enabling the practice and the PCN to start operating from the space by Summer 2023.

2.6 Grove View Integrated Health & Care Hub

Priory Gardens Surgery have had to postpone their provisional move date into Grove View Hub due to lead times for the procurement of the furniture they require in the new premises. Their move in date is now targeted for 28th April, subject to confirmation of dates for furniture delivery.

The practice has engaged a solicitor who is working through the Heads of Terms document provided by Bedfordshire Hospitals Trust in January 2023. The ICB Estates Team and the practice are meeting regularly with the solicitor to ensure momentum is maintained and any questions are dealt with speedily. Timeframes remain tight and we understand that the Head Lease between Central Bedfordshire Council and the Hospitals Trust has not yet been signed. This delay may mean that a Licence to Occupy is required between Priory Gardens and Central Bedfordshire Council in order for the practice to move in at the end of April; the practice solicitor is sighted on this possibility.

Priory Gardens have raised concerns regarding the increased level of service charges in Grove View, which have increased significantly since initial discussions and a quotation from CBC in Summer

2022. The ICB team is facilitating negotiations to support the practice to move into the new building and realise the benefits of transformation.

Chiltern Hills PCN are also in the process of reviewing the Heads of Terms, quotes for legal support and furniture costs for the PCN space in the building.

2.7 Ampthill Health Centre

Project to reconfigure space on the first floor at Ampthill Health Centre for both Greensands and Oliver Street Surgeries awaiting final designs and costings from NHS PS planner. The proposal is to create an additional 4-6 clinical rooms for the benefit of both practices in the building, plus additional admin space to be made available to the practices. A potential risk to the development has been highlighted by Greensands Surgery regarding the increase in service charge costs for 2023/2024, i.e. the affordability for the practice to take on extra space in the building. To be reviewed with the surgeries once the costings and designs are produced.

2.8 Asplands Premises Project

The proposal to reconfigure Asplands Medical Centre and Woburn Surgery (branch surgery) to reconfigure both premises to increase clinical capacity utilising S106 monies from Milton Keynes Council (MKC) has been approved. The scheme was supported by the Estates Working Group and Primary Care Delivery Group, and signed off by the Chief Officers' Group.

Any increase in notional rent reimbursements because of these improvement works will be disregarded at future rent reviews for a period of 15 years in line with NHSE Premises Costs Directions (43)2c. District Valuer has reported favourably on the specification of works and design alterations.

It was recognised that costs may have gone up in the meantime and the practice is obtaining up-to-date costs and confirming with MK Council there are sufficient funds for any increase. The practice is aware it will have to carry out value engineering if required and confine work to meet the S106 envelope.

The practice will be required to enter into a Grant Agreement to formalise the Improvement Grant arrangements. Currently the ICB does not have an approved format for a S106 Grant Agreement. The national Primary Care Estates team within NHSE have developed a standard Grant Agreement for Premises Improvement Grants which are funded using BAU Capital, which can be cumbersome for smaller projects and can result in high legal costs for practices and ICBs to complete. Other ICBs in the Region have developed their own briefer Grant Agreements for S106 funded grants.

It has been agreed that the ICB Estates Team will seek legal advice around the use of a shorter Grant Agreement template, in line with other ICBs.

2.9 PCN Estates Schemes

Leighton Buzzard, Medics and Phoenix Sunriser PCNs have all submitted business cases for extensions to their current PCN estates arrangements. All three of these schemes are already operational and are being funded non-recurrently by the ICB until end of March 2023. This extension to the current arrangements was supported in principle at the 11th January 2023 extraordinary meeting of the Primary Care Commissioning and Assurance Committee as part of the prioritisation programme of Primary care estates.

Note that due to an increase in Service Charge costs for 2023/24 (due to inflation and utilities cost increases), two of these schemes will cost more than expected, creating a cost pressure. The costs are set out in the table below:

Scheme	Budgeted Cost	Actual Cost	Variance
Leighton Buzzard PCN	£47,163	£68,253	£21,090
Medics PCN	£37,886	£60,334	£22,448
Phoenix Sunriser PCN	£20,700	£15,100	-£5,600
TOTAL	**£105,749**	**£143,687**	**£37,938**

Hatters PCN have non-recurrent funding in place until 31st March 2023 for their initial quick win PCN estates scheme, utilising a number of admin rooms at the Leagrave Centre. The continuation of these arrangements or a relocation to an alternative facility were supported within the prioritisation process (recognising that the space at Leagrave Centre is time-limited and doesn't provide clinical space for seeing patients face-to-face) with a budget of up to £41,400 allocated to this scheme.

Sundon Park Medical Centre (one of the GP practices within the PCN) have approached the ICB around stopping delivering services from their branch surgery at Sundon Park Health Centre (100 yds from their other surgery at Sundon Park Medical Centre), with a corresponding increase in their utilisation of their Harlington branch surgery. Hatters PCN have developed a proposal to take on this space instead of the practice, to provide the PCN with access to suitable administrative and clinical estates capacity. The Primary Care Commissioning Team have been assured that this will not affect access levels for patients of Sundon Park Medical Centre, and will help to future-proof provision within Harlington where housing growth is taking place.

The proposal is for a lease to be entered into between Sundon Park Medical Centre (practice) and NHS PS, as the lead practice for the PCN, with full reimbursement of rent and service charges by the ICB. This will need to be a minimum of a three-year lease to ensure that NHS PS commit to carrying out some minor improvement works to the building.

This scheme will cost £24,746 less than budgeted costs, when the existing premises reimbursement costs for Sundon Park Health Centre of £51,373.50 per annum are taken into account. towards the practice's occupation at Sundon Park Health Centre. The total cost of this proposal (reimbursement of rent and service charges for the PCN at the Health Centre) will be £68,027.50 per annum.

All four of the PCN Estates business cases have been reviewed and supported by the Estates Working Group, and will also be discussed at the Primary Care Delivery Group before final approval by the Chief Officers' Group – in line with the ICB Scheme of Delegation.

2.10 PCN Estates Toolkit

Community Health Partners have been commissioned by NHS England to support PCNs with the roll-out of the PCN Estates Toolkit. It was agreed that this would be rolled out in phases in BLMK.

Five of the six PCNs in Luton have engaged in the first part of Phase 1 of the roll-out, and have developed Clinical Strategies aligned to their Population Health data and their workforce strategies. All five are now receiving support with developing an Estates Plan which is based on enabling delivery of their Clinical Strategy. This work was presented to the Luton Place Board in February.

The programme has now been extended to all Bedfordshire and Milton Keynes PCNs and there has been a strong support from clinical leaders. Work is now commencing on the development of Clinical Strategies for a further fourteen PCNs. The BLMK programme is expected to complete in June 2023.

2.11 Energy Assessments in the GP Primary Care Estate BLMK

The ICB has received funding from the Healthier Futures Action Fund to conduct a pilot scheme for Energy Assessments across GP Premises in BLMK Primary Care Settings. The twelve premises shortlisted for this scheme were based upon geographical location, age, condition/building fabric and known history of current Display Energy Certificates.

This scheme will site survey the 12 premises and issue an Energy Performance Certificate and Recommendation Report. The properties will then be assessed on a desktop model EPC Plus, which offers a cumulative and costed plan to improve premises Energy Ratings in line with The Government's own mandated Carbon Emission plans and the NHS Net Zero by 2040 targets.

The plan is to measure the success of this pilot and share best practice and learnings with all the Estates GP Premises and encourage engagement within this wider community.

Additionally, six of these twelve premises (again shortlisted to those that will benefit most) will have a more in-depth assessment produced by Mott McDonald

This report is similar to the EPC Plus model but digs into energy readings and advice on changing to one supplier across PCNs to a green supplier and make savings on energy costs. This process will use a pre-built calculation tool that determines carbon and energy savings for proposed decarbonisation measures and associated budget costs for these proposals. This also look at the buildings and system in more detail than an EPC assessor, looking at actual design feasibility of the measures proposed based on experience of producing detailed designs of these systems.

With this proactive approach BLMK Primary Care Estates will be in a good space for any additional funding available to achieve the challenging Net Zero targets that lie ahead.

2.12 Reinforced Autoclaved Aerated Concrete (RAAC)

There is a requirement from NHS England for all ICBs to establish assurance that there are no primary care buildings contained RAAC, which has been found to have structural weaknesses. An allocation of £100k has been made available to BLMK to support this work, although the timescales are very tight for using these funds within 2022/23.

A desktop exercise has confirmed that surveys and inspections are required for 84 identified Primary care sites in BLMK. A request for Quotation for RAAC inspections has been sent to specialist surveying firms and are being assessed to identify the preferred provider and costs.

Further assurance is being sought from Third Party Landlords around the structural integrity of their buildings, in line with a series of safety alerts issued by regulatory bodies/industry experts concerning RAAC (Reinforced Autoclaved Aerated Concrete) materials used in the construction of buildings.

2.13 Wixams

As per previous updates to this Committee, designs have been developed for a facility attached to a mixed-use development, as part of the Master Plan for Wixams Town Centre. The ambition is to develop a branch surgery facility, which could be used by two practices (one from Bedford Borough, one from Central Bedfordshire).

Delivery of the facility is challenging due to lack of capital funding, including no S106 financial contribution from the developer. There is a large plot of land designated for health in the original S106 Agreement, but no capital funding to support delivery. This is one of the thirty schemes not able to be supported at this stage following the prioritisation process.

There is a significant sum of S106 expected to become available at a later stage (linked to an attached development within the Central Bedfordshire border) and this is likely to be a key enabler for delivering a new facility in due course, but the timescales are uncertain as they are dependent on the rate of housing construction.

Bedford Borough Council and Central Bedfordshire Council Planning Teams are developing a Deed of Variation to the S106 Agreement which would reduce the size of the plot of land for health in exchange for a capital contribution (expected to be £500k) towards the delivery of the health facility.

3.0 Summary

Developing primary care estates to help achieve improvements in access for patients, and to help develop more integrated and sustainable services, is a priority for the ICB. In the context of the available funding, the ICB has confirmed support for twenty-three primary care estates schemes across BLMK, these schemes are at various stages of delivery. This report provides updates on fourteen of these projects.

There are risks associated with some of the larger schemes, due to factors outside of the control of the ICB. Action is being taken to mitigate these risks as far as possible, and as swiftly as possible, to support delivery.

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Primary Care Commissioning & Assurance Committee 17 March 2023
14. Primary Medical Services Primary Care Financial Report (January 2023)

Vision: "For everyone in our towns, villages and communities to live a longer, healthier life"	
Please state which strategic priority and / or enabler this report relates to	
Strategic priorities	
☒	**Start Well:** Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
☒	**Live Well:** People are supported to engage with and manage their health and wellbeing.
☒	**Age Well:** People age well, with proactive interventions to stay healthy, independent and active as long as possible.
☒	**Growth:** We work together to help build the economy and support sustainable growth.
☒	**Reducing Inequalities:** In everything we do we promote equalities in the health and wellbeing of our population.

Enablers			
Data and Digital ☐	Workforce ☐	Ways of working ☐	Estates ☐
Communications ☐	Finance ☒	Operational and Clinical Excellence ☐	Governance and Compliance ☐
Other ☐(please advise):			

Report Author	Roger Hammond Associate Director of Finance (Primary Care)
Date to which the information this report is based on was accurate	26th February 2023
Senior Responsible Owner	Nicky Poulain Chief Primary Care Officer

The following individuals were consulted and involved in the development of this report:
Nicky Poulain (Chief Primary Care Officer) and Stephen Makin (Deputy Chief Finance Officer)
This report has been presented to the following board/committee/group:
N/A

Purpose of this report - what are members being asked to do?

The members are asked to **note** the following:
A) January 2023 primary care financial position.

Executive Summary Report

1. Brief background / introduction:

The Primary Care Commissioning & Assurance Committee seeks assurance from the Primary Care Delivery Group that the financial position is being reviewed and managed appropriately. The Primary Care Commissioning & Assurance Committee has delegated authority to the ICB Chief Primary Care Officer (Nicky Poulain) to lead a Primary Care Delivery Group.

The Delivery Group receive detailed financial reports summarising total BLMK primary care spend along with further splits at place level. Reports include forecasts and basis of any assumptions made along with risks and mitigations. The Delivery Group is then able to scrutinise the finances, discuss risks and make informed decisions in overseeing the delegated budget to promote increased quality, efficiency, productivity and value for money across primary care services.

2. Summary of key points:

The Delivery Group reviewed the January '23 report at its meeting on 7th March '23. A high-level summary of the financial position is shown below. The report covers the period from 1st July 2022 to date along with estimated forecast to 31st March 2023.

Primary Care Delegated position

The table below summarises the BLMK ICB delegated Year to Date and forecast position as at 31st January 2023.

BLMK

CCG EXPENDITURE ANALYSIS	Year to Date			
	Plan £000	Actual £000	Variance £000	Variance %
GMS Contracts	51,842	51,744	98	0.2%
APMS/PMS Contracts	7,675	7,665	10	0.1%
Primary Care Networks	14,911	15,710	(799)	(5.4%)
Enhanced Services	747	724	23	3.1%
Premises	7,495	7,818	(323)	(4.3%)
Primary Care Other	782	842	(60)	(7.7%)
QoF	7,570	7,567	3	0.0%
Prescribing & Dispensing	1,268	1,559	(291)	(22.9%)
PMS Re-investment	3,179	3,138	41	1.3%
Other	122	111	11	9.0%
Reserves	(125)	(759)	634	507.2%
Primary Care Delegated	95,466	96,119	(653)	(0.7%)

CCG EXPENDITURE ANALYSIS	Forecast Net Expenditure			
	Plan £000	Actual £000	Variance £000	Variance %
GMS Contracts	66,652	66,632	20	0.0%
APMS/PMS Contracts	9,917	9,882	35	0.4%
Primary Care Networks	19,606	21,147	(1,541)	(7.9%)
Enhanced Services	1,012	1,004	8	0.8%
Premises	9,175	9,481	(306)	(3.3%)
Primary Care Other	1,077	1,080	(3)	(0.3%)
QoF	9,736	9,736	-	0.0%
Prescribing & Dispensing	1,619	1,961	(342)	(21.1%)
PMS Re-investment	4,087	4,021	66	1.6%
Other	157	149	8	5.1%
Reserves	(163)	(758)	595	365.0%
Primary Care Delegated	122,875	124,335	(1,460)	(1.2%)

YTD and forecast are currently showing an overspend which is a deterioration from the position last reported to this Committee. The position is primarily due to Additional Roles (ARRS) recruitment. PCNs' monthly ARRS pay costs now exceed the ICB's baseline funding and the £1.3m excess expenditure is recoverable from NHSE. This has yet to be passed to the ICB and is therefore not reflected in the reported position. Additional pressures reflect further belated rent reviews being brought up to date, increased dispensing fees, prior year claims from practices and short-term support to practices and are offset against reserves and prior year benefits.

Other Primary Care Services

The table below summarises other primary care expenditure for the BLMK ICB.

CCG EXPENDITURE ANALYSIS	Year to Date			
	Plan £000	Actual £000	Variance £000	Variance %
Local Incentive Schemes	1,689	1,132	557	33.0%
GP IT	2,177	2,257	(80)	(3.7%)
GP Investments	3,935	3,774	161	4.1%
Precribing and Drugs	81,364	87,667	(6,303)	(7.7%)
Total Primary Care (Other)	89,165	94,830	(5,665)	(6.4%)

CCG EXPENDITURE ANALYSIS	Forecast Net Expenditure			
	Plan £000	Actual £000	Variance £000	Variance %
Local Incentive Schemes	2,187	1,573	614	28.1%
GP IT	2,805	2,979	(174)	(6.2%)
GP Investments	5,147	5,271	(124)	(2.4%)
Precribing and Drugs	105,234	112,265	(7,031)	(6.7%)
Total Primary Care (Other)	115,373	122,088	(6,715)	(5.8%)

Local Incentive Scheme position is activity undertaken. Whilst activity has shown some increase in recent months, cumulatively, activity has been below budgeted levels.

GP IT increasing monthly run-rate for additional Community SystemOne Support costs and additional IT for expanding Primary Care Network roles (equipment, VPN licences etc.).

GP Investments includes GP Access, workforce and training allocations. Overall underspent and is from extended access costs being less than allocations received for first six months of the year. From October, Extended Access transferred to Primary Care Networks (delegated primary care commissioning) under a block contract arrangement. Other allocations are phased to be spent in the latter part of the year and in some cases, allocations are awaited.

The Prescribing and Drugs position is a £6.3m YTD overspend with a forecast overspend of £7m at year-end. The underlying pressures seen in recent months from increased drug costs and Cat M supply issues have been reported to the Primary Care Delivery Group, the ICB Finance Committee and ICB Board. Pressures are also being seen within the home oxygen and central drugs expenditure (£0.6m across the two areas). The overspend is not at present putting the ICB financial performance at risk as it is being mitigated by other services and reserves across the ICB system.

3. Are there any options?

Not applicable.

4. Key Risks and Issues

Delegated: None at the present time. Any emerging risks will be considered and assessed as part of the on-going monthly reporting cycle.
Other Primary Care services: potential risk of prescribing expenditure increasing yet further due to drug supply costs. Further work underway to assess financial impact. Impact also raised with NHSE.

Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☐	No ☒

Not applicable.

5. Are there any financial implications or other resourcing implications, including workforce?

None.

6. How will / does this work help to address the Green Plan Commitments?

Click to view Green Plan

Improved social prescribing via Primary Care Network pharmacists,
Increased use of online services for patients reducing travel requirements.

7. How will / does this work help to address inequalities?
Work underway to develop a universal offer to patients by primary care to address historic inequity of access to primary care services.
8. Next steps:
Committee is asked to comment on any changes it may wish to see in future reports.
9. Appendices
None.
10. Background reading
None.