NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Meeting of the Integrated Care Board in PUBLIC

Date: 24 March 2023
Time: 10:00 – 13:00
Venue: Milton Keynes City Council, Civic Offices, 1 Saxon Gate East, Milton Keynes MK9 3EJ

Agenda

No.	Agenda Item	Lead	Purpose	Time
Opening Actions				
1.	Welcome, Introductions and Apologies	Chair	-	10.00
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.	Approval of Minutes and Matters Arising			
5.	Review of Action Tracker			
6.	Chair's Report - *verbal*	Chair	Note	10.10
7.	Chief Executive Officer's Report	Chief Executive Officer	Note	10.15
8.	Questions from the Public	Chair	-	10.20
System Strategy				
9.	Resident's Story	Chief Transformation Office`	-	10.30

No.	Agenda Item	Lead	Purpose	Time
10.	Integrated Musculoskeletal and Pain Services	Chief Transformation Officer	Note / Support	10.45
11.	BLMK Fuller Programme – Outcome of Table Discussions from ICB Workshop	Chief Primary Care Officer	Note	10.55
12.	Core 20 + 5 for children and young people	Chief Nursing Director	Approve	11.10
11.15 – 11.30 – Refreshment Break				
13.	Managing Conflicts of Interest in Procurement	Chief Transformation Officer	Note / Agree	11.30
14.	Transition of Delegated Community Pharmacy, Optometry and Dental (POD) Contracts to the ICB	Chief Primary Care Officer	Note / Approve	11.35
15.	Proposed Approach: BLMK ICS Joint Forward Plan	Chief Transformation Officer	Approve submission of draft	11.45
16.	BLMK ICS 2023/24 Financial and Operating Plan	Chief Transformation Officer / Chief Finance Officer	Note / Agree	11.50
17.	Place Plans, Health and Wellbeing Board Updates and Guidance for Health and Wellbeing Boards and Integrated Care Boards: • Bedford Borough • Central Bedfordshire • Luton • Milton Keynes	Local Authority Chief Executive Officers	Note	11.55
Operational				
18.	Quality and Performance Report	Chief Nursing Director and Chief of System Assurance & Corporate Services	Note / Agree	12.05
19.	Finance Report January 2023 – Month 10 – *paper to follow*	Chief Finance Officer	Note	12.15

No.	Agenda Item	Lead	Purpose	Time
		Governance		
20.	Board Assurance Framework	Chief of System Assurance and Corporate Services	Note	12.20
21.	Corporate Governance update: ▪ Primary Care Commissioning & Assurance Committee (ARAC) – amendment to Terms of Reference ▪ Resignation of Non-Executive Member (NEM) ▪ Interim Appointment of additional NEM to the ARAC ▪ Recruitment of NEM and Chair of ARAC ▪ Update on Primary Medical Services ICB Board Member recruitment ▪ Plan for development of Annual Report & Accounts 2022/23 ▪ Committee Chairs' Updates	Chief of System Assurance and Corporate Services & Committee Chairs	Approve / Note	12.30
22.	Annual Cycle of Business 2023-24	Chief of System Assurance and Corporate Services	Note	12.40
23.	Communications from the meeting	Chair	Discuss	12.45
24.	Review of meeting effectiveness	Chair	Discuss	12.50
		Closing Items		
25.	Any Other Business	Chair	-	12.55
26.	Date and time of next meeting: ▪ 30 June 2023 ▪ Time and venue tbc	Chair		

Resolution to exclude members of the press and public

The Board of the Integrated Care Board resolves that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest, Section 1(2), Public Bodies (Admission to Meetings) Act 1960.

Members & Participants 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 the Corporate Sec email address.

Extract from the Register of Conflicts of Interest - as at 10.3.23

(NB: Lines in grey are expired interests which must remain on the register for 6 months after expiry date)

				Type of Interest								
Surname	**Forename**	**Position within or relationship with the ICB**	**Interests to Declare**	**Financial Interest**	**Non-Financial Professional**	**Non-Financial Personal**	**Indirect**	**Details of Interest**	**Date From**	**Date To**	**Actions to be taken to mitigate risk**	**Date Declared**
Borrett	Alison	Non Executive Member	No									21/06/2022
Bracey	Michael	Chief Executive, Milton Keynes Council	Yes	Y				Employee of Milton Keynes City Council	2009	Ongoing	None required	21/11/2022
Carter	David	Chief Executive, Bedfordshire Hospitals Foundation Trust	Yes	Y				Chief Executive of Bedfordshire Hospitals NHS Foundation Trust	08/05/2017	Ongoing		18/05/2022
Carter	David	Chief Executive, Bedfordshire Hospitals Foundation Trust	Yes				Y	Wife employed by NHS England Eastern Region	2019	ongoing		18/05/2022
Cartwright	Sally	Director of Public Health, Luton Council	No									22/06/2022
Church	Laura	Chief Executive, Bedford Borough Council	Yes	Y				Bedford Borough Council, Commissioner of Public Health and Social Care Functions	05/10/2021	Ongoing	Declare in line with conflicts of interest policy	27/05/2022
Church	Laura	Chief Executive, Bedford Borough Council	Yes		Y			East of England Local Government Association - Chief Executive lead on health inequalities	01/12/2021	Ongoing	Declare in line with conflicts of interest policy	27/05/2022
Church	Laura	Chief Executive, Bedford Borough Council	Yes				Y	Ian Turner (husband) provides consultancy services to businesses providing weighing and measuring equipment to the NHS	05/10/2021	Ongoing	Declare in line with conflicts of interest policy	27/05/2022
Coiffait	Marcel	Chief Executive, Central Bedfordshire Council	Yes	Y				I am the Chief Executive of Central Bedfordshire Council which is an may be commissioned to work on behalf of the ICB	01/11/2020	Ongoing	Declare in line with conflicts of interest policy	27/05/2022
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
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
Graves	Stuart Ross	Chief Strategy & Digital Officer, CNWL NHS Foundation Trust	Yes		Y			Chief Strategy & Digital Officer CNWL NHS Foundation Trust, 350 Euston Road, London NW1 3AX	May-20	Ongoing	Declare in line with conflicts of interest policy	15/11/2022

Surname	Forename	Position within or relationship with the ICB	Interests to Declare	Financial Interest	Non-Financial Professional	Non-Financial Personal	Indirect	Details of Interest	Date From	Date To	Actions to be taken to mitigate risk	Date Declared
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes	Y				Chief Executive Officer, NHS Milton Keynes University Hospital	2013	Ongoing	Declare in line with conflicts of interest policy	21/11/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes		Y			Chair NHS Employers Policy Board	2021	Ongoing	Declare in line with conflicts of interest policy	16/05/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes		Y			Trustee of NHS Conferation	2021	Ongoing	Declare in line with conflicts of interest policy	16/05/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes		Y			Council Member - National Association of Primary Care	2020	Ongoing	Declare in line with conflicts of interest policy	16/05/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes	Y				Keele University - Lecturer	2016	Ongoing	Declare in line with conflicts of interest policy	16/05/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes	Y				Advisor to Alphasights, MM3 Global Research, Silverlight and Stepcare	2018	Ongoing	Declare in line with conflicts of interest policy	16/05/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes		Y			Chair, Clinical Research Network Thames Valley & South Midlands Partnership Group Meeting		Ongoing	Declare in line with conflicts of interest policy	16/05/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes		Y			Member, Oxford Academic Health Science Network		Ongoing	Declare in line with conflicts of interest policy	16/05/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes				Y	Spouse, Samantha Jones, Expert Advisor to the Secretary of State for Health & Social Care	Nov-22	Ongoing	Declare in line with conflicts of interest policy	23/11/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes				Y	Sister, Ruth Harrison, Director of Durrow Ltd	Circa 2012	Ongoing	Declare in line with conflicts of interest policy	21/11/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes	Y				National Director for Digital Channels	Jan-23	Ongoing	Declare in line with conflicts of interest policy	01/02/2023
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes	Y				Interim Chair, University of Buckingham	Apr-22	Oct-22	Declare in line with conflicts of interest policy	16/05/2022
Head	Vicky	Director of Public Health, Bedford Borough, Central Bedfordshire and Milton Keynes.	No									27/06/2022
Makarem	Rima	Chair, BLMK ICB	Yes		Y			Chair of Sue Ryder (non remunerated)	01/05/2021	Ongoing	Declare in line with conflicts of interest policy	17/06/2022
Makarem	Rima	Chair, BLMK ICB	Yes	Y				Chair of Queen Square Enterprises Ltd (remunerated)	01/11/2020	Ongoing	Declare in line with conflicts of interest policy	17/06/2022
Makarem	Rima	Chair, BLMK ICB	Yes	Y				Lay Member of General Pharmaceutical Council	Apr-19	Ongoing	Declare in line with conflicts of interest policy	17/06/2022
Mattis	Lorraine	Associate Non Executive Member	Yes	Y				Director - Community Dental Services Community Interest Company	Nov-17	Ongoing	Declared in line with conflicts of interest policy	10/01/2023
Pointer	Shirley	Non-Executive Member, Chair Remuneration Committee	Yes		Y			Bpha (a not for profit Housing Association). Non-Executive Director and Chair of the Remuneration	April i2019	Ongoing	Declare in line with conflicts of interest policy	15/12/2022
Pointer	Shirley	Non-Executive Member, Chair Remuneration Committee	Yes			Y		Pavilions Management Co Ltd, (residents management co), Director. This is a voluntary role which is not remunerated	Sep-20	Ongoing	Declare in line with conflicts of interest policy	15/12/2022
Porter	Robin	Chief Executive, Luton Borough Council	Yes	Y	Y			Chief Executive of Luton Council, an ICB Partner organisation	May-19	Ongoing	Declare in line with conflicts of interest policy	16/11/2022

Surname	Forename	Position within or relationship with the ICB	Interests to Declare	Financial Interest	Non-Financial Professional	Non-Financial Personal	Indirect	Details of Interest	Date From	Date To	Actions to be taken to mitigate risk	Date Declared
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	17/02/2023
Roberts	Martha	Chief People Officer, BLMK ICB	No									04/07/2022
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	20/05/2011
Shah	Mahesh	Partner Member	Yes				Y	RightPharm Ltd, 60a Station Road, North Harrow, HA2 7SL, co no 08552235, community pharmacy, 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	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	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	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
Stanley	Sarah	Chief Nurse Director	No									08/09/2022
Stock	Tracey	Chair ICP	Yes				Y	Member of the East London Foundation Trust (ELFT) Council of Governors	15/12/2021	01/05/2023	None	05/07/2022
Taffetani	Maxine	Healthwatch Representative for Bedfordshire, Luton and Milton Keynes	Yes	Y				Employee of Healthwatch Milton Keynes	2017	Ongoing	Declare in line with conflicts of interest policy	14/12/2022

Surname	Forename	Position within or relationship with the ICB	Interests to Declare	Financial Interest	Non-Financial Professional	Non-Financial Personal	Indirect	Details of Interest	Date From	Date To	Actions to be taken to mitigate risk	Date Declared
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
Whiteman	Sarah	Chief Medical Director	Yes	Y				Akeso (coaching network) – coach – Executive and Performance Coach	01/04/2021	Ongoing	Open declaration, no monies received	14/06/2022
Whiteman	Sarah	Chief Medical Director	Yes	Y				NHS England – Appraiser	2001	Ongoing	Exclusion of self from involvement in related meetings, projects or decision-making	14/06/2022
Wogan	Maria	Chief of System Assurance & Corporate Services	Yes			Y		I am a member of Inspiring Futures Through Learning Multi-Academy Trust which covers schools in Milton	2016	Ongoing	Will be declared in any relevant meetings.	14/07/2022
Wogan	Maria	Chief of System Assurance & Corporate Services	Yes	Y				I am a Director of Netherby Network Limited which is a consultancy company that has provided services to Milton Keynes Clinical Commissioning Group in the past. It does not currently provide any services for health or care clients. Address: 69 Midland Road,	Mar-14	Ongoing	No actions required as the company is not trading.	14/07/2022
Wogan	Maria	Chief of System Assurance & Corporate Services	Yes	Y				Chair of Trustees for Arts for Health Milton Keynes (MK) a registered charity that is responsible for the art collection at MK University Hospital NHS Trust and provides art on prescription for MK residents. Address MK University Hospital, Standing Way, Eaglestone, Milton Keynes MK6 5LD	2010	30/09/2022	Will be declared as relevant in meetings and will not be involved in any funding or other decisions where Arts for Health MK may be a beneficiary. Standing down from role by 30/09/22.	14/07/2022

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 27 January 2023

Time: 09.00 – 12.00

Venue: Council Chamber, Bedford Borough, Borough Hall, Cauldwell Street, Bedford, Beds MK42 9AP

Minutes of the: Board of the Integrated Care Board (ICB) in **PUBLIC**

Members in attendance:		
Alison Borrett	Non-Executive Member – *remotely*	AlBo
Michael Bracey	Partner Member, Local Authorities	MB
David Carter	Partner Member, NHS Trusts and Foundation Trusts	DC
Laura Church	Partner Member, Local Authorities	LC
Marcel Coiffait	Partner Member, Local Authorities	MC
Felicity Cox	Chief Executive Officer	FC
Manjeet Gill	Non-Executive Member	MG
Ross Graves	Partner Member, NHS Trusts and Foundation Trusts	RG
Joe Harrison	Partner Member, NHS Trusts and Foundation Trusts - *part*	JH
Dr Omotayo Kufeji	Partner Member, Primary Medical Services	OK
Dr Rima Makarem (Chair)	Chair	RM
Shirley Pointer	Non-Executive Member	SP
Robin Porter	Partner Member, Local Authorities – *remotely, part*	RP
Sarah Stanley	Chief Nursing Officer	SS
Dean Westcott	Chief Finance Officer	DW
Dr Sarah Whiteman	Chief Medical Director (member)	SW

Participants:		
Anne Brierley	Chief Transformation Officer	AnBr
Sally Cartwright	Interim Director of Public Health, Luton	SC
Vicky Head	Director of Public Health, Bedford Borough, Central Bedfordshire and Milton Keynes Councils	VH
Lorraine Mattis	Associate Non-Executive Member	LM
Nicky Poulain	Chief Primary Care Officer	NP
Martha Roberts	Chief People Officer	MR
Maxine Taffetani	Participant Member for Healthwatch within Bedfordshire, Luton and Milton Keynes	MT
Maria Wogan	Chief of System Assurance & Corporate Services	MW

In attendance:		
Anthony Aldridge	Head of DCO Programme, Luton Rising – *part*	AA
Kim Atkin	Committee Governance & Compliance Office (minutes)	KA
Georgie Brown	Chief of Staff	GB

In attendance:		
Gaynor Flynn	Governance & Compliance Manager	GF
Peter Horne	Programme Director, Bedfordshire Care Alliance - *part*	PH
Mark Peedle	Head of Digital	MP
Julia Robson	Inequalities Programme Lead	JR
Tim Simmance	Associate Director of Sustainability & Growth	TS
Geoff Stokes	Interim Programme Director – Governance	GS
Michelle Summers	Associate Director of Communications and Engagement	MS
Dominic Woodward-Lebihan	Deputy to Chief of System Assurance & Corporate Services	DW-L

Apologies:		
Andrew Blakeman	Non-Executive Member (member)	AnBl
Mahesh Shah	Partner Member, Primary Medical Services	MS
Cllr Tracey Stock	Chair, Bedfordshire, Luton and Milton Keynes Health and Care Partnership (participant member)	TS

No.	Agenda Item	Action
1.	**Welcome, Introductions and Apologies** The Chair welcomed all to this Meeting of the Board of the Bedfordshire, Luton & Milton Keynes Integrated Care Board (ICB). Apologies were noted as above and it was noted that two members, Alison Borrett and Robin Porter, were attending virtually. As this was a Meeting in Public, members of the public were welcome to observe but their microphones were muted and their cameras turned off. Two questions had been received from the public, and these would be answered under item 6 on the agenda. It was confirmed that the meeting was **quorate**. The meeting was being recorded for the purpose of the minutes.	
2.	**Core Purposes of Integrated Care Systems** The Chair highlighted the core purposes of the Integrated Care System (ICS) and stated that these should be borne in mind during discussions and when taking decisions: • **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.**	
3.	**Relevant Persons Disclosure of Interests – Register of Interests** Members had reviewed the Register of Interests: • DW had requested a correction to the register: the dates for his advisory appointment to London School of Commerce should be from 1/12/22 and ongoing. This had been noted and amended on the register;	

	• JH stated that he had been appointed as National Director for Digital Channels with effect from January 2023. This was noted and would be added to the register. Attendees were asked to confirm that any offers of gift or hospitality received in the last 28 days, in relation to ICB business, had been registered with the Governance & Compliance Team. FC stated that she had attended an NHS Think Tank for which a donation was given to charity, which had been declared and added to the register. In relation to today's agenda, RP declared an interest as Chief Executive of Luton Borough Council, in relation to item 19, Luton Airport Proposed Development Health and Community Impact ("Development Consent Order - DCO Programme"). The Council is the sole shareholder of Luton Rising, and that it was deemed that RP does not personally have a conflict of interest and therefore he could remain in the meeting and participate in the discussion and decision making. This was duly noted.	
4.	**Approval of Minutes and Matters Arising** The Board **approved** the minutes as a full and accurate record of the meeting. There were no matters arising that did not form part of the meeting's agenda.	
5.	**Review of Action Tracker** Actions were followed through between meetings and the action tracker has been updated. This was presented for review with updates and proposed items for closure. • Item 7 remained open due to the cancellation of the System Assurance & Oversight Group (SOAG) meeting in December; • Items 33 and 34 would be closed once the meetings of Place Boards and the Health & Care Partnership (H&CP) had taken place; • All other items were proposed to be shown as complete. The updates and proposals were noted and **agreed**.	
6.	**Questions from the Public** Two questions had been received from members of the public, both of which related to primary care services across BLMK. The full questions and formal responses would be shared on the ICB public website. The first question (from Cllr Victoria Harvey) related to the need for facilities for Leighton Buzzard in order to alleviate pressure on hospitals. The questioner included examples of where more use could be made of GPs and other primary care services to carry out minor procedures and diagnostics, supporting preventative services. The question also asked about how recruitment and retention of GPs was encouraged. The second question (from William Hollington) asked about whether a special case could be made for Biggleswade to have a hub to address planned growth in the town. The Chief Primary Care Officer (CPCO) responded that, in answering both questions, it was important to state that the ICB Board was also keen to encourage the development	

	of primary care services as that would bring benefits across the entire healthcare system, not just for GP practices. Data shows that primary care access in Leighton Buzzard is comparable with other areas in BLMK, as well as regionally and nationally. The data also shows the diversity of the workforce available in Leighton Buzzard, with 57% of appointments in the three practices in the Leighton/Linslade Health Connections Primary Care Network being provided by health professionals other than GPs. The ICB's response to the Fuller Review aimed to transform primary care and support the development of integrated neighbourhood teams. There were already good examples of collaborative working, including the 'Working Together in Leighton Buzzard' programme, which supports the population with a range of complex health needs and the geriatric consultant team from Bedfordshire Hospitals NHS Foundation Trust providing support to primary care in the management of the elderly population with frailty. The Primary Care Training Hub hosts a number of specific initiatives to locally grow and retain our GP workforce. These include a comprehensive GP trainee expansion programme and GP Fellowships to aid retention and develop integrated posts as well as New to Practice and New to Partnership programmes. In relation to Biggleswade, we are working with our health and care partners to develop integrated health and care hubs across BLMK. No decisions have been made about a potential new hub in Biggleswade. The ICB will continue to support practices and PCNs with addressing operational pressures, as we are already doing in the Biggleswade area. **Action: Questions from the Public and responses to be shared on the ICB website.**	MS
7.	**Chair's Report (Verbal)** The Chair advised that she is actively involved in the recruitment of NHS Chairs within the system, which continues and summarised the following: • Mark Lam, Chair of East London Foundation Trust (ELFT), will be succeeded by Eileen Taylor; • A new Chair will be announced soon to succeed Simon Linnett as Chair of Bedford Hospitals Foundation Trust (BHFT); • Interviews are taking place this week for a new Chair for Central & North West London NHS Foundation (CNWL), to succeed Dot Griffiths; • Interviews will take place in the next few weeks for a new Chair for EEAST, to succeed Nicola Scrivings. The Chair thanked the outgoing Chairs for their hard work and contributions and congratulated Eileen Taylor on her new appointment. In relation to the Board of the ICB, there remains a vacancy for one primary medical services partner member and a further recruitment exercise will commence next month, with the ideal candidate being a GP from either Bedford Borough or Central Bedfordshire to complement the other partner members already recruited.	

	The Non-Executive Members and the Chair visited the Lea Vale GP Practice which was rated "outstanding". This practice is innovative in its approach and the way it runs itself to help to protect the time of GPs and other health care professional to allow them to focus on clinical work. A lot was learned from this visit which could help us more generally as we go forward, thinking about the Fuller Neighbourhoods and thinking about how we support primary care to be more sustainable. The ICB also ran briefings for Trust Non-Executive Directors and, separately, for Governors of Foundation Trusts, to tell them about the role and functions of the ICB and to help them to understand how this related to their roles. Some very positive feedback has been received from these sessions. RM stated that she is now a member of the NHS Confederation Health Inequalities Reference Group which is a useful forum to learn from other ICBs, from experts in health inequalities and also helps to consider the relevant policy as it develops nationally. Learnings from that will be brought into the ICB and our own conversations on health inequalities. The Board **noted** the Chair's verbal update.	
8.	**Chief Executive's Report** *Presented by Felicity Cox, Chief Executive, ICB* FC highlighted the following: - She emphasised the incredible work that had been done across the whole of the NHS, but specifically locally, in a very high peak of activity in January, where local authority, acute and community service partners worked well with our ICB teams; a perfect example of what good partnership working looks like; - The report draws attention to some of the ways that we are working with partners to improve health care, in section 2.2, with links to obtain further information; - In relation to Emergency Planning Resilience & Response (EPRR) and industrial action, she stated that to date our area had not been heavily affected by industrial action, but a second ballot is currently taking place at the ambulance trust. The fire service is also due to ballot in February which would also impact us due to their level of support for the ambulance service; - We will be holding a further Multi Agency Discharge Event (MADE) before the next scheduled industrial action, as is mandated for all systems. The two that were conducted before Christmas were both very useful; - The primary care acute respiratory infection (ARI) hubs are now up and running which will provide access to all with ARIs and take pressure off elsewhere; - Much work has been undertaken in relation to the delegation of pharmacy, optometry and dentistry which will be discussed later on in the agenda; - Before Christmas, the Secretary of State requested an organogram for the organisation, which was submitted by the deadline. This was based on our status at the time and, as we are still in transition, this will change over time; - Planning Guidance was issued on 23 December and we are working our way through that, with partners. The guidance did not include Management Cost Allowances and a further announcement is awaited on that; and - FC continues to be part of the Hewitt Review and was invited to co-Chair the integration and place workstream. We submitted, on behalf of the organisation, evidence of a review which will be circulated to members of the Board. There was input from 400 organisations, which has been summarised into an 80-page document. It is hoped that this will prove a useful outline. Further information will be submitted to the Minister today. This work is going at speed and has required substantial time commitment. This is an important piece of work, looking at how ICSs can be supported and how NHS England (NHSE) and the Department of Health can work in different ways to enable place and localities to thrive.	

	In response to a question about publication of BLMK's Integrated Health and Care Strategy, it was confirmed that a plan for communication with residents was being developed and that Healthwatch's input would be welcomed. It was highlighted that funding for acute respiratory support ceases in March and it was confirmed that this would be looked at as part of the planning process and it was hoped that some of the recurrent "winter funding" might be able to support this initiative. The effectiveness of this service and how it is being supported in communities is being reviewed, with particular regard to health inequalities, and additional work is ongoing with other ICBs in the East of England in this regard. **Action: MW to circulate submission for Hewitt review to members and participants of the ICB Board.** **Action: MS and MT to discuss communication of the newly published strategy to residents.** The Board **noted** the Chief Executive's report and verbal updates.	MW MS / MT
9.	**Corporate Governance Update** *Presented by Maria Wogan, Chief of System Assurance & Corporate Services* The Board **approved** the proposed amendment, to remove a clause which was causing confusion, to the Terms of Reference (ToRs) of the Health & Care Partnership (H&CP). An amendment was proposed to the ToRs of the Working with People & Communities Committee (WWP&C), in relation to quoracy, with the wording slightly changed since publication of the meeting papers, to: "At least one third of committee members, including; At least one Non-Executive Member; and The Chief of System Assurance & Corporate Services or their Deputy". This was **approved**. The following items were **noted** from the report: - Alison Borrett (AlBo) has been appointed as Deputy Chair for Audit Risk & Assurance Committee (ARAC) and will be covering that role in Andrew Blakeman's absence; - Dr Sarah Whiteman has been appointed as the Health & Care Senate Representative on the WWP&C Committee; - The mandated annual Conflicts of Interest exercise was progressing well; - The Board Effect platform has been implemented this month and feedback would be welcomed; - The Board of the ICB will meet quarterly next year and proposed dates are included in the paper, with formal invitations to follow soon; and - Committee Chairs' updates were included in the report. Alison Borrett, Chair of the Primary Care Commissioning & Assurance Committee (PCC&A) drew the Board's attention to a meeting of the PCC&A Committee on 11 January, and read a short statement: *"The meeting was well attended and has attracted a lot of attention in the media.* *I would like to take this opportunity to correct some of the factual inaccuracies that have been reported about the meeting by reading a short statement to the Board, so we are clear on what was – and was not – agreed.* *"Many GP practices and Primary Care Networks (PCNs) across BLMK aspire to improve their premises to meet the growing needs of their local populations.*	

	"These aspirations include, but are not limited to, the development of new premises, extensions to existing premises and the relocation and consolidation of existing surgeries into Integrated Health and Social Care Hubs. *"To support these ambitions, Bedfordshire, Luton and Milton Keynes Integrated Care Board needs to invest an additional £1.95m per annum in primary care estates. This represents a 22% increase in the ICB's investment in primary care and takes the full amount spent on primary care estates to just under £11m per annum by 2025/26.* *"This additional funding will enable twenty-three local projects to progress, with benefits for a wide range of communities across Bedford Borough, Central Bedfordshire, Luton and Milton Keynes.* *"The ICB's current revenue budget for primary care services was, unfortunately, not able to support all GP practices and Primary Care Networks wishing to make improvements. So the ICB's Estates Team carried out a robust prioritisation exercise, based on national criteria with aligned clinical leadership. My committee, on 11 Jan, decided that twenty-three schemes could be supported. Details about the criteria against which the decisions were made is set out on the ICB's website.* *"My Committee decided that, at this stage, thirty schemes were unable to be supported. The ICB will work with partners to explore opportunities to progress these schemes, including alternative approaches to funding, and will continue to support practices and PCNs with addressing operational pressures as necessary.* *"More information for residents, including the list of schemes that we have supported, is available on the ICB's website."* The Board **noted** the resolutions of the PCC&A Committee as set out in the papers for today's meeting. In relation to the ARAC Part 2 Meeting, AlBo, reported that a deep dive into climate change risk had taken place. There was extensive and helpful debate which has given us some good next steps to take this forward. There were no further Committee Chairs' updates. The statement in relation to the PCCA Committee and the short update relating to the climate change risk debate were **noted** by the Board.	
19.	**Luton Airport Proposed Development Health and Community Impact ("Development Consent Order - DCO Programme")** RP presented this item as Chief Executive of Luton Borough Council. Antony Aldridge, Head of DCO Programme, Luton Rising, and Tim Simmance, ICB Associate Director of Sustainability & Growth, were also present for this item. The report was presented to the ICB as it relates to the ICB's strategic priority for growth that we should all be working together to build the economy and support sustainable growth for BLMK. RP stated that Luton is seeking to grow Luton Airport in order to optimise the benefits of the airport for the residents and businesses of BLMK. This proposed development is in line with current national policy. The Government projects that nationally we will need considerably more aviation capacity in future years. This is also set in the context that the London aviation system is the most competitive globally and we are therefore competing against other London airports.	

The Luton Rising proposition to the Government will be that growth in Luton is better for the planet, better for communities and also better for health and wellbeing than growth at any of the other airports.

We are already the country's number one most socially responsible airport as Luton Airport and the company that Luton Council owns, Luton Rising, contributes 53p per passenger, circa £7.2m, to voluntary and community sector groups in Luton and the local area, compared to 2p per passenger at the second most socially responsible airport. Within the proposal, Luton Rising is proposing to directly increase the amount that is given to the community, with up to £14m additionally aimed at projects addressing deprivation or decarbonisation.

The Green Controlled Growth Proposal is market leading and will see Luton as not only the most socially responsible airport in the country, but also the most environmentally responsible. The proposal will deliver substantially more funding for local services. Luton Council already benefits this year with £22m contribution to the Council budget that helps to fund core frontline services that support our residents.

The proposal is expected to generate 4,500 new jobs and £1bn of economic growth in an area of severe economic deprivation.

RP drew attention to the statement in the report that "the expansion proposal is expected to have overall positive health and community benefits due to direct and indirect economic growth, employment and skills opportunities for local residents, and improved access to green space. The proposal sets out initiatives and mitigations (supported by legally enforceable limits) to ensure air pollution, noise, and any other potential negative community impacts are prevented or minimised."

RP advised that the proposal is fundamental to the Luton 2040 agenda to eradicate poverty in Luton and has an overall positive benefit to health and wellbeing and sought the ICB's support.

TS added that the report that has been presented is a summary of the detailed analysis that has been undertaken by the DCO Project Team.

In response to a question, it was clarified that 77% of current employees of Luton Airport are from the three surrounding areas – Bedfordshire, Buckinghamshire and Hertfordshire - with circa 60% living in Luton or Bedfordshire. Luton Rising is looking to reduce the commuting impact of those travelling in and out of Luton – which would reduce congestion, improve air quality and work life balance for the community.

The skills required for the new roles have been identified and there is a training and employment strategy so that local skills better match the profile of skills that will be required. It is therefore hoped that an increased percentage of individuals would be employed from the local areas. It was acknowledged that there needs to be more technology-based training for young people in the local area.

There is a plan to increase presence in local secondary schools, to make sure that children understand the opportunities within aviation and the broad range of employment opportunities at the airport. This is not built into the proposal as it is part of the Council's Skills Strategy and is ongoing.

In response to a question around the social impact on health and wellbeing, AA advised that green spaces that are currently not accessible for the population are being moved away from runway areas to more accessible places for the enjoyment of the population.

It was clarified that the Government considers the climate change impact of increased aircraft to be a national responsibility and not something that can only be addressed at a local level.

	It was confirmed that the lessons learnt from previous DCO work have been embedded in the work. There is a strong track record of working towards getting this right and we benefit from having the 2040 strategy, where improving the health and wellbeing of the town is one of the five key priorities. The Board **agreed its support** for the Luton Airport DCO. *AA and PH left the meeting.*	
10.	**Board Assurance Framework (BAF)** *Presented by Maria Wogan, Chief of System Assurance & Corporate Services* MW gave an update report on the BAF in terms of work on the process and thanked the NHS trusts that have worked with the ICB to develop an escalation process. There will be further work to build that into place and collaborative working. There was a useful deep dive at the Audit & Risk Assurance Committee meeting into the climate change risk with good participation from local authorities and trusts. Since the last meeting, the System Transformation risk, BAF 5, has increased due to operational pressures and the impact that has on our capacity to focus on transformation, which is something that the Board will need to consider as we go into further work on our joint forward plan. The risk for Rising Cost of Living, risk BAF 9, has also increased due to the increased pressure on cost of living on our population. There had planned to be a System & Oversight Assurance Group (SOAG) meeting in December, where the BAF would have been reviewed at an executive level, but that meeting was postponed until next week due to operational pressures. The main risks for discussion will be the Population Growth risk, BAF 8, and also a potential risk that was identified at a recent Board seminar relating to a failure to collaborate. An update would be brought to the next Board meeting in March. Comments and feedback were welcomed from members in regard to the risks themselves and the mitigation plans. - It was confirmed that more input would be sought from local councils as well as from NHS organisations; - OK enquired as to how risks relating to primary care are fed into the BAF and it was confirmed that assurance would be sought from the PCCA Committee in this area; - The mitigation plan for the population growth risk will be discussed further at the next Board seminar, and local authority members will be asked to share information on population and housing growth; - With reference to the Health Inequalities risk, MG suggested including something in the description about the risk of capability and cultural change, and how that impacts inequality outcomes. This will be covered under item 14. The Board **noted** the BAF update.	
11.	**Bedfordshire Care Alliance (BCA) Progress Report** *Presented by David Carter, Chief Executive, Bedfordshire Hospitals NHS Trust* The progress report which was taken as read. There are four key elements of the BCA Work Programme:	

- To address the unwarranted variation in quality, access and outcomes of what people receive in different parts of Bedfordshire;
- To design, plan and organise health services integrated with social care provision in Bedfordshire;
- To focus on things that need to be done once across Bedfordshire; and
- To support the Place priorities with coherent engagement from providers covering a larger footprint and tailoring where particular place population needs require it.

One of the top priorities is the Digital Shared Care Record where good progress is being made, with all providers in the BCA. Most of this will be completed before the end of 2022/23 with final implementation completed by the end of Q1 2023/24. Connections are also being made with the Herts & West Essex ICB, as 20% of the population accessing the Bedfordshire hospitals come from within Hertfordshire.

Frailty and complex care is at the heart of what the BCA is trying to achieve and complex patients drive a lot of the spend. Some initiatives that have been put in place have been very successful: The Silver Phone; 24 hour Same Day Emergency Care (SDEC) which went live at Luton & Dunstable Hospital (L&D) in December; and virtual wards where the ambition is to achieve 250 virtual beds by April 2024 focussing initially on frailty and respiratory.

A re-design of community services is being considered and there was real progress at a workshop yesterday into how services can work better together across Bedfordshire.

There is a recognition that, despite the challenges we have had in the two hospitals over the last two months, the escalation work that has been carried out has been very successful. All partners have come together to solve problems and make decisions quickly.

In terms of governance, the BCA has been established as a formal committee of the ICB with an ICB Non-Executive Member, Shirley Pointer (SP) as Chair.

Going forward, the BCA will be looking at the priorities to make sure that they are the right ones, making sure that the governance structure is right and that there is no duplication of work with other entities. The intention is to use the existing ICB PMO function more, but not to create new bureaucracy either at Place or at ICB level. Preparation is also underway for potential delegation of budgets from the ICB to Place and the BCA.

The Board discussed the paper and the following questions were asked:

- *How are residents involved in owning their own patient record and the process around that?* There is a partnership project with residents for the patient portal. It is vital that patients are enabled to take more responsibility for their care and understand what the BCA is doing.
- *It would be good to understand more fully the community services in terms of prevention and health inequalities work, and how it aligns with the Fuller programme of work.* There are currently two community providers who work separately and differently, and work is underway to bring these together. The Fuller Programme is an umbrella programme that is driving a number of priorities and the work of the BCA and Fuller are fully aligned.
- *How will the mapping of projects play out?* A couple of months ago all of the projects in the system were mapped out and how they relate to BCA and MK and further work is being done to determine which are the priorities which will then feed into the planning process. It is crucial to collaborate with communities on co-producing projects.

	Action: "Fuller Report" to return to the agenda for the WWPAC Committee meeting as appropriate The Board **noted** the update and direction of travel for the BCA and **agreed** the "asks" that had been identified and set out in the report.	MS
12.	**People Strategy** *Presented by Martha Roberts (MR), Chief People Officer* The People Strategy has been developed from the People Plan that was previously shared with the Board. It is very much linked to the ICB/ICS strategy and to ensuring that we do the right things at the right place with each partner to add the best value. There had been a lot of discussion with partners in developing this strategy and the Chief People Officer extended thanks to them. The four focus areas are: - To make BLMK ICS a welcoming place to learn, work and volunteer; - To make working across organisations, systems and specialties the norm (e.g. Fuller neighbourhoods); - To provide a system-wide framework to enable integrated care and empower place and neighbourhood teams; and - To do things together and at scale that benefit staff and populations. There are lots of examples at the moment, such as discharge to assess (D2A) work, the virtual ward work and admissions avoidance and how the neighbourhood schemes support that. Care Home Champions & Coordinators are being appointed, to help us to understand the needs of the residents and to better inform their personalised care. In response to questions the CPO confirmed that work is underway to understand how willing colleagues are to work in different settings, and how to match culture and pay differences to make this work. Staff will be involved in helping to design this. Primary Care may be able to lead some of that work in terms of previous conversations about social prescribing, personal coaches and personalised care and caring for people in their homes and community – taking us back to Place and neighbourhood teams. This represents transformational changes for the workforce, and it is important to factor in resource planning at planning level. The Board **approved** the People Strategy. *RP left the meeting.*	
13.	**Resident's Story in Relation to Inequality** (verbal) A resident's story was shared by the Chief Nursing Officer in relation to a transgender person who had been asked inappropriate questions by ambulance crew, when needing emergency treatment. This had caused considerable upset to an already vulnerable individual. East of England Ambulance Trust has extended their sincere apologies for the experience that the patient and their partner experienced. They have established an LGBT+ group and are leading engagement with staff on inequalities issues. This story has helped us to think about our experiences towards our residents and also think about how we treat residents in all settings. The resident has been invited to the Private part of the meeting to share his experience with the Board in private.	

14.	**The Inequalities Journey – "Where are we Going and Where have we Been?"** *Presented by Sarah Stanley, Chief Nursing Director and Julia Robson (JR), Inequalities Programme Lead* A one year piece of work on inequalities started in 2021/2022 and is intended to build on and continue the work on tackling inequalities, and plan for the longer term, in partnership with population health, Public Health, sustainability and improvement colleagues. The inequalities dashboard, designed by BLMK, has been very successful and enables us to understand and measure improvements at a PCN or neighbourhood level. A sum of £200m was made available nationally to tackle inequalities and £3.3m of this was made available to BLMK. The proposal was created collaboratively with system partners and included the following: This year it has possible to allocate £3.3m that had been ringfenced for health inequalities and was not on the current funding: - £1m was allocated to Place, which has mainly gone towards mitigating the cost of living crisis such as the use of warm hubs. Some of the PCNs' health inequalities projects have been bolstered as well as specific projects such as supporting pregnant mums to quit smoking which is specific to Luton; - £1.1m was given to the clinical programme to tackle Core20+5 which mainly targets the 20% most deprived communities, but also some of the more vulnerable groups such as LGBT+, the homeless and those in BAME communities; and - £300k has been allocated to Community Connectives, which helps to deliver on the Core20+5 programme. These consist of members of communities such as religious leaders or shopkeepers, who help with 3-way conversations with the communities of interest. The final amount has gone towards the following: With Healthwatch and the VCSE sector, engagement exercises have been undertaken with some of the vulnerable groups, such as Roma and Gypsy Travelling Communities following a literature review which was commissioned last year. Separate from the programmes, work is ongoing with digital teams, Public Health and population health colleagues on the design and delivery of the programme and projects such as the data warehouse and the intelligence units have been funded. An Inequalities Lead has been funded and an Improvement Advisor has been recruited to help us to understand the system but also collaboratively to design improvement ideas and test them robustly in a way that they can be measured. Tackling inequalities training and practical workshops are being rolled out, primarily to medical optimisation and primary care teams. Training on building an inequality strategy has started with some teams, which will be further rolled out, linked to the inequalities workshop that took place in October. It is planned to build capability and capacity within the system, to recruit more Improvement Advisors and Data Experts to Place and to work with Public Health colleagues to ensure that the programme is evidence-based and a holistic approach to inequalities. *From the Floor* *How can we help to ensure that we tackle the wider determinants of health inequalities and do not only fund those directly related to health, and ensure that inequalities work is part of our business as usual (BAU), and done collaboratively not in siloes and not duplicating work already being done elsewhere? How do we develop the metrics to determine the interim milestones so that we know that we are on the right track or whether we need to change direction?*	

	JR explained that the programme was able to work with Places and Programme Leads to ensure that the focus was not just on health inequalities, but also on funding preventative programmes, which is one of the five national priorities. Some of the funding has also gone to VCSE workstreams to mitigate the cost of living crisis. The programme team is working closely with Public Health leads to ensure that there is an evidence-based approach to the programmes of work. When there is a quality improvement lens on everything, focus is not just on one thing; it allows understanding of the system and working collaboratively with those closer to the issues. In terms of measurement, we have developed the dashboard which helps us to measure the health inequalities against the Core20+5. Quality improvement will allow the ICB to create and own those measures in a collaborative way, but also include process measures. When ideas start to be developed, measures are put against each one and progress monitored on a monthly basis. SW added that our aspiration is to become a Research ICS and, as part of that, a Research & Innovation Hub was formed in collaboration with the University of Bedfordshire. JR is also a link to a study looking at health and inequalities, particularly in Luton, which seeks to include the homeless, people with substance abuse and sex workers. *How we do make sure that we are maximising this programme of work and complementing what is happening at Place? We need to be mindful that there are a lot of inequalities in healthcare services and must make the most of our collective resource. Because of short term funding, we do not yet sufficient intelligence but look forward to being able to use the intelligence in a more meaningful way.* JR responded that it is important to acknowledge that "inequalities" is everyone's business, but the programme gives a lens to help to determine where that is done either together or separately and how different populations are serviced. This is a good and timely opportunity to consolidate and simplify a common approach, with engagement with Public Health being key. *How are we hearing back from residents on the impact of what we are doing?* We work closely with Healthwatch and VCSE colleagues and also have our Community Connectives where we hope to share pieces of work with our populations, rather than have one off conversations with residents. We will also continue to invite residents to events, such as the one in October, to work with us to define ideas rather than to tell them what we intend to do. The Inequalities Journey paper was **noted**.	
15.	**Update on Strategy and Planning** *Presented by Anne Brierley (AnBr), Chief Transformation Officer* The BLMK Integrated Health and Care Partnership Strategy was approved by the BLMK Integrated Health & Care Partnership (H&CP) on 14 December 2022 and has now been published on the BLMK ICB website. The strategy focusses on what we want to achieve differently through collaboration and partnership over the next 20-25 years and "increasing years lived in good health". We are looking at what we can best do together for the benefit of our residents, rather than as individual organisations. Thanks were given to the two Public Health Directors for their work on the 15 key inequalities which helped to bring alive the purpose and the reason for the strategy and helped us to understand how that has a different impact in different places across BLMK. The next stage is the production of the operational and financial plan and contracting for this year and the following year. The 240+ key performance indicators (KPIs) that	

	were given to the NHS through planning guidance last year, have been reduced to 32, which is positive. The contracting round will give us the opportunity to reflect on our collaborative ways of working, in terms of our legal agreements between each other and how we hold each other accountable. This year there will be a shift to move NHS or local authority bilateral agreements with community service providers to a more collaborative approach. We need to move forward with our VCSE sector, building on the work that local authorities already have in place and the work being done in the ICB with the VCSE sector. Some of these plans need to be agreed by the spring in order to make an impact for next winter. It is a key priority and we must find a sustainable way of working, rather than stop/start initiatives due to funding constraints. This will be very much Place specific and Place driven, in line with the Fuller Programme. We are continuing to build on what we have already done together but are also looking at populations that we have not reached and where residents do not come forward. For example, in neighbourhoods where we are not achieving their clinical standard around cancer treatment, we are not only trying to improve existing pathways, but are also looking at how to bring in those residents who are not coming forward for early diagnosis of cancer. We want to understand the impact on the whole of our population, so need to work harder on engaging with neighbourhoods where accessing services is an issue. There are also a number of "wicked" challenges that continue to come up across BLMK, such as complex placements, particularly for children, continuing health care and mental health care. It is suggested that these should be the key themes of the joint forward plan that we can only resolve if we work together and would not form part of individual operational plans. The feedback from the last Board meeting was that we should invest this year in some detailed benchmarking as to how we are delivering against those key criteria, to give us a baseline that we can work from in co-production at Place and in Collaborative to build a sustainable future. The Board was asked to note that the timing around the Joint Forward Plan has now been extended to the end of June, although the first draft must still be submitted by the end of March. The CFO confirmed that we are required to submit a draft Financial Plan before the end of February and the final Plan at the end of March. A detailed system timetable has been developed, although some of the detail is not yet available. Having run initial settlement numbers through our medium-term Financial Plan, the efficiency ask is likely to be around £90m or 5%, in line with previous calculations. However, a significant piece of the guidance around the Elective Recovery Fund has yet to be issued. That could potentially increase productivity for this system considerably. It was acknowledged that there may be a degree of flexibility in the Financial Plan in terms of funding key priorities, as long as the national targets are being met. It was confirmed that currently there is engagement at Place through Place Boards, but that there will be further engagement with communities at a later point in the development of the Joint Forward Plan. The Board **noted** the approval of the BLMK ICP strategy, **noted** the revised submission date for the joint forward plan and **supported** the proposed approach to the development of the 23/24 operational, financial and workforce plans and the longer-term joint forward plan.	
16.	**Progress Report: Implementation of the Voluntary, Community & Social Enterprise and BLMK ICB Memorandum of Understanding (MoU)**	

	The Co SACS gave a progress report since the last meeting where the MoU was agreed, to provide assurance that there is work underway to make sure the MoU is fulfilled. There is a Strategy Group across BLMK which MG Chairs. A VCSE co-Chair is being appointed. The reports on the MoU are going to Place Boards in February or March to ask for colleagues' support and for discussion on the role of VCSE in delivering our strategy at place. Work is also underway on mapping our investment of partners in VCSEs to help us to maximise the benefit and articulating the benefits that VCSE can bring to the system. MG added that the key aim of the initial Strategy Group workshop was to make sure the partnership had a collective shared understanding. It was hoped to bring some of the findings from the initial Strategy Group workshop, which included the value of population management and health inequalities, to the Board, once they have finalised. MT asked that the potential conflict of interest for VCSEs between their role as potential providers of the system and their role as a valuable resource from their direct experience with residents to collaborate with us to inform our strategy be acknowledged. MW offered support to Healthwatch, if needed, to produce an MoU between them and the ICB. The Board **noted** progress with the development of the strategic partnership of the VCSE and **supported** the discussion of the MoU and the opportunities for greater partnership working with the VCSE at Place Boards in February. **Action: MW and MT to discuss a potential MoU between Healthwatch and the ICB.** *There was a short refreshment break.*	MW / MT
17.	**Health & Care Senate (H&CS) Update** *Presented by Dr Sarah Whiteman, Chief Medical Director, BLMK ICB, and Chair of H&CS.* This item was brought to the meeting to identify the role of the H&CS. It is a non-statutory advisory committee to the ICB, its main purpose being to provide robust, evidence-based views and recommendation on care and health issues. H&CS members are a diverse group of senior care and health professionals from a wide range of organisations within the BLMK ICS. Examples of some areas of work have been Percutaneous Coronary Intervention (PCI) services review, Musculo Skeletal (MSK) health needs assessment and Head & Neck cancer services for MK patients. The forum also works closely with the University of Bedfordshire in relation to the Research & Innovation Hub, and with the Bedfordshire Fire Service in relation to falls prevention. Future development around transformation includes how best to include meaningful participation from VCSE and patient representations, identifying transformation and efficiencies, including to ophthalmology and other elective pathways where there are delays and working with partners to improve system flow. This committee meets quarterly and reporting back will flow through the appropriate Committees or the Board itself, should there be a need for Board review or approval. The members **noted** the Terms of Reference and Programme of Work of the Health & Care Senate.	

18.	**Green Plan – Health Impact Assessment Report** *Presented by Maria Wogan, Chief of System Assurance & Corporate Services, and Tim Simmance, Associate Director of Sustainability & Growth* Climate change and the carbon emitting activities that cause it already drive disease and health inequalities in BLMK and will likely worsen without proactive action; the Green Plan therefore present a significant and urgent opportunity to improve health. The ICS Green Plan was created with input from NHS, local authority, VCSE and academic partners in BLMK. Published in April 2022, this gave the high level ambitions for the ICS, with the intention to develop detailed delivery plans as our collective understanding and plans in the area developed. The Green Plan Health Impact Assessment (HIA) was undertaken between September and December 2022 and is an initial attempt to connect BLMK's carbon reduction commitments with local health outcomes. The purpose is to help identify priorities for the Green Plan at the intersection between commitments in environmental sustainability and the impact on the health and wellbeing of our populations. The baseline data for carbon reduction commitments in the ICS Green Plan is limited, making the impact of these commitments on emissions uncertain. Based on the scope and scale of interventions in the scientific literature, current ICS Green Plan commitments were not ambitious enough in scale or scope to measurably improve health for BLMK communities or staff. Climate change, current emissions and the systems that generate them are damaging health and contribution to inequalities in BLMK now, notable across domains from air pollution to extreme heat, to travel and nutrition. There was a discussion as to how bold we should be as an ICS on the net zero and environmental sustainability agenda, the role of the Board's individual and collective leadership in furthering the work and how to ensure that environmental sustainability forms a core part of existing work to improve the health and wellbeing of our residents. The Board **noted** the findings of the BLMK Green Plan Health Impact Assessment, and **approved** the recommendations as set out at paragraph 2.2	
20.	**Quality and Performance Statement** *Presented by Sarah Stanley, Chief Nursing Director and Maria Wogan, Chief of System Assurance & Corporate Services* Based on a risk-based assessment of overall quality and performance across the system, the report focusses on winter and elective performance as well as providing an exception report in relation to other areas of performance. We continue to see challenged performance in meeting urgent and emergency care standards, access and quality. Our population is experiencing long waits to access emergency care both in our emergency departments and ambulance response times. A&E attendances in December have increased by 11.73% on the same time in 2019, with all Trusts seeing record numbers of attendances over the last two months. Hospitals have been operating with high levels of bed occupancy 95.9% (December to 10th January) and the pressure on hospitals has seen ambulance handover delays. Although our system has relatively good performance it is not the standard of care we want to provide for our residents. A quarterly review meeting for the ICB with NHSE Regional Leadership Team was held recently at which the development and overall performance of the ICB and ICS was discussed. The BLMK ICB continues to be rated against the Single Oversight Framework (SOF) at level 2 (on a development journey but demonstrates many of the	

	characteristics of an effective ICB). No significant concerns about performance or quality were raised at the meeting. The process and approach to NHSE review and regulation for ICSs is being developed for 2023-24 and will be reported to the Board in March, when confirmed. Some key points were drawn from the report: - There has been a significant increase in activity, with primary care appointments 12.8% higher than pre-pandemic and 79% delivered face to face**;** - The opening of four Acute Respiratory Infection (ARI) hubs has increased primary care capacity in response to the significant increase in demand related to respiratory infections, which should reduce pressure on the system's A&E departments and enable people to be seen closer to home; - There is now a System Control Centre which supports the system with the management of operational pressures and over 1000 contacts have already been received since the centre opened in December; - Patient Safety Incident Response Framework (PSIRF) implementation is on track. A "community of practice" for all provider PSRF implementation leads has been established and BLMK is developing process for patient safety investigation system panels to review where harm may have been attributed across system partner touchpoints; - Winter operational pressures have impacted residents and the report summarises actions taken to manage the high pressures during December and January; - Elective waiting lists are summarised in the report, with the longest areas being ophthalmology, trauma and orthopaedics, gynaecology and ear, nose and throat; - Trade unions representing NHS staff are in dispute over the 2022/23 pay award, but no Trusts in BLMK took part in the strikes on 18-19 January and only South Central Ambulance Service (SCAS) members took part in a strike on 11 January; - BLMK is below the planned target levels for Dementia Diagnosis Rate and a new specialist dementia diagnosis service for care home residents is being set up by ELFT in Central Bedfordshire as part of a national NHS pilot; - A review is underway on the current pathways for suspected autism in adults and children and recommendations will be presented to the Children & Young People Board in February**;** - As part of a national programme, Community Eating Disorder Services are being expanded across BLMK; and - Quality teams are working closely with main providers ELFT and CNWL on establishing a position of assurance regarding safety on inpatient wards. A task and finish group is in development for wider areas of provision where people may be placed in other inpatient service including patients under Section 117. This is a large piece of work and will be updated on a quarterly basis. The Board **noted** the areas of improvement and concern and **agreed** any additional actions required to manage risk in the system.	
21.	**Finance Report – November 2022 – Month 8** *Presented by Dean Westcott, Chief Finance Officer* Taking the report as read, the following key points were highlighted: - NHS organisations hosted within the system are reporting a £0.3m favourable Income & Expenditure variance to plan at month 8 and the forecast remains delivery of a breakeven position; - System efficiency plans are on target year to date and forecast to deliver in full by the end of the year; and - The ICS will manage capital schemes within the capital limits (CDEL) set by NHSE.	

	The key risks are: - The delivery of efficiency and productivity plans; - Inflationary pressures over funding levels; and - The impact of the pay settlement for NHS staff not being fully funded. The levels of emergency activity and ongoing work to reduce waiting lists will have an impact, and we are also experiencing pressures with regard to strike and continuing healthcare. It is considered that we will be able to balance in the first three months of the year, but this position is not sustainable going forward. There is a commentary on the financial position of Local Authority partners in Appendix A which reflects the latest available publicly available information of partners. Local Authorities are experiencing pressures, some of which may mean that they struggle to balance their positions. The Board **noted** the month 8 forecast and position for revenue and capital and the risks to the financial forecast.	
22.	**S75 2022/23 Agreements** Section 75 (S75) agreements for the 2022/23 year, which govern arrangements agreed with local authority (LA) partners, are already in place. An approach for 2023/24 has been agreed with LA partners, which was supported at the Finance & Investment (F&I) Committee and was brought to the Board for approval. *JH left the meeting* The Board **approved** the proposed 2023/24 S75 agreements for the 2023/24 year.	
23.	**Communications from the meeting** A formal report will be produced of key points from the meeting, which could then be taken to partner board and place meetings. The Chair proposed that the following items be included: - Luton Airport - People Strategy - Resident's Story and the importance or raising awareness amongst all staff to be sensitive to all our residents and not inadvertently create barriers to accessing healthcare - Inequalities journey - Green Plan - Strategy and Planning and the need for Place plans to be presented at H&CP Committee and need for Joint Forward Plan. **Action:** MS to prepare formal report of communications from the meeting which can be taken to partner board and place meetings.	
24.	**Annual Cycle of Business – Items for Next Meeting** Items proposed for the March meeting, as taken from the Annual Cycle of Business had been shared for information and review. The programme for 2024 is being developed and will be presented at the March Board meeting.	

	The Annual Cycle of Business update was **noted**. **Action:** KA - 2024 Annual Cycle of Business to be taken to March meeting.	
25.	**Review of meeting effectiveness** This agenda item forms part of the Board Assurance process and informs how we develop, and a more detailed process map will be produced in due course. The Board was asked if they are satisfied that items are put on the ICB agenda in a timely fashion for discussion and/or decision, and what else would they like to see in the future. - LC suggested that there should more discussions on the budget in the run up to it, particularly around capital, although it was acknowledged that it is difficult to create a budget when it is not known what is available to us; - MC questioned the performance report, when decisions have already been taken; - LC – queried why the DCO item had been brought to the Board, FC advised that Luton Borough Council had asked us to take this to the ICB and that taking any future proposals to the Board would be considered on a case by case basis.	
26.	**Any Other Business** There was none.	
27.	**Date and Time of Next Meeting:** The next meeting of the Board will be held on Friday 24 March 2023 at Milton Keynes Council Chamber. Exact timings will be confirmed nearer the time. The deadline for reports will be noon on Monday 13 March 2023. There will also be a Board seminar on Friday 24 February, details to be confirmed. The meeting closed at 12.07.	

Approval of Minutes:		
Name	Role	Date

Integrated Care Board MASTER Action Tracker as at 6.1.23

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

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	**COMPLETE** - GREEN
CLOSED (dd/mm/yyyy)	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
7	29/07/2022	Peer Accountability	To take forward peer accountability across the system at System Oversight Assurance Group and CEO Groups	Felicity Cox		31/03/2023	**15/3/2023** System Peer Accountability and Support approach agreed at System Oversight & Assurance Group on 3/2/23 **18/01/2023** December SOAG cancelled. To be discussed at next meeting on 3 February 2023. 17/8/2022: Individual discussions being held with each CEO and then discussion at CEO Forum in October. Approach will be tested and refined throughout the year. Next discussion at SOAG meeting in December.	**COMPLETE: Propose closure at next meeting (24/3/23)**
33	25/11/2022	MOU with the VCSE Sector	Action: Place Linked Directors to discuss how the MOU is being implemented at Place at their next Place Board meetings	MW - Milton Keynes NP - Luton AnBr - Cbeds SS - Bedford		Next Place Board Meetings	**15/3/23** Action to close when last place board meeting has taken place on 12/4/23. **18/01/2023** A paper has been drafted and will go to Place board meetings in February/March	**COMPLETE: Propose closure afater 12/04/2023**
34	25/11/2022	ICP and ICB Operational Delivery Planning Update	Action: AnBr to collaborate with Places to establish what they are doing and the minimum that they need to do by next month and then identify next steps	Anne Brierley		End December 2022	**7/3/23** A summary of the current Place Plans was reported to the H&CP on 7/3. The Place Plans are at different stages of development	**COMPLETE: Propose closure at next meeting (24/3/23)**
35	27/01/2023	Questions from the Public	Questions from the Public and response to be shared on the ICB website	Michelle Summers		31/01/2023	**7/3/23** Questions from the public have been captured and were published on the website, together with answers from the primary care team. The notes can be found here Board Meetings - BLMK Integrated Care Board (icb.nhs.uk)	**COMPLETE: Propose closure at next meeting (24/3/23)**
36	27/01/2023	Chief Executive's Report	Circulate submission for Hewitt review to members and participations of the ICB Board	Maria Wogan		31/01/2023	**15/3/23** Has been made available in the "library" on Board Effect.	**COMPLETE: Propose closure at next meeting (24/3/23)**
37	27/01/2023	Chief Executive's Report	MS and MT to discuss communication of the newly published strategy to residents	Michelle Summers and Maxine Taffetani		27/02/2023	**7/3/23** The Health and Care Partnership Strategy has been published to the website. We are currently looking at how we provide accessible versions of the plan, including video to make this information easy to access for local people.	**In Progress**
38	27/01/2023	BCA Progress Report	"Fuller Report" to return to the agenda for the WWPAC committee meeting as appropriate	Michelle Summers		27/02/2023	**7/3/23** A workplan is currently in development for the Working with People and Communities Committee. Work around Fuller and how local people will be able to get involved in this has been added to the work programme.	**COMPLETE: Propose closure at next meeting (24/3/23)**

Action No.	Meeting Date	Agenda Item	Action	Action Owner	Past deadlines (Since Revised)	Current Deadline	Current Position (latest update)	RAG
39	27/01/2023	Progress Report on VCSE	MW and MT to discuss a potential MoU between Healthwatch and the ICB	Maria Wogan and Maxine Taffetani		30/06/2023	**15/3/23** A draft MoU between the ICB and the 4 Healthwatch organisations is in development and will be presented to the Working with People & Communities Committee and the Board in June 23.	**In Progress**
40	27/01/2023	Communications from the Meeting	Prepare formal report of communications from the meeting which can be taken to partner board and place meetings	Michelle Summers		03/02/2023	**7/3/23** Headline communications from the meeting was produced and has been completed and was distributed to all partners following the meeting.	**COMPLETE: Propose closure at next meeting (24/3/23)**
41	27/01/2023	Annual Cycle of Business	Add ACOB 2023/24 to next meeting agenda	Kim Atkin		30/01/2023	**15/3/23** On agenda for 24/3/23 meeting.	**COMPLETE: Propose closure at next meeting (24/3/23)**

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Board of the Integrated Care Board (ICB)
7. Chief Executive Officer's 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	Georgie Brown Chief of Staff
Date to which the information this report is based on was accurate	3rd March 2023
Senior Responsible Owner	Felicity Cox Chief Executive Officer

The following individuals were consulted and involved in the development of this report:
Michelle Summers, Associate Director, Communications and Engagement Sandra Vanreyk, Senior Programme Manager Dominic Woodward-Lebihan, Deputy Director System Assurance and Corporate Services Abimbola Hill, Deputy Head of Organisational Resilience
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 report

Executive Summary Report

1. Brief background / introduction:

This report provides a summary of corporate activities since the last Board meeting on 27th January 2023.

2. Summary of key points:

2.1 ICB running cost allowances: efficiency requirement

NHS England wrote to ICBs on 2nd March 2023, setting out the requirement for ICBs to reduce running costs by 30% by 2025-26, with at least 20% delivered in 2024-25. There is flexibility for ICBs to determine locally how to meet these requirements, including how we configure our teams, what functions we may want to outsource, and where to work across multiple geographies. The letter is clear that there is no intention to drive changes to ICS footprints through this work. The letter provided the clarity we needed to move forward with our current direction of travel: We see our ICB as being a small, central, enabling organisation delivering our core statutory functions on behalf of our system. Our focus is on working on a partnership basis, strengthening our contributions to partnership teams at our four Places and through Provider Collaboratives. We are committed to supporting all staff through this process and we remain focussed on our core statutory duties and the delivery of our vision: for everyone in our city, towns, villages and communities to live a longer, healthier life. I will keep you updated as we learn more and will continue to engage and work with Board and Partnership members to make sure we get this right.

2.2 How we are working together to deliver improved health and care:

- **Healthier You** is the local name for a national NHS diabetes prevention programme, which identifies people at risk of developing type 2 diabetes and refers them onto a nine-month, evidence-based lifestyle change programme. It enables people to take charge of their health by giving them advice on how to eat more healthily and be more physically active. Link: Victor's diabetes prevention journey in Luton
- **Crisis Cafes:** The ICB funds crisis cafés in Luton, Bedford, Milton Keynes and Central Bedfordshire. These are delivered by Mind BLMK, in partnership with ELFT and CNWL. They can support people who live with a range of mental health conditions, including post-traumatic stress disorder, bereavement, depression and anxiety. Cafés are open in the evenings for people who experience a crisis or distress when many services are closed. A trained mental health worker will listen and identify ways to help. Link: Local people benefit from mental health support at Crisis Cafés
- **Health and Wellbeing:** A monthly coffee morning in Bedford, started up six months ago by Terry Haydon, a social prescriber working with East Bedford PCN, offers health and wellbeing advice to people living in some of the more deprived neighbourhoods in the town. A range of organisations providing advice and support attends the coffee morning each month, including Age UK, Healthwatch, Sight Concern and Mind. Link: Bedford coffee mornings provide people with health and wellbeing advice

2.3 Communications and Engagement

The ICB's Communications and Engagement Team is changing the way we communicate as an organisation. At the heart of this work is a more proactive communications strategy, focussed on working with partners to celebrate more of the exciting initiatives happening across the system and doing a better job of explaining what it all means for our residents. Our communications are becoming

more structured and better disciplined, underpinned by a new Communications Grid setting out each day's press releases, stakeholder bulletins, social media activity, events, visits, internal communications, and national and local news updates (where known). Use of social media is also growing to promoting the work of the ICS, connect digitally with partners and raising the charitable endeavours of staff.

2.4 Nursing Associate Apprentice Celebration and Engagement Event, Thursday 9th February

On the evening of Thursday 9th February, we were pleased to welcome our 23 current Primary Care Nursing Associate (NA) apprentices to Bedford, along with Minister Quince as the keynote speaker.

The Nursing Associate Apprentice Celebration and Engagement Event was planned to coincide with National Apprenticeship Week. It was designed to celebrate our 23 current primary care Nursing Associate (NA) apprentices and to encourage general practices and primary care networks within BLMK to support their staff members to access the apprenticeship

The BLMK Primary Care Training Hub has been working to support practices and staff members to access the apprenticeship through providing information on the NA role and how the apprenticeship works and providing support to the NA apprentices as they progress through their apprenticeship.

Nursing Associates see their own caseload of patients thus free up registered nurses to see more complex patients. The role can also be an intermediate step between healthcare assistant and registered nurse and NAs can train to become registered nurses through the completion of a two-year top-up degree. Therefore, the NA apprenticeship is a route into nursing which many applicants would previously have been unable to access.

This is a new role in primary care designed to bridge the gap between healthcare support workers and registered nurses. Given the workforce pressures in the NHS it is right that we are opening new routes and being innovative about how we get great talent into key roles

Completing the NA apprenticeship is a major commitment, both from the apprentice and from their supporting practice. We wanted to recognise this hard work and thank our apprentices and their practices through a celebration event.

2.5 Community Diagnostic Centres (CDC)

I am pleased to share with you the February announcement from the Department of Health & Social Care (DHSC) that 19 additional community diagnostic centres (CDCs) will open this year. Three of which are in BLMK:

- North Bedfordshire CDC; go-live is planned for Q3 of 2025.
- Lloyds Court (Milton Keynes); go-live is planned for 1st October 2023
- Whitehouse Health Centre (Milton Keynes) planned for 1st April 2023

The proposed Luton CDC site was also well supported, and we are working further to confirm an appropriate location. A number of venues are being considered with Local Authority partners sharing estates opportunities with the Trust. Floor plans and exact requirements are worked through. Estates leads from both parties are in regular dialogue and we hope to find a solution soon.

The CDCs will house a range of equipment including MRI, CT, X-ray, and ultrasound scanners and offer services including blood tests or heart rhythm and blood pressure monitoring. They will also increase the number of diagnostics patients receive in one visit which will reduce travel requirements.

Once referred by a GP, pharmacist or hospital, patients can access CDCs in their local area to get any concerning symptoms checked out.

The intention of a CDC is to provide separate, dedicated locations for carrying out elective diagnostic tests, ideally away from acute hospital sites. They are designed to deliver additional, digitally connected, diagnostic capacity, providing all patients with a co-ordinated set of diagnostic tests in the

community, in as few visits as possible, enabling an accurate and fast diagnosis on a range of a clinical pathways. CDCs not only support increases in activity and meet local populations needs beyond 2022/23, but they also provide diagnostic resilience by separating the provision of acute and elective diagnostic services (where it makes sense to do so) and provide pathway improvements by giving GPs more direct access to diagnostics.

We look forward to working with our partners across all BLMK to build on this announcement and enhance the diagnostic offer for residents.

2.6 2023/2024 Operational Planning

I briefed the Board in January of the expectations set out in the NHS 23/24 Operational Planning requirements. The BLMK ICB Draft Operational Plan was submitted to NHS England on 23rd February, and I would like to recognise the hard work of teams to date and thank them for their continued commitment. Further detail will be discussed at the substantive paper later in the agenda.

2.7 Industrial Action

Trade unions representing NHS staff advised the Secretary of State for Health and Social Care last year that they were in dispute over the 2022/23 pay award. A number of the unions balloted or are balloting their NHS members to take part in industrial action. Each Integrated Care System was requested to coordinate an early self-assessment of the potential impact of strike action in each of the affected Trusts, as well as the impact at ICB level.

The planning and preparation for the industrial action has been significant for partners and I would like to extend my thanks to all those involved. The priority for system planning was to limit harm to patients and clinical prioritisation. System partners are working in support to maximise out of hospital capacity including Urgent Community Response and discharge. We will be working to quantify the impact of the Industrial Action on services and to ensure recovery is as timely as possible.

Junior Doctor Strikes (BMA, BDA, HCSA): Dates confirmed 06:59 Monday 13th March to 06:59 Thursday 16th March. This is a full walk out with no emergency care provision.

BMA has also undertaken a consultative ballot of Senior Hospital Doctors (Consultants) with 86% in favour of strike action. This is indicative of the potential for strike action, not a legal mandate for it. BMA have asked the government to review and outline serious proposals to address the ongoing pensions crisis and cuts to pay by 3rd April, otherwise they will proceed to statutory ballot around 17th April. Strike action by consultants would mean consultants running a “bank-holiday” service on weekdays ensuring that emergency or urgent care remains in place.

This Industrial Action is a full stoppage of work, including night shifts, on call shifts and non-resident work. The BMA has confirmed that there will be no derogation of services negotiated at any level for the during the strike period, with the exception being arrangements to recall staff in event of a mass casualty incident.

British Dental Association (BDA) balloted hospital dental trainees including within Bedfordshire Hospitals NHS Foundation Trust. BDA have aligned their Impact Assessment (IA) with that of the BMA with a complete cessation of labour for 72 hours 06:59 13th March to 06:59 16th March.

Royal College of Nursing postponed strikes scheduled for 1st to 3rd March pending the outcome of government talks. There are currently no further dates announced at this stage.

Chartered Society of Physiotherapy announced further for strike action 20th March.

UNITE announced postponement of the strike action for 6th March

GMB and Unison postponed Ambulance strike action for 6th March. However, industrial action for 20th March is currently scheduled to go ahead

Teachers industrial action scheduled for 15th and 16th March.

The ICB Command and Control arrangements were mobilised on each of the strike days. Martha Roberts, ICB Chief People Officer, the Senior Responsible Officer for Industrial Action, will continue to coordinate the system in response to the ongoing Industrial Action.

2.8 Update on Hewitt Review

We have had the opportunity to feedback on several key areas, including estates and capital funding. Workstreams are hosting open meetings to test recommendations and gather feedback and Confed has commissioned some expert research papers to test the emerging themes and recommendations. These outputs will be cross referenced ahead of the thematic reference groups to engage with the wider ICS membership. The review is also looking at the role of CQC (Care Quality Commission) and its operating framework and the role of Ofsted in Children and Young People's care. On finance, clear messages regarding multi-year recurrent funding with proportionate reporting and targets attached. I look forward to reporting on the findings and outputs from these sessions.

2.9 Staff Engagement Events

I reported to you in January that the ICB planned to commence its Organisational Development plan with Staff Engagement Events to support a year of transition. The events were a great success and the Executive Team received feedback from staff who articulated their energy and readiness to be part of the journey towards integrated working across the system. Through the participation in several interactive workshops, the staff learned about the excellent work that is already underway in co-production, VCSE, the MK Deal, prevention, and professional leadership. Staff were keen to undertake more sessions throughout the year to build on their learning so far.

2.10 Key Events during February and March

2.10.1 MP Briefings

The Chair and I have offered and undertaken a series of MP Briefings with BLMK MPs. We have had the opportunity to discuss local issues and priorities for them and to let them know of what is happening and planned for health care services in their area. Much of this focus has been in relation to Primary Care access, estates and future needs aligned to growing populations and housing developments.

2.10.2 ICB and Bedfordshire Fire and Rescue Service Collaboration Event, 20th February

The CEO, members of the Executive Team and key leads from across the ICB attended a joint workshop with the Bedfordshire Fire and Rescue Service (BRFS) with the objectives of clarifying the value of place-based collaboration; identifying community risks, vulnerable people, and places; and gaining an understanding of what is possible. Delegates held discussions on different tables to cover key topics such as population data; community insight; community risk analysis; operational capabilities; estates and community engagement.

2.10.3 ICB Board Development Seminar, 24th February

On 24 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. Directors of Public Health and Local Authority Chief Executives presented on population growth in BLMK – one of the fastest growing areas in England. The Board discussed the impact of this growth on demand for health and other public services, and how best to respond to it. This was followed by place table discussions on Fuller Neighbourhoods and how we work together, our vision and ambition, next steps and timescales, workforce and estates, enablers and support requirements. The discussions between leaders in each of our four places has been collated and will be considered at future Place Board meetings as the basis upon which place leaders can build their plans for developing a diverse, modern, and effective primary care offers that meets residents' needs.

The ICB's Chief Finance Officer and Chief Transformation Officer then took the Board through the next steps for Planning – both financial planning and the Joint Forward Plan.

2.10.4 NHS England Executive Team and ICB CEOs Meeting 28th February 2023

Maria Wogan attended the national NHSE and ICB CEOs meeting on my behalf. The national team shared thanks with all for the hard work of all through winter and planning to date. The meeting focused on the current financial and delivery position of the NHS and asked all to focus on some key issues, including closing the financial gap, increased productivity opportunities and digital solutions. The Primary Care Delivery Plan is due to be published which will focus on improving access and a series of actions designed to take the pressure off the GP workforce, including greater use of the NHS App, 111 online, community pharmacy, improved telephony, and ways of working, which all supports the Fuller programme. As an ICB we will need to ensure our continued focus on mental health and learning disabilities alongside the national targets associated with urgent and emergency care, capacity and waiting lists.

2.10.5 The Chief Executive Officer has attended the following events and meetings on behalf of the ICB:

1st February	Visit to Fujifilm, Bedford The Executive Team met with Allan Elborn, General Manager, Fujifilm Healthcare UK, and his team to observe some of their advanced technology that could revolutionise patient testing and some emergency care pathways.
3rd February	MP Briefing - Ben Everitt, MP for Milton Keynes North
6th February	Introductory Meeting with Kids Speech Labs The CEO met Gordon D'Arcy, Co-Founder and Chief Commercial Officer of Kids Speech Labs to observe a demonstration of a digital solution for children's speech and language therapy and to discuss trials of their remote platform.
6th February	NHS Confederation ICB CEO Network The CEO attended a virtual session to discuss some of the main challenges ICBs are facing before receiving an update on the latest activity surrounding the Hewitt Review.
7th February	Meeting with Neil O'Brien, Minister for Primary Care and Public Health The CEO and Chief Finance Office met with Minister O'Brien to share with him the issues the ICB is facing regarding primary care funding for estates and the complexities of funding. The Minister committed to take the information away and to see what support could be offered.
8th February	Executive to Executive with Central Bedfordshire Council The Executive teams of both organisations met together for the first time. We discussed some of our key challenges and opportunities and began to develop our thinking of the Place Priorities for CBC, with a real appetite to improve outcomes and access to care, our core offering through better integration. We spoke about growth and the need to align our strategic thinking: workforce, estates, prevention.
8th February	MP Briefing – Richard Fuller, MP for North East Bedfordshire
9th February	Leighton Buzzard Public Meeting
1st March	Executive to Executive with Bedfordshire Police The ICB Executive Team met with Bedfordshire Police Chief Constable and his team to discuss areas for collaborative working. We discussed key challenged areas of

	mental health, neighbourhood, place and community level working and how we can best serve our joint populations. The meeting was positive and both organisations had ideas for working together to support our population and we have committed to hold a joint face to face session to progress ideas.
1st March	Health and Wellbeing Board Development Session with Central Bedfordshire Council The CEO represented the ICB at a development session focusing on reducing health inequalities – the Denny Review and Fairness Report. The session concluded with an action planning discussion.
8th March	Introduction to Oxehealth The CEO had an introductory call with Karen West, Head of Transformation for Mental Health at Oxehealth, who develop technology to provide insights that enable clinicians to plan patient care and to proactively intervene to help patients.
8th March	Luton & Bedfordshire Community Awards The launch event took place on 8th March, in advance of the 2023 award ceremony on 27th April, to celebrate the unsung heroes of our diverse and multicultural community and applauding those that that seek to make the lives of our population, easier, happier and more fulfilled. The ICB is sponsoring "The Caring Hero" award in recognition that throughout our community there are vast numbers of carers – both paid and unpaid – and foster parents who have helped to protect and look after, often very vulnerable, people. Also recognising that the huge rise in living costs is impacting even more lives and will continue to do so.
13th March	Executive to Executive with Luton Borough Council Following a consistent approach to all inaugural Executive to Executive Meetings, we discussed some of our key challenges and opportunities and began to develop our thinking of the Place Priorities for Luton.

2.11 Recently published ICB guidance

Since the last Board meeting on 27th January 2023, the following guidance relevant to Integrated Care Systems has been published. Key guidance for the Board to note:

NHS England published guidance on Capital Investment and property business case approval for NHS trusts. This guidance aims to ensure that there is appropriate governance and assurance to facilitate approval. The guidance is relevant to ICBs in their role in providing support for capital investments but is not designed to set out ICB responsibilities for capital planning or prioritisation in relation to operational capital envelopes. As an example, support will be required to demonstrate that public consultation where required was carried out, that the proposed investment assists the system in meeting current and future issues, agreement of activity and finance levels and that any efficiency assumptions align, affordability within available revenue and capital envelopes, alignment with system plans and strategies for Estates and Digital, and that the scheme is a priority for the ICS\ICB and has its full support

NHS England » Capital investment and property business case approval guidance for NHS trusts and foundation trusts.

Building an ICS Intelligence Function: Using data and analysis to enable effective decision making

NHSE published the above data in early March, focusing on the use of integrated data and population health analytics to develop a deeper understanding into the extent and nature of health inequalities

within populations within a system intelligence function. An intelligence function is a system-wide, multi-disciplinary collaboration of intelligence professionals, with representation from analytical leaders and key teams across the whole ICS. At its core, it is a way of co-ordinating a diverse range of analytical skills to support the needs of the system. Data-driven population health approaches will be a key tool in our response to these inequalities. We will need to quickly develop our use of population health analytics, from using data to inform our approach to condition management, to utilising predictive risk factors that help to increase early detection and prevent ill health. Link: NHS England » Building an integrated care system intelligence function

New guidance on reducing health inequalities for NHE estates and facilities staff
NHS England has developed new practical information to help estates, facilities, and other relevant colleagues to understand the role they can play in reducing health inequalities. Further information can be found at Building for health document and via a short film on one of the exemplar projects.

NHS England has published new guidance on virtual wards: Supporting Clinical Leadership in Virtual Wards-A Guide for ICS clinical leaders
NHS England publishes guidance on creating and developing virtual wards

3. Are there any options?

Not applicable.

4. Key Risks and Issues

Risks are logged and managed through the specific pieces of work and the corresponding governance.

Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☐	No ☐

Not in relation to this report but are reported and managed through the specific pieces of work and the corresponding governance.

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**]**

None

6. How will / does this work help to address the Green Plan Commitments?
Click to view Green Plan

Not applicable

7. How will / does this work help to address inequalities?

Tackling health inequalities runs through all the programmes outlined in this report.

8. Next steps:

As described in report

9. Appendices

None

10. Background reading

None.

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Board of the Integrated Care Board (ICB)
10. Integrated Musculoskeletal and Pain Services

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	Tara Dear, Head of Planned Care, BLMK ICB [redacted]
Date to which the information this report is based on was accurate	10th March 2023
Senior Responsible Owner	Anne Brierley, Chief Transformation Officer

The following individuals were consulted and involved in the development of this report:

- Anne Brierley, Chief Transformation Officer
- Maria Wogan, Chief of System Assurance and Corporate Services
- Kathryn Moody, Director of Contracting
- Michael Ramsden, Associate Director of Planned & Specialist Care

Development of the case for change and proposed service model has been led by BLMK ICB with invaluable input from the BLMK Musculoskeletal (MSK) Collaborative representing all core BLMK stakeholders (excluding the development of commercially sensitive material).

Development of the Business Case has been led by the BLMK ICB MSK Steering Group with representation from a wide range of ICB teams, GP Clinical Leadership and Procurement/Business Intelligence support from Arden and Gem Commissioning Support Unit (AGEM CSU).

This report has been presented to the following board/committee/group:

- BLMK ICB Executives Meeting on 15th February 2023 and 1st March 2023; and
- A variation of this report, focussing specifically on engagement outcomes and planned activities, was presented to BLMK ICB Working with People and Communities on 16th December 2023.

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

The members are asked to:

A) **Note** the content of this report, including the process and outputs in developing the case for change;
B) **Note** that the Integrated MSK and Pain Business Case will be presented to the Finance and Investment Committee on 19th May 2023 for approval, prior to competitive procurement;
C) **Note** the further engagement activities that are planned with both patients and with each of the four places via the Place Boards; and
D) **Support** the approach to place based partnerships for MSK and each Local Authority member is asked to nominate a representative (Public Health or Social Care) by 6th April 2023 to work in partnership with the ICB to identify new MSK provider arrangements from 1st April 2024.

Executive Summary Report

1. Brief background / introduction:

Musculoskeletal (MSK) conditions are those affecting the bones, muscles, and joints such as arthritis, frozen shoulder, fibromyalgia, chronic pain, plantar fasciitis, carpal tunnel syndrome, tennis elbow, slipped disc, sciatica, rheumatoid arthritis, ankylosing spondylitis.

Approximately 80,000 BLMK residents are referred to Community MSK services each year – this equates to circa 8% of the BLMK population. Our population is living longer with more comorbidities and more years in care. MSK is the leading cause of disability and sick days globally, disproportionately affecting people from more vulnerable, deprived and underrepresented demographics. People with MSK conditions find their ability to move, work and care for others is limited, often severely, leading to a significant impact on an individual's mental health, physical health and quality of life.

An MSK Health Needs Assessment was completed jointly between Public Health, BLMK ICB and the MSK Collaborative which highlighted the following key insights:

- Between 10-30% of GP consultations are accounted for by MSK conditions nationally;
- 30% of work-related ill health is due to MSK conditions nationally (second most common cause behind cold/flu);
- 725 people over 65 years old fractured their hip in BLMK (2020/21) with much of these 'fragility fractures' caused by osteoporosis. More preventative and supportive action would prevent falls and subsequent injuries;
- Average quality of life score for people with MSK and living in BLMK is 0.60, this is significantly worse than adults without a long term condition (0.92); and
- 20-26% of people in BLMK with an MSK condition, also report depression or anxiety, however it is likely this rate is much higher due to a number of patients not reporting their mental health issues

- The prevalence of long-term MSK conditions in BLMK is 14.95% – 17.5%, this is lower than the national prevalence (18.6%), however with projected growth in BLMK and the impact of Covid on healthy lifestyles, there is a high likelihood this will increase.

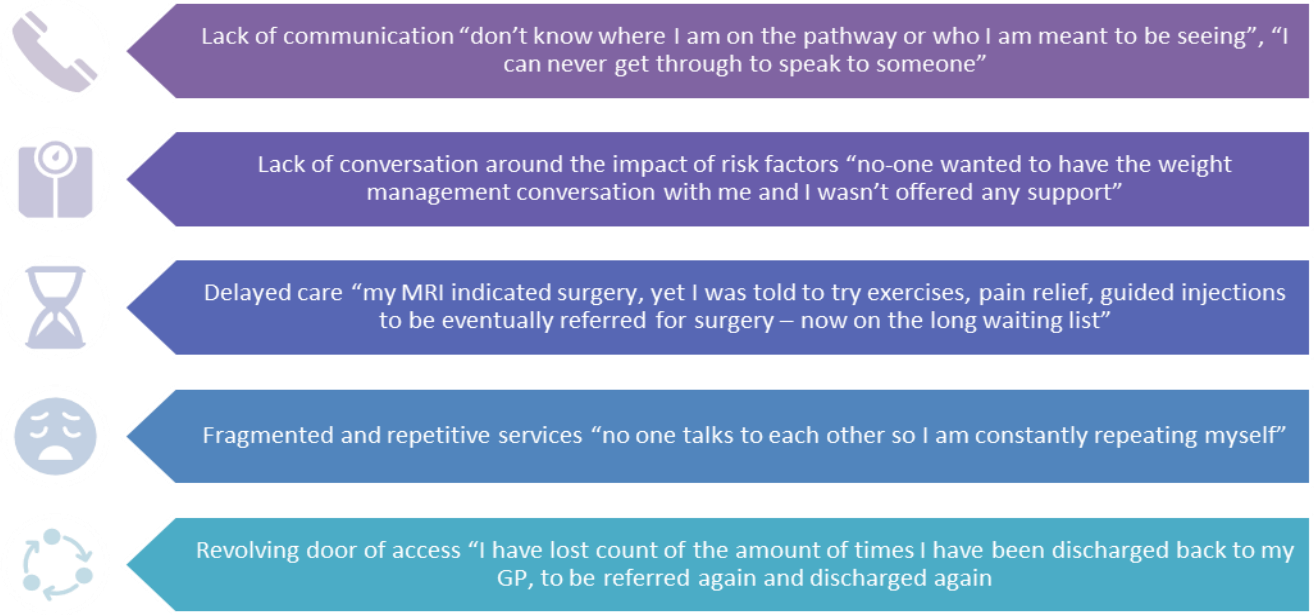
BLMK Integrated Care Board (ICB) contracts community MSK services from the following four private providers (Table 1) with a total annual spend of £15.8m. The Community MSK services act as a central part of a wider MSK pathway, providing assessment, diagnosis and treatment services where clinically appropriate for a community setting. There is a significant variation in the level of services offered across the four BLMK places, with Bedford Borough and Central Bedfordshire service being the most comprehensive offer, but also significantly higher in contract value.

Table 1 – Summary of Community MSK providers by place

Place	Contracted Provider:	Current Contract Expiry Date	Total Contracted Length	Option to extend to
Bedford Borough	Circle MSK	31/03/2024	9 years	31/03/2025
Central Bedfordshire				
Luton	HCRG (was Virgin)	31/03/2024	7 years + 6 months	31/03/2025
Milton Keynes	Ravenscroft	31/03/2024	6 years	31/03/2025
Milton Keynes	Connect	31/03/2024	5 years +2 months	31/03/2025

Historically, services have been designed and commissioned to focus on treating MSK illnesses as opposed to broader MSK health, which has led to patients cycling between services and not getting the holistic support that they need. Alongside positive experiences when receiving clinical care, people have told us (Figure 1) that they find the services fragmented, difficult to navigate and lacking the rounded personalised conversation about what matters to them as an individual and what is more likely to lead to significant improvement.

Figure 1. MSK Patient Feedback Themes



The expiry of BLMK's four Community MSK contracts on 31st March 2024 has presented an opportunity to look at the delivery of MSK services. By establishing the BLMK MSK Collaborative in July 2021 and by undertaking a number of patient engagement events, the ICB has worked with BLMK partners and patients to identify seven core change drivers (Figure 2).

Figure 2. MSK Case for Change

In line with procurement legislation, BLMK ICB intends to formally commence procurement in June 2023, securing new provision to start in April 2024. The pre-procurement phase has provided a valuable opportunity to understand how the services are working and could be improved, listening to and acting on the views from patients, residents and local provider workforce.

2. Summary of key points:

Key points to note:

2.1. Business Case Development and Approval

BLMK ICB is in the process of finalising an Integrated MSK and Pain Service Business Case that will set out the detailed findings from the case for change work, the proposed service changes, the expected outcomes/benefits and the financial and contracting implications.

As per the process set out in the 'Managing Conflicts of Interest in Procurement' paper that is also being presented to the ICB Board on 24th March 2023, the decision to approve the Business Case will be taken by the Finance and Investment Committee on 19th May 2023 with conflicts managed according to the BLMK ICB Conflicts of Interest Management and Standards of Business Conduct Policy.

2.2. MSK and Pain Improvement Opportunities

The overarching ambition is to improve the quality of life for people with an MSK and/or Chronic Pain condition, from the point of presentation, throughout their MSK journey and beyond.

Informed by local / regional feedback and best practice, there are five key opportunities that are being considered as part of the future Integrated MSK and Chronic Pain Service plans and are subject to further governance:

- Shift in the balance from reactive care to proactive care, focussing on prevention and partnership with health and non-health partners to support wider determinant needs of an individual with MSK illness;
- Recognising the variation in service provision across BLMK, there is a need to align the service offer for patients with national and local best practice;
- Increased capacity of First Contact Physiotherapists (FCPs) roles in Primary Care to enable rapid support at the early stage of the pathway. FCPs can provide self-care guidance, pain management, diagnosis, treatment plan and onward referral to other services where required. FCPs will work closely with Health & Wellbeing coaches and Social Prescribers to offer holistic support tailored to the individual;

- Increased pain management support for MSK and non-MSK Chronic Pain, including a Multidisciplinary Team approach to personalised care plans and access to psychological support; and
- Referral triage, advice and guidance for children aged ≥2 to <16, providing reassurance to worried parents and carers in cases of natural variants that naturally resolve. Currently these cases are referred to hospital and often wait a considerable period before receiving assessment and reassurance.

A more holistic MSK and Pain offer has the potential to yield significant benefits in quality of life improvement, reduce workplace illness, reverse MSK illness, prevention of MSK illness onset, reduction in the need for specialist hospital care, reduction in falls and much more.

2.3. MSK Market Engagement

In addition to the work carried out locally with the MSK workforce, including the 119 local clinicians that have contributed to date, BLMK ICB is planning to undertake formal Market Engagement.

Market Engagement enables the ICB to seek input from a broad market of providers that are interested in or are currently providing MSK services. The ICB intends to test proposals and seek specific feedback on:

a) the draft service model and specification;
b) the draft financial envelope; and
c) the preferred contracting model amongst other areas. Information is currently being finalised with the Market Engagement exercise due to commence mid-March 2023.

2.4. Ongoing Patient Engagement

Various engagement activities have been carried out over the last couple of years for MSK – these include attendance at local festivals and groups, MSK specific face to face and virtual events, patient surveys and 1:1 discussions, all of which have been supported and promoted by Healthwatch and other local patient groups. The feedback has helped provide invaluable insights into current services and helped to determine the opportunities highlighted above.

During and in parallel with the procurement, further patient engagement is planned:

- Patient representation on the procurement panel, ideally from each of the four BLMK Places;
- The procurement process will seek to understand improvements against the issues patients have shared and the improvements they would like to see;
- Regular Co-Design events will be held with the awarded provider during mobilisation; and
- Broader engagement discussions will continue in parallel with the procurement, including with hard to reach groups, working with current providers to make improvements

2.5. Place Based Focus

The four BLMK Place Boards play a significant role in supporting the wider focus on MSK health and wellbeing whilst ensuring the delivery and access to services is supportive of local population needs and helps to identify and reduce inequalities. The awarded provider/s of MSK services will provide a partnership approach to place-based needs and priorities. The awarded provider/s will also rely upon strong working relationships with places to reduce the fragmentation in pathways described by patients.

Further MSK discussions are planned for forthcoming Place Boards in March/April, highlighting the impact that risk factors (such as obesity, smoking, low physical activity) have on the development and management of MSK illness, as well as how MSK illness impacts wider determinants of health.

As a starting point in forming strong partnerships between the awarded provider/s and both the BLMK system and the four places, BLMK ICB is seeking a nominated Social Care or Public Health partner from each of the four Local Authorities to join the procurement and mobilisation of Integrated MSK and Pain services. Representatives will need to be confirmed by 6th April 2023 and will work with the ICB to develop the procurement strategy (including focus on social value opportunities) and to develop local partnership specifications that set out partner expectations, priorities for MSK at place and how the awarded provider can contribute to place-based priorities.

2.6. Health Overview & Scrutiny

All four BLMK Health Overview & Scrutiny Committees (HOSC) have been engaged (either through off agenda briefings or formal presentation) in the development of future MSK plans. Further presentations were requested by both Bedford and Luton committees. Bedford HOSC met on 6th March and Luton HOSC is scheduled to meet on 20th March.

Discussions to date have recognised the feedback from residents, the opportunities to improve services and the timetable for securing new services. Acknowledging the size of the service, the changes being proposed, there continues to be further opportunities to engage with the public and the ICB are keen to ensure they are beyond compliant with the public services duty to consult.

The approach and timetable that is being taken strikes a balance between commitment to ongoing engagement activities in parallel with securing local services and to avoid delaying the realisation of benefits to the BLMK population.

The HOSCs will continue to be consulted on a regular basis, including the output of ongoing engagement activities described above.

3. Are there any options?

A number of options have been considered as part of the Business Case process and will be presented to the Finance & Investment Committee on 19th May 2023.

Of particular note, the option to enact the one year contract extension was considered, however given the improvement opportunities that have been identified and described in this paper, it is felt the contract extension would limit the realisation of benefits. Subject to further engagement and governance, the ICB therefore intends to commence procurement in June 2023, securing new provision for April 2024.

4. Key Risks and Issues

There is a risk of the proposed model not being deliverable within the financial envelope, this will be mitigated through further financial modelling, market engagement feedback and financial benchmarking.

There is a risk of no or limited market appetite which will again be mitigated through market engagement, gauging the level of interest.

There is a risk of lack of partnership approach between the new provider arrangement and local place and system partners which will be mitigated by the proposals set out above (2.5) alongside procurement and contracting enablers.

Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☒	No ☐

ECD 10

5. Are there any financial implications or other resourcing implications, including workforce?

The proposed changes are intended to be delivered within the existing financial envelope, but the ICB will also be exploring the viability of efficiencies in support of the system financial plan.

The exact financial impact of the proposed changes will be set out in the Business Case and considered by the Finance and Investment Committee on 19th May 2023.

An increase in First Contact Practitioner resource will have workforce implications and therefore a phased approach to the increased offer will be taken.

6. How will / does this work help to address the Green Plan Commitments?

Click to view Green Plan

The procurement of Integrated MSK and Pain Services will enable the ICB to determine the impact on the Green Plan commitments.

7. How will / does this work help to address inequalities?

Providing a more holistic and personalised offer will help to identify how the service offer can be varied to support needs. It is expected that this, alongside local partnerships working with community and voluntary organisations will lead to an improvement in health inequalities and improvement in quality of life, particularly in areas or high deprivation and areas with high MSK risk factors.

8. Next steps:

The timeline following discussion at the March 2023 Board is below:

- March-April 2023 – Market Engagement exercise
- March-April 2023 – Place Board engagement
- 19th May 2023 – MSK Business Case approval by Finance & Investment Committee
- June-October 2023 – Procurement Phase, including contract award approval
- October 2023-March 2024 – Mobilisation Phase
- 1st April 2024 – Service Go Live

9. Appendices

N/A

10. Background reading

N/A

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Board of the Integrated Care Board (ICB)
11. BLMK Fuller Programme – outcome of table discussions from ICB Workshop

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	Nicky Poulain, Chief Primary Care Officer.
Date to which the information this report is based on was accurate	13th March 2023
Senior Responsible Owner	Nicky Poulain, Chief Primary Care Officer.

The following individuals were consulted and involved in the development of this report:
4 Place Boards. Members of the ICB 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:

- Note the feedback report from the ICB Board workshop with the priority for each of the four Local Authority (LA) areas to define neighbourhoods that are meaningful to residents; and
- Note that the ICB will support work at place, with wide stakeholder engagement through the Collaborative Stakeholder Group, to develop well-functioning and diverse integrated neighbourhood teams that meet residents' needs.

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. The outcomes from Place specific table discussions at the ICB Workshop on the 24th January 2023 have been distributed for Place Boards to consider their approach to defining neighbourhoods.

2. Summary of key points:

The BLMK Fuller Programme is supported by the ICB Primary Care team and the ICB Project Management Office (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; and
4. An ambitious and joined up approach to prevention.

The BLMK Fuller Programme is accountable to the Primary Care Commissioning and Assurance Committee and informed by the system wide BLMK Fuller Stakeholder Collaborative Group, with coordination by the ICB Fuller Programme Working Group.

The BLMK Fuller Stakeholder Collaborative Group will help 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.

Internally the ICB's Fuller Programme Working Group (meeting fortnightly) is tracking progress, resolving escalated issues and ensuring system connectivity to ensure that place is facilitated to delivered for its population.

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:
❖ To work collaboratively with Place Boards to define neighbourhoods; ❖ To continue to evolve the BLMK Fuller Ambition in the context of developing neighbourhood teams; ❖ To continue to develop and mobilise the BLMK Fuller Programme Plan with all system partners in the context of the BLMK operational Plan; ❖ To map existing good practice and innovation to model and champion new ways of working; and ❖ To clearly define the 1,3 and 5 year deliverables as part of the ambition and programme plan.
9. Appendices
Appendix A – ICB Board Development Workshop Output from Table Discussions
10. Background reading
NHS England » Next steps for integrating primary care: Fuller stocktake report

BLMK Fuller Programme – Progress Update

13thth 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 (Primary Medical, Community Pharmacy, Community Dental and Optometry) 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 and tailored delivery at place to support local neighbourhoods.

2. Progress

The outputs from the Board Workshop held on the 24th January 2023 have been distributed to Place Boards to support their discussions in defining what neighbourhoods are at place.

The ICB Board members' place-based discussions and actions were not intended to form the final agreed plan of action to implement the Fuller Programme as collaborative work continues to build on these recommendations. Importantly, the place summaries firmly establish and reflect the 'buy in' that each place and place leaders are fully 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.

- ❖ The ICB Primary Care Team will work with the Collaborative Stakeholder Group to design, facilitate, and develop the components of Integrated Neighbourhood Teams with health, care and VCSE stakeholders.

From all the place-based table discussions there were consistent themes which emerged:

- There was agreement that the draft roadmap captures the ambition and each place needs to define the *what* and the *how;*
- Neighbourhoods should be well defined, understood and recognised by residents and stakeholders;
- 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; and
- Current Primary Care Networks (PCNs) will 'lean-in', with a range of other stakeholders/providers, to support neighbourhoods. Integrated (Health and Care) Neighbourhood Teams may include more than 1 PCN, depending on geography.

Appendix A

ICB Board Development: 24 February 2023

Fuller Framework - Table Discussions

On 24 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.

A link to the Fuller Report: Next Steps for Integrating Primary Care is found here

This document captures the discussion between leaders in each of our four Places. It will be considered at future Place Board meetings and at the next ICB Board meeting on 24 March 2023. This document is not the agreed plan of action to implement the Fuller Programme, but instead reflects the important table discussions from the Board Development Session on 24/02. It should be considered as a basis upon which Place leaders can build their plans for developing a diverse, modern, and effective primary care offer that meets residents' needs.

1. Bedford Borough
2. Central Bedfordshire
3. Luton
4. Milton Keynes

Consistency across BLMK

There is significant consistency across Place discussions, including:

- Neighbourhoods should be well defined and understood;
- 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; and,
- Piloting our approach to delivering the Fuller Roadmap will mean we learn important lessons that we can share across BLMK.

If you have further questions, please contact Nicky Poulain, Chief Primary Care Officer or the BLMK ICB Corporate Governance Team - blmkicb.corporatesec@nhs.net

Bedford Borough

Present:

- Laura Church, CEO, Bedford Borough
- Felicity Cox, CEO, BLMK ICB
- Paul Calaminus, CEO, ELFT
- Lorraine Mattis, Associate Non-Executive Member
- Jane Kocen, Caritas PCN (Bedford) Clinical Director
- Sarah Stanley, Chief Nursing Director, BLMK ICB
- Shabina Azmi, Chief Pharmacist (deputising for Chief Medical Director) BLMK ICB
- Tim Simmance, Associate Director of Sustainability and Growth, BLMK ICB (notes)

Feedback on the BLMK Fuller Framework? – is it agreed? any changes needed?

- The table agreed with the broad principles and enablers as described – the concepts of prevention, community, same-day care, personalised care etc., and the rationale, are unarguable, but this needs to have a meaningful impact and delivery of the model is not straight forward.
- The definitions of primary, secondary, and tertiary are helpful [the definition being that access to each requires a referral from one of the previous levels, with primary care accessible to the public].
- Care is delivered under different levels (primary, secondary and tertiary), but could be by the same people on different days or times of the day – this needs to be explicit.
- "Research" should be included alongside Digital Innovation (within the enablers).
- The name "Fuller Framework" does not reveal what it is:
    - we need easily-accessible language about what it means to the public; and
    - we need to help our workforce understand what it means in practical terms to encourage changes in behaviours.
- In general, language could be adapted to change perceptions and behaviours, and remove stigma, such as:
    - "Long Term Condition", which might make a patient feel their condition is not within their control to do something about;and
    - Using "care navigator" instead of receptionist, which might both reduce antagonism from patients and support receptionists to feel valued.
- There is a risk that the GP is seen as being at the centre of the Neighbourhood, which might engender or entrench further certain behaviours from both staff and patients. Diagrams and language need to reflect that GPs are part of the Neighbourhood but not necessarily at the centre.
- A big challenge is that it is hard for people to meet each other and understand each other's roles, even if working for the same organisation.

- Does the framework need to be more explicit around culture change?
    - How do we get teams to be able to make improvements themselves?
    - How can we help teams and organisations feel empowered to act differently, with assumed permission, backed-up by cover from those in leadership roles. This needs Occupational Development (OD) support.

What will Fuller Neighbourhoods look and feel like in 5 years' time in our Place? What's our vision/ambition?

- Staff will understand the "why" of Fuller and will have had permission and a safe space to work with and around it – a focus on outcomes, rather than a specific model to deliver it.
- Neighbourhoods will be well-defined and understood – who is in it, and what community assets are present – but may be different from each other ie. not defined by the organisations, but by the Geography, Demography, Topography and Community:
    - This will have been worked out with the people who live in the Neighbourhood, asking them to define their own Neighbourhood (rather than according to the organisational boundaries that exist) – understanding what they need to help them manage their lives together, with services provided by whichever organisations that can deliver them.
- Care would be provided on a needs basis, not just on who each person knows – the same need might be addressed by several agencies and having the discussion as a group could identify the best service to deliver for that particular person.
- Partners will understand each other's strengths and service offer, supported by:
    - A directory of service (MiDOS or equivalent); and
    - The ability to come together physically.
- The Neighbourhoods will have shifted from a model that builds on successes (rather than a deficit model), with people sharing what works.
- The patient/resident will have ownership of their care, with access to / ownership of their own care records.
- The first port of call may not be the GP – either as a new model, or through having a shared "front-door" (to help people access the correct part of the system, when they come to the GP e.g. co-located services and care navigation).

Agree the next steps and the timescales for your Place to develop Fuller Neighbourhoods in 23/24 (and beyond?)?

- Education and communications drive:
    - what is the ambition (and the why), and what does the plan mean for primary care (including pharmacy, optometry and dental (POD)) and all first contact professionals; and
    - greater understanding between sectors (e.g. what does secondary care know about what primary care do etc.); and

    - convey messages to both workforce and communities – creating the key messages in common plain language.
- Identify and define Neighbourhoods and understand community assets that could contribute to the Neighbourhood team – at least 1 Neighbourhood identified and mapped within a year (in each Place), based on early adopters:
    - This conversation will involve partners, patients and public to understand what community assets exist, what the population need is, and how can we design services around them; and
    - People working within a Neighbourhood to meet each other face to face – Bedford Borough Council can facilitate this at Borough Hall.
- Identify top 1% of high intensity users in full range of settings:
    - identify urgent cases and focus on that cohort to develop service offering, working out how to separate acute and chronic care as required; and
    - understand what led them to becoming the top 1%, in order to look at what preventative / structural measures might be needed in the future.
- Develop measures of success – quantitative and qualitative outcomes (including patient experience) – both overarching and for each Neighbourhood.

Identify any support needed from the ICB / the Collaboratives (Mental Health, Learning Disabilities and Neurodiversity & Bedfordshire Care Alliance) / wider partners?

- Coalescing around the top healthcare users – how do we find out the "top 1%" of users of primary and secondary, physical and mental health, adult and children services? Need to use SystemOne to extract data and work with providers to understand impact and potential reasons.
- Understand what works in terms of collaborative working across providers, and across different tiers of health and care (primary, secondary, tertiary, care, VCSE etc.)
- What can we learn from Expert Patient Programme and bring back what worked from it, using it as a mechanism to create patient-led support groups.

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? (15 mins)

- Develop a property and service asset map, aligned with house-building, on a year-by-year (?) basis, overlaying primary care (including POD) and other health locations to show the potential existing opportunities for sharing resource, before considering the need for new options.
- How can we develop ways to attract and retain:
    - what can we build on that already happens (nursing, optometry, pharmacy etc);

  - what can we consider as opportunity areas to develop – insourcing their development to BLMK (e.g. should we be partnering to develop a medical school with one of the local universities?); and
  - what's the long-term plan around training, academia/research for clinical professions – making use of our academic institutions.
- Co-locating services into the same space – convenience for patients and staff - and looking to maximise space and reduce environmental burden.
- Identify lift-and-shift-type services to place them in other spaces (rooms) in other buildings – i.e. those that can exist with a degree of isolation without damaging their ability to deliver a service and/or divorcing them from a team, or where it destigmatises a service. e.g. post-surgery recovery, smoking cessation, weight-loss - school gyms, private gyms, community pharmacies, universities.
- Develop a check-list for people when considering estates required for service developments to ensure they have considered all options before deciding a new build is required.
- Introduce more point of care testing (including how we can build on partnerships with private organisations e.g. Fujifilm).

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? (10 mins)

- Patients
- Primary care
- Community organisations, within and outside traditional health and care settings
- Health and Wellbeing Board

Actions are summarised below, with estimated timeframes (timescales were not explicitly discussed at the time and will need to be confirmed/agreed)

Question / Topic	**Action**	Timeframe (estimated – agreement required)
Fuller Framework and Neighbourhoods in 5 years' time vision	Revise framework to take into consideration feedback from Bedford Borough table. Use the starter vision as a jumping off point for Bedford Borough.	31/3/2023
Neighbourhoods in 5 years' time	Develop strategy to build culture and supportive environment both for the transition and once in the new model. Start to develop possible BB vision for testing within Neighbourhoods as they define and develop.	Q2 2023/24

Question / Topic	Action	Timeframe (estimated – agreement required)
Neighbourhoods - next steps	Education and communications plan – what is the ambition, why it's needed, and how can we work together across sectors (in plain language)	Developed and begun implementation by April 2023
Neighbourhoods - next steps	Identify and define with local people Neighbourhoods in Bedford Borough	Q4 2023/24
Neighbourhoods - next steps	Bring together people working within each Neighbourhood to understand what services are offered and opportunities to work more closely together	Q4 2023/24
Neighbourhoods - next steps	Identify top 1% of high-intensity users of services	Q1 2023/24
Neighbourhoods - next steps	Develop measures of success – qualitative outcomes (including patient experience) – both overarching and for each Neighbourhood	Q1 2023/24 (overarching) Q4 2023/24 (Neighbourhood)
Place-based actions on workforce and estates	Develop property and service asset map, aligned with house-building, on a regular basis	Q3 2023/24
Place-based actions on workforce and estates	Opportunity analysis of skillsets developed within BLMK and those outsourced	Q2 2023/24
Place-based actions on workforce and estates	Identify opportunities for services to be lifted and shifted from within existing locations (without negatively impacting delivery or culture)	Q4 2023/24
Place-based actions on workforce and estates	Develop check-list for service development/transformation regarding options for estates	Q2 2023/24
Place-based actions on workforce and estates	Identify opportunities for alternative settings for multi- agency service delivery (as part of town regeneration?)	Q2 2023/24

Central Bedfordshire

Present:
Alison Borrett – NEM, BLMK ICB
Anne Brierley – Chief of Strategy & Transformation BLMK ICB
David Carter – CEO, Bedfordshire Hospitals
Marcel Coiffait – CEO Central Bedfordshire Council
Belinda Ekuban – Clinical Director, Titan PCN
Vicky Head – Director of Public Health, BBC, CBC and MK
Rima Makarem – Chair BLMK ICB
Tracey Stock - Chair of BLMK Health and Care Partnership
Michelle Evans-Riches – Programme Manager, BLMK ICB (notes)

Feedback on the BLMK Fuller Framework? – is it agreed? Any changes needed?

- High level Fuller framework supported. Need to identify what it means for each Place and the population.
- Not just a medical issue to solve
- It is about wider issues than just estates and GPs. Clarify why people are going to general practice e.g. non-medical reasons or reasons that don't require GP intervention.
- Same day urgent care with practices leaning in – minor injuries facility? How easy will it be in practice to direct patients appropriately to Same Day Emergency Care (SDEC) vs care for chronic patients?
- Streamline referral process so as to bypass GPs as referrals gatekeepers for some services
- Invest time to understand frequent flyers' needs and their touchpoints across different public services
- Change service delivery to provide equity of access. Central Bedfordshire Council (CBC) undertaken this for transactional services on a service by service basis.
- Take the population with us, some will still want to see a GP so need to be shown why there are other professional types better placed to help them
- Specialist practitioners for long term conditions, who can get to know their patients and their needs.
- Signposting people to appropriate services.

<u>Challenges</u>

- Not all GPs want to collaborate
- Co-locating services is not the same as integrating them
- Cultural changes need to take place.

What will Fuller Neighbourhoods look and feel like in 5 years' time in our Place? What's our vision/ambition

- 'No wrong door' approach – people can be helped regardless of where in the system they first present.
- Enable community networks to support local people.
- Digitally enabled alternative solutions.
- Using community facilities e.g. children's centres.
- Utilise VCSE to support people to keep well at home and minimise social isolation
- Enable communities to flag issues / concerns about other residents' wellbeing.
- Support people before they reach the threshold for intervention, eg in mental health.
- Sharing information and alerts between partners.
- Co-produce solutions with local people.

Agree the next steps and the timescales for your Place to develop Fuller Neighbourhoods in 23/24 (and beyond?)

- Understand and agree what is meant by Neighbourhoods
- Asset mapping – including community and VCSE
- Demographics – what is it now and future changes. Map current health and care infrastructure against projections of future population need. This will help support allocation of Section 106 funding.
- Work with Patient Participation Groups (PPGs) on how to improve access to general practice.
- Understand why people are accessing general practice and how to redirect them elsewhere
- Investigate whether additional general practice roles could work in the communities e.g. in community pharmacies. (Recognised that this may fragment the service and GP surgery is a known location)
- Identify and communicate services that people can self-refer to e.g. MSK
- Use Grove View as a test site to examine what the population needs and integrate services, linking into nearby available community assets such as the library and VCSE services across the road
- Identify a social model test site e.g. children's centre or community facility to try out an alternative way of providing services that doesn't require new buildings.

Identify any support needed from the ICB / the Collaboratives (Mental Health, Learning Disabilities and Neurodiversity & Bedfordshire Care Alliance) / wider partners?

- Modelling of test site services, health, social care and other services. Signposting of services in locality e.g. VCSE and usage of the services.
- Examine how population use Grove View and use information to change services accordingly.

- All partners need to lobby for additional general practice workforce.

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?

- Use test of social facility to inform decisions on service provision in localities
- Council and ICB to jointly fund an integration post which MUST include children's services.
- Consider establishing a joint leadership team responsible for delivery and reports to Health & Wellbeing Board (HWB).

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?

- Residents, partners, VCSE
- Other partners, eg education, police, etc?

Key Issues

- Not all organisations are signed up to break even which puts pressure on system finances
- Impact – what do changes mean for our population
- Children with complex care needs – including out of area placements
- Sharing risk and benefits of investment between organisations – important to start with what is right for the person and what is required to be put in place.
- Financial framework needs to enable investment in Neighbourhoods and community
- Non-elective pathways – management and support for people at home
- Children diagnostics – audiology, Autism Spectrum Disorder (ASD), Special Educational Needs and Disability (SEND)
- Frail elderly – social isolation

ACTIONS

Action	Deadline
Identify another existing facility to use as a social test site	Q4 22/23
Modelling of services to be provided at Grove View and social test site	Q4 22/23
Identify reasons why people accessing general practice, especially non-medical reasons	Q1 23/24
Streamline referral process so GPs not required	Q1 23/24
Understand and agree what Neighbourhoods are	Q1 23/24
Mapping of assets including community and VCSE	Q1 23/24
Understand current and projected demographics	Q1 23/24
Work with PPGs to find solutions to improving access to general practice, including communication.	Q1 23/24
Identify and communicate what services people can self-refer. Eg MSK	Q1 23/24
Grove view to be a test site of local service provision. Opportunity to learn and flexibility to alter services.	Q1 23/24
Risk and Benefit sharing agreement to be investigated	Q1 23/24
Identify frequent fliers and work with them to support their needs	Q1&2 23/24
Examine usage of services at Grove View and social site and build in flexibility to change service provision.	Q4 23/24

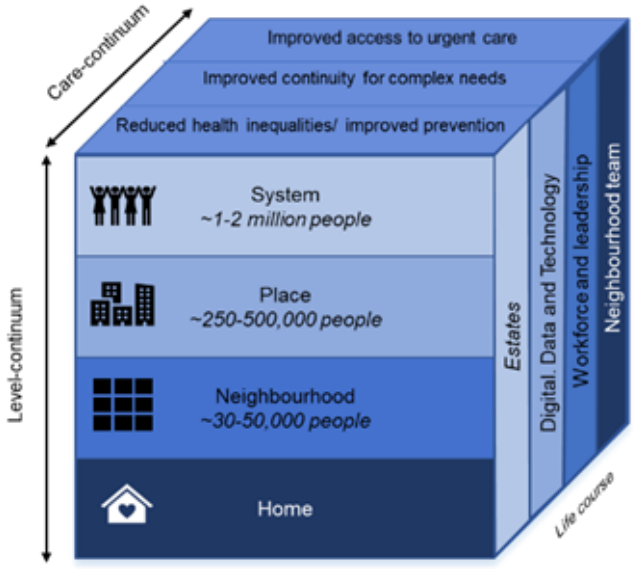
Luton

Present:
Robin Porter – CEO Luton Council
Nicky Poulain – Chief Primary Care Officer, BLMK ICB
Matthew Winn – CEO Cambridgeshire Community Services
Sally Cartwright – Director of Public Health, Luton Council
Mahesh Shah – Primary Medical Services Partner Member, BLMK ICB
Shirley Pointer – Non-Executive Member, BLMK ICB
Martha Roberts – Chief People Officer, BLMK ICB
Manraj Barhey – Clinical Director PCN
Bethan Billington – Deputy Chief People Officer, BLMK ICB (notes)

Feedback on the BLMK Fuller Framework? – is it agreed? Any changes needed?

- What do we mean by the framework – what is it? What resonated was when Claire said it's not a Primary Care Network (PCN) but that these are the 5 pillars – this needs to come out of the population needs to understand that to meet the needs it's not just the GP practice it's the other services that help the patient. I had assumed a PCN was an entity – assumed Neighbourhood sat around a PCN but PCNs will feed in to more than one Neighbourhood
- We need to consider the step before that – what is a definition of a Neighbourhood – we need a consistent definition to be understood by all. Need it to be simple
- We need to consider what we can do with the people that use a lot of public resources? How do we get ahead of things to get the population to be healthy and out of poverty?
- Concern that our documents don't easily explain the Fuller framework, a 3d model is needed to illustrate- person, Neighbourhood and Place – we can then explain in a more simplistic way
    - What happens locally
    - What must be covered at Neighbourhood
    - What happens at Place

[Note: attached below is our best assumption of such a model]



The integrated care cube

- Some things need to be standardised for example. Cancer screening
- Need step change in the same day episodic care
- Got to make the Neighbourhoods geographic
- There are 730 Local Authority (LA) services – they can be reorganised around Neighbourhoods – there are different needs in each area
- The current PCN's geographical cover would mean they more than one Integrated Neighbourhood Team and vice versa Integrated Neighbourhood Team (INT) would cover more than one PCN- this needs addressing
- Cannot lose the economies of scale

What will Fuller Neighbourhoods look and feel like in 5 years' time in our Places? What's our vision?

- Do Domiciliary care contracts move towards being Neigbourhood/Place-based
- What is the problem we are trying to solve – need to understand each Neighbourhood
- If there is something about efficiency – can it be done at Luton Place level – champions – community connectors – resource to the town and reaching into communities that aren't coming forward to us for example cancer screening – people in Luton come at stage 3 or 4 cancer. There are so many different examples and opportunities and can either say leave it to the Neighbourhood where they prioritise their actions or should we look across the patch.

- From an LA perspective, Neighbourhoods could be simple either using geography, economic situation and demographics
- It was suggested there are about 6 Neighbourhoods in Luton, for example in NW – Lewsey – sees itself as a community
    1) East of the town – the hill – old village Wigmore and Stopsely – community
    2) Centre of the town and south most significant issues and churn
    3) Centre of urban area – the Dallow – defines itself because of the demographics
    4) North of the town – Leagrave/Northwell
    5) Marsh farm
- It was agreed that Public Health will take the proposed above, away to finalise the Neighbourhoods and use the new wards to help reset
- There was general consensus that the Neighbourhood team is the team who does everything that isn't low volume activity or needing subject matter experts.
- There will also need to be teams that cover cohorts of patients in their entirety i.e sickle cell teams. Cross cutting themes at Place /cohort of patients – dependent on size if it is done at scale or as a community under Neighbourhood
- A suggested vision: Neighbourhoods – everything the public purse pays for being connected at a Neighbourhood level.
- It should feel that everyone knows who does what
- For resident – I can access services in my community. Own my own care. Be aware of what is available. Aim for increased self-belief .
- Target capital towards where the resources are missing – community facilities
- If I am the staff I feel part of a team – more common way of doing business, put information in once, go to the bank, a lot more enablement for people , people to help themselves – feel a lot more digitally enabled. More working with the voluntary sector
- Meaningful work for people in these Neighbourhoods – pay differentials – how do we use ourselves as a way of influencing and connecting by taking people out of poverty – what opportunities can we provide – economic model of employment
- Everyone can do the right thing and have influence to control how they manage and deliver the care/work – the closer you can get the carer to work well with the patient

Agree the next steps and timescales for your Place to develop Fuller Neighbourhoods in 23/24 (and beyond)? (30 mins)

- Workforce – policies and procedures, staff passports, OD piece for sense of belonging, sharing vision and purpose, understanding different roles, clarity of where vicarious liability lays – Standards of Operating Practice (SOPs)
- IT- need interconnectivity and access to summary care records
- BI team to sketch out Neighbourhoods
- Leadership team to describe what is in each Neighbourhood and what an INT looks like
- Enablers to make the team fly
- What is the interface between different services

- Systems leadership development
- Development of 730 LA services possibly realign to Integrated Neighbourhood Team on the basis of assisting connections
- Localism needs support from local leaders
- Engagement with front line staff – OD at every level – enterprising change agents

Identify support needed from the ICB / the Collaboratives / wider partners? (15 mins)

- Where do we take the plans – Place Boards, and BLMK collaborative, and using link directors

Agree Place Based collaborative actions on workforce and estates needed to enable Fuller Neighbourhoods? (15 mins)

- Will be developed as a result of identifying the Neighbourhoods and the assets within these

Who do we need to take on this journey with us (key partners / decision-makers)? How will we – and who – will do that

- Leaders of Multi Disciplinary Team (MDT) shape and lead – how does each organisation take a lead
- Accountability for setting up INT (Integrated Neighbourhood Team) – need to support Nicky to achieve subsidiarity clear support needed from ICB Board and Luton Council HWB

Actions

Item	Date Created	Action	Deadline
1	24/2/23	Review the Business Intelligence (BI) around demographics and geography to identify the Neighbourhoods in Luton	Q1
2	24/2/23	Public consultation on the proposed Neighbourhoods	Q2
3	24/2/23	Map the services/assets available within the identified INT	Q2
4	24/2/23	Identify the Estate within the INT	Q2
5	24/2/23	Review and define the patient population needs within the INT and what the impact of the projected growth and demographics may have on this to future proof INTs	Q1/Q2

6	24/2/23	Identify what can be delivered at Place level	Q2/Q3
7	24/2/23	Stakeholder mapping for each proposed INT	Q2
8	24/2/23	Map the interfaces between services within the INT	Q2
9	24/2/23	Workforce baseline for the INT	Q2
10	24/2/23	Plan for the implementation of staff digital passports	Q1
11	24/2/23	Develop shared vision and purpose for INT to enable staff to belong and work within the new model	Q2
12	24/2/23	Plan for enabling staff across the INT to understand different roles involved in delivery	Q2
13	24/2/23	Engagement sessions with workforce on Vision and purpose	Q2
14	24/2/23	Develop plan for systems leadership development	Q1
15	24/2/23	Wrap LA services around INT	Q2/3
16	24/2/23	Engagement plan for local leaders in the INT	Q1
17	24/2/23	Identify change agents in each INT to drive the change	Q3
18	24/2/23	Responsible, Accountable, Consult, Inform (RACI) for the delivery	Q1
19	24/2/23	Governance for Place – communities have ease of access	Q2

Milton Keynes

Present

Michael Bracey – CEO Milton Keynes Council
John Culley – Central North West London NHS Foundation Trust
Manjeet Gill – Non-Executive Member, BLMK ICB
Tayo Kufeji – Primary Medical Services Partner Member, BLMK ICB
Maxine Taffetani – Healthwatch Milton Keynes
Dean Westcott – Chief Financial Officer, BLMK ICB
Maria Wogan – Chief of System Assurance and Corporate Services, BLMK ICB
Rebecca Green - Head of Milton Keynes Improvement Action Team, BLMK ICB

How do we want to work together today as a Place?

- Be practical and pragmatic. Moving from theory to more tangible outcomes, looking for something to take away and back to our own organisations. Make sure we are all on the same page, agree and use consistent terminology. Agreed to develop the Fuller Neighbourhood proposal and principles first and then have the debate to change organisation existing geographical boundaries if needed.

Feedback on the BLMK Fuller Framework? – is it agreed?

- High level principles agreed - The principles in the framework were accepted as were felt to be the same everywhere, how we make it work locally is where the uniqueness comes from and will be the challenge.

Any changes to the framework needed?

- "People need to be able to describe the geography of a Fuller Neighbourhood" – Milton Keynes as a whole feels like a collective Neighbourhood which lends itself to us delivering some aspects of the fuller framework at scale. Same day access could work well at scale with a smaller locality focus for prevention and other priorities.

What will Fuller Neighbourhoods look and feel like in 5 years' time in our Place? What's our vision/ambition

- Pilot, test, learn, spread approach
- Ownership by local community
- Trust between professionals
- Reduced transactional activity such as referrals/hand-offs – Self referrals are maximised.
- Digitally enabled sharing of records

- GP practices and their patient lists to form the anchor of the Fuller Neighbourhood as a 'brand' that is recognised by all.
- Consistent principles for all MK Fuller Neighbourhoods with variation of the delivery model to meet the individual needs of each locality.
- Residents are able to access emergency care when they need it and have good access to non-emergency appointments – we support people to avoid using emergency only services when they want to have conversations about minor issues and prevention.
- Each Neighbourhood has a clear profile of its top 1% of users and a service model focused on reducing the top 3 inequalities facing their population group. The make-up and skill set of Neighbourhood teams reflects these priorities and there is rich contact and working with VCSE groups to support the health and wellbeing of residents.

Agree the next steps and the timescales for your Place to develop Fuller Neighbourhoods in 23/24 (and beyond?)

- Pilot first approach, try Fuller in one Neighbourhood and change based on learning. 18 months approx. pilot length. More discussion required on roll-out approach / how other localities develop during the pilot. Important that all localities feel part of the pilot in terms of sharing learning and experience.
- Agree principles to guide choice of pilot Neighbourhood and select first Neighbourhood
- Develop a proposal for one Fuller Neighbourhood by June 2023.
- Use existing Place Joint Leadership Team for ownership.
- Data mapping – demographics including future trends
- Stakeholder mapping and engagement
- Asset mapping and opportunities

Identify any support needed from the ICB / the Collaboratives / wider partners?

- There are noticeable demographic variations across all the estates with each having pockets of deprivation. What data is available to understand our Neighbourhoods in the detail we need? For example do we know who the Milton Keynes top 1% of service users are and do we know this for wider than purely health data?
- ICB asked to avoid taking decisions that may have an unintended impact on local Fuller work – for example destabilising partners through contract changes. ICB to provide a stable and safe environment for change.
- ICB to provide 'air cover' to allow testing of new ways of working.
- Support to undertake a piece of work looking at how could additional capacity in primary care be freed up? This was seen as an important change tool to give space to support primary care to move to new ways of working. The example focused on for discussion was the time-consuming nature of primary care referrals into community services and secondary care and the ongoing support patients needed whilst their waited for their appointment. This theme would also be a potential 'hook' for secondary care into Fuller Neighbourhoods.

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?

- ***Workforce –*** There are a range of support worker roles within health and social care that have a common skill set. We could make these more generic roles to enable the support to be flexed to match the needs of the resident/patient and cover multiple support needs at once. We could consider the potential Brazil model of community support worker, targeting specific population groups with support.
- ***Estates -*** Utilise opportunities offered by S106 funding, not always looking at building new as adapting surplus or existing estate can work well and have a quicker lead in time. Make best use of homeworking / back office sharing options too.

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?

- Health & Care Partnership in MK has asked the Joint Leadership Team to develop a proposal to pilot a Fuller Neighbourhood, table participants agreed to support the development of this. Will also look to undertake engagement with residents and wider stakeholders including police, housing, schools, business sector, VCSE. Healthwatch expertise to support co-production with patients.

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Board of the Integrated Care Board (ICB)
12. Core20Plus 5 for children and young people

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	Julia Robson, Inequalities Lead
Date to which the information this report is based on was accurate	10/03/23
Senior Responsible Owner	Sarah Stanley Chief Nursing Director

The following individuals were consulted and involved in the development of this report:
Sarah Breton, Associate Director, Children and Young People
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 **agree** this approach as a way forward in terms of focusing on a population group and wrap the pathway around this.

Executive Summary Report

1. Brief background / introduction:

Core20PLUS5 is a national NHS England approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort and identifies five focus clinical areas considered nationally to require accelerated improvement.

The approach, which initially focussed on healthcare inequalities experienced by adults, has now been adapted to apply to children and young people. This gives the ICB a clear framework with which to focus inequalities work for the population of children and young people, building on existing work at Place and identifying where working across BLMK will add value in terms of reducing inequalities.

Core20

The most deprived 20% of the national population as identified by the national Index of multiple deprivation (IMD). The IMD has seven domains with indicators accounting for a wide range of social determinants of health. For children and young people wider sources of data may also be helpful including the national child mortality data base and data available on the Fingertips platform.

Across BLMK each local authority has a Children's Joint Strategic Needs Assessment that will be built upon to identify the 20%.

PLUS

Nationally the PLUS population groups for children and young people include those populations who may not be covered by the 20% but may still experience poorer healthcare outcomes. The national framework gives ICBs the opportunity to identify the most relevant local population groups and based on local data and national evidence these groups for BLMK will include looked after children and care leavers (up to 25 years), children with Special Educational Needs and Disabilities (SEND), children who have been exploited (sexual and drug exploitation), children in contact with the youth justice system. Inclusion groups would include children from ethnic minority backgrounds and those living in temporary or poor standard housing.

5

The final part sets out five clinical areas of focus that build on the NHS Long Term Plan. Roll-out of the national care bundles for **asthma, diabetes and epilepsy** is already underway in BLMK with clinical reference groups and multi-agency project boards driving improvements. The BLMK Mental Health Programme Board has been responsible for driving a programme of improvement across **children's mental health** provision. Oral health promotion currently happens through public health teams at Place. Each of these work programmes could be tasked to ensure that implementation targets inequalities.

NHSE have set the following 5 areas of focus, however each ICS is at very different stages and maturity levels, so each area is asked to contribute towards these set priorities and make relevant for BLMK.

1. Asthma

- Address over reliance on reliever medications; and
- Decrease the number of asthma attacks.

2. Diabetes

- Increase access to real-time continuous glucose monitors and insulin pumps across the most deprived quintiles and from ethnic minority backgrounds; and

- Increase proportion of those with Type 2 diabetes receiving recommended NICE care processes.

3. Epilepsy

- Increase access to epilepsy specialist nurses and ensure access in the first year of care for those with a learning disability or autism.

4. Oral health

- Tooth extractions due to decay for children admitted as inpatients in hospital, aged 10 years and under.

5. Mental health

- Improve access rates to children and young people's mental health services for 0-17 year olds, for certain ethnic groups, age, gender and deprivation.

Notably, the model considers healthcare inequalities specifically, rather than health inequalities generally. It adopts a medical and clinical approach, including outcomes that are within the traditional responsibility of healthcare organisations to monitor and improve on. The model does not capture broader preventative actions within society that we know have a huge impact on young people's health, such as access to clean air, warm homes and green spaces.

The five conditions reflect clinical commitments already laid out for children and young people in the NHS Long Term Plan. Obesity is not listed as a clinical area, despite the fact that young people aged 10-11 living in the most deprived areas of England are twice as likely to be obese compared to the young people living in the least deprived areas. In BLMK excess weight in children is closely associated with deprivation and the inclusion groups. Work programmes are already happening at Place.

The methodology would take us through a sequence of improvement looking at:

- Identifying a population/community/cohort of patients who are experiencing the greatest inequalities
- Work in collaboration with the community to gather a deeper understanding of the issues they face
- Work in collaboration with stakeholders to understand their perspective of the issues
- Build a strategy from the themes collected and work in collaboration across the ICS, taking a wider approach to the issue rather than focusing on individual clinical pathways
- Add measures to the strategy and test ideas to understand where we are making improvements, then scale up.

2. Summary of key points:

- This framework gives the ICB a great opportunity to focus on reducing inequalities for children and young people.
- There are already structures in place though the BLMK Children's Transformation Board to align the inequalities work with existing work programmes.
- Working with local Place there is the opportunity to identify and champion work to reduce inequalities in one or more BLMK identified 'Plus' groups. This should be agreed with Place.
- The framework needs to consider wider outcomes than 'healthcare' and so for BLMK it will include the wider public health agenda from prevention to intervention.

3. Are there any options?

1. Strengthen the projects aligned to the Core20PLUS5 with current QI resources with no extra projects
2. Strengthen the projects aligned to the Core20PLUS5 with current resources with an extra focus on a population group and as a different approach to work in a more systematic, holistic approach

4. Key Risks and Issues

- There is a risk that there will not be sufficient programme capacity to deliver the outcomes.
- This is linked to BAF risk 4 - Inequalities

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?

Uncertainty about recurrent inequalities funding in 2023/24 will impact the programme.

6. How will / does this work help to address the Green Plan Commitments?

Click to view Green Plan

By improving on the quality of care and the services we provide through the inequality lens, we will be addressing the commitment to Sustainable models of care. By improving the access to services, we will in turn be supporting the digital transformation commitment. Within our Clinical Programme proposals, we wish to improve on priorities such as LTC and mental health, which could reduce emissions generated by the transport of medicines over the years.

7. How will / does this work help to address inequalities?

The framework is to reduce inequalities for children and young people.

8. Next steps:

Agree on high level approach and begin with engagement

9. Appendices

Appendix A – slide deck

10. Background reading

https://www.longtermplan.nhs.uk/
https://ayph-youthhealthdata.org.uk/health-inequalities/health-outcomes/obesity/

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CYP Core20+5

High Level approach to the Core20+5 framework

Julia Robson – Inequalities Programme Lead

What is the Core20+5 CYP?

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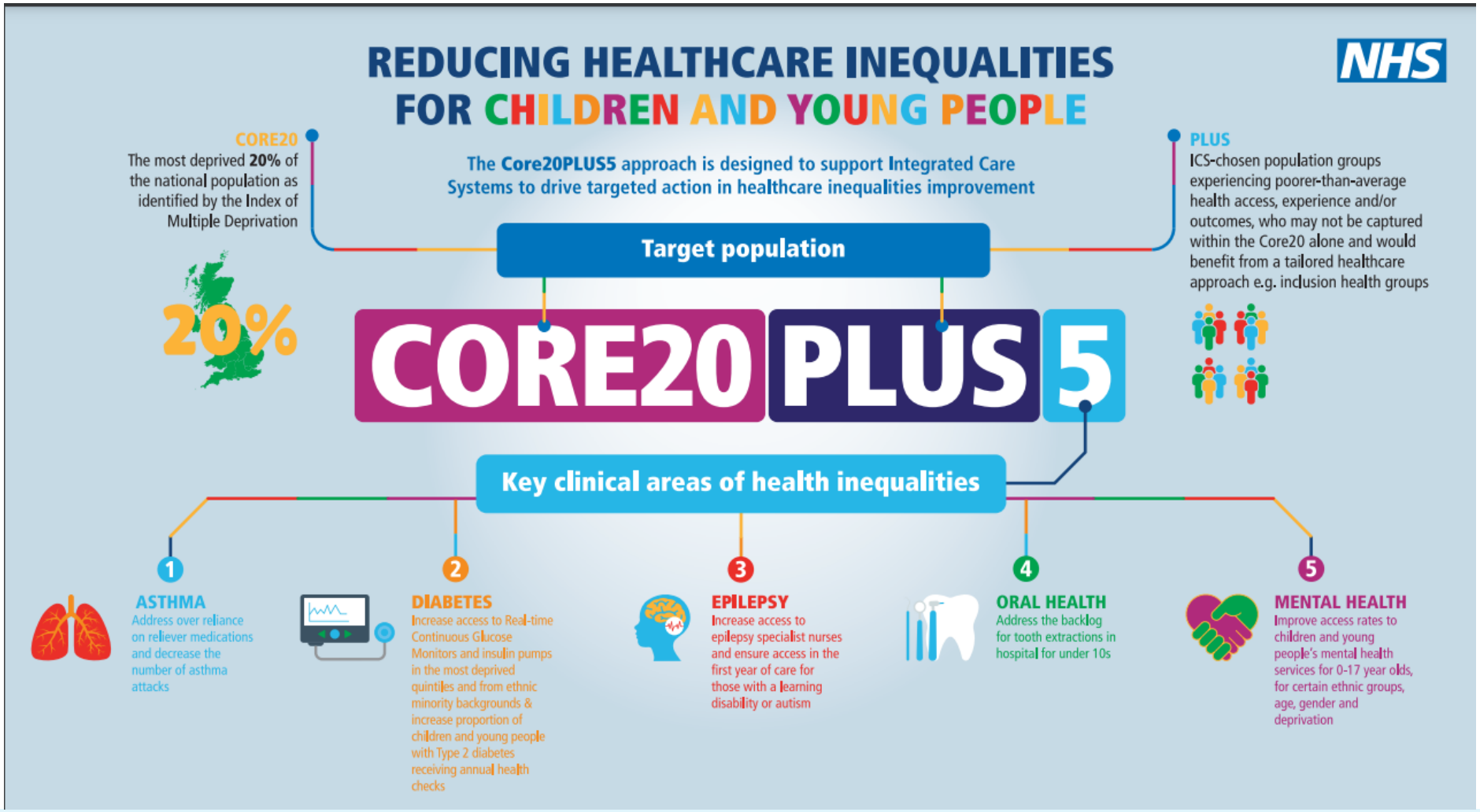
Integrated Care Board

Core20PLUS5 – An approach to reducing health inequalities for children and young people is a national NHS England approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort and identifies '5' focus clinical areas requiring accelerated improvement.



1 For consideration

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- Notably, the model considers healthcare inequalities specifically, rather than health inequalities generally.
- It adopts a medical and clinical approach, including outcomes that are within the traditional responsibility of healthcare organisations to monitor and improve on.
- The model does not capture broader preventative actions within society that we know have a huge impact on young people's health, such as access to clean air, warm homes and green spaces.
- The five conditions reflect clinical commitments already laid out for children and young people in the NHS Long Term Plan.
- Obesity is not listed as a clinical area, despite the fact that young people aged 10-11 living in the most deprived areas of England are twice as likely to be obese compared to the young people living in the least deprived areas.

3 Working in Partnership

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We as the NHS can play a wider role in combating these health inequalities through greater collaboration with local partners, such as Local Authorities and schools.

There is clearly more work to be done in this broader space and we hope that the framework will inspire us to think about the impact that is possible on these wider issues.

The ‘Plus’ Groups

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- The ‘Plus’ element does offer the opportunity to address outcomes for locally identified groups that experience disadvantage e.g. Looked After Children.
- There are already work programmes both at Place (e.g SEND Strategies) and at ICB level (e.g Neurodiversity pathways) that can be built on to address inequalities for all elements of Core20Plus5.
- It is proposed that these existing programmes identify specific measurable improvements as part of their programme.
- In addition it is proposed that one locally agreed ‘Plus’ group is identified for focused work on inequalities.

2 Approach for the ‘Plus’ group

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- Identify a population/community/cohort of patients who are experiencing the greatest inequalities
- Work in collaboration with the community to gather a deeper understanding of the issues they face
- Work in collaboration with stakeholders to understand their perspective of the issues
- Build a strategy from the themes collected and work in collaboration across the ICS, taking a wider approach to the issue rather than focusing on individual clinical pathways
- Add measures to the strategy and test ideas to understand where we are making improvements, then scale up!

Governance

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- Identify workstreams and prioritise
- Understand who can sponsor the work being undertaken to help unblock barriers
- Map meetings to understand who holds responsibility and where we can influence

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Report to the Board of the Integrated Care Board (ICB)
13. Managing Conflicts of Interest in Procurement

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):	Contracting and Procurement		

Report Author	Kathryn Moody, Director of Contracting
Date to which the information this report is based on was accurate	10 March 2023
Senior Responsible Owner	Anne Brierley, Chief Transformation Officer

The following individuals were consulted and involved in the development of this report:
Geoff Stokes, Interim Head of Governance Gaynor Flynn, Governance and Compliance Manager Ros Clarke, Head of Procurement, Arden GEM CSU
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 risks, issues and proposals herein B) Confirm agreement to the ways of working recommended

Executive Summary Report

1. Brief background / introduction:

As the ICB begins to implement the programmes of work within the Operational Plan and the Joint Forward Plan (JFP), there will be a number of decisions to be taken by the ICB Board and its sub-committees relating to the procurement of supplies and services; this will include both the procurement vehicles to be used (e.g. direct award, restricted or open market tenders) and the selection of providers. To ensure that conflicts of interest (CoIs) relating to these discussions and decisions are effectively declared, managed, and mitigated, and to ensure decisions are sound and the risk of challenge to any procurement process or outcome is minimised, the ICB Board therefore needs to agree the approach to the management of CoI in these instances. This paper therefore presents proposals for noting and agreement to enable this.

2. Summary of key points:

Overarching Process and Approach

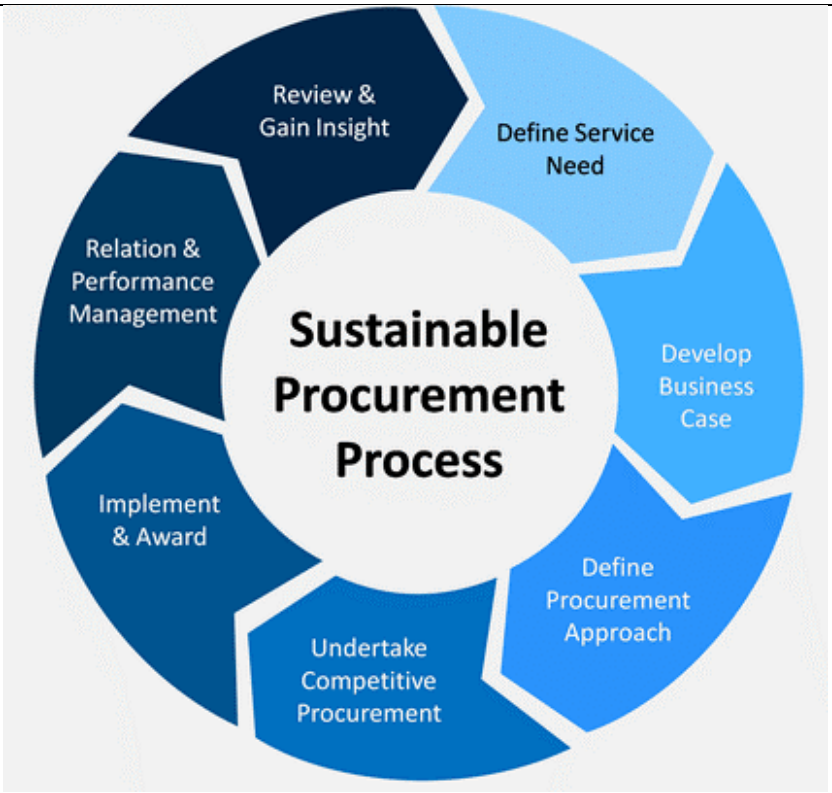
The overarching process for the management of CoIs across all activities is contained within the *Conflicts of Interest Management and Standards of Business Conduct Policy*, approved by the ICB Board on 1 July 2023. Within this document, section 6.7 gives an overarching approach to be taken in relation to procurements. It is important therefore that this paper is seen as 'unpacking' this element of the policy and not as an alternative approach; the policy remains the primary document in relation to this area and should be fully adhered to by officers of the ICB and members of the ICB Board at all times.

Definition of Procurement

Within the policy above, it is noted that procurement refers to the purchase of any goods, services or supplies, and not simply anything that is put out to tender. The emphasis of this paper, however, is in relation to procurement decisions that the ICB Board and its constituent members may make and therefore the focus is much more in relation to the procurement of significant services (those which are of strategic importance or which require approval via ICB Board because of financial value).

Stages of Procurement

There are a number of steps to the procurement process and at each step CoIs need to be understood and managed. These steps are as shown in the diagram below:



For the purposes of this paper, the stages following contract award are seen as operational business as usual (BAU), and so the focus is on the five steps from the definition of service need to the implementation and award of contract. By looking at each of these steps and reflecting on the potential impact of any CoIs, BLMK ICB can minimise the risk of legal challenge and/or unsafe decision making.

- **Define Service Need**
  When defining the service need, as well as reviewing intelligence emanating from any current services, it is vital that stakeholder voices are heard. These stakeholders should be able to express views openly and honestly, and this includes current or potential providers. At this stage, therefore, whilst conflicts should be noted, individuals and representatives from all organisations should be allowed to share their views, experiences and expertise, including around the ICB Board table (noting that the reason wider system partners are around the Board table is to bring their particular perspectives).

  There are however two things that need to be considered when defining service need. Firstly, it is important to ensure all stakeholders have the opportunity to be equally engaged and feed into the discussions; it is the responsibility of the procurement leads to ensure stakeholder engagement/soft market testing is publicised and available to all through appropriate procurement channels and if engagement happens only with a partial group of individuals, any resulting stated service need may be questioned.

  Secondly, engagement should ideally take place in a formal session of which a record of attendees and discussion points is kept. Individual Board members should never approach service leads in an unsolicited manner to discuss service needs, and whilst incidental conversations do happen in the normal course of business conduct, these should be noted as soon as possible after the event to maintain transparency and protect any individuals from challenge.

Members of the ICB Board can share views, expertise and experience as stakeholders within a formal stakeholder engagement programme. Members should avoid individual and unsolicited

conversations which may be construed as seeking to unfairly benefit their own organisations and/or the services they provide.

- **Development and Sign-Off of Business Case**
  When developing the business case for a new or existing service, as with the above, discussions with stakeholders are valuable and, whilst CoI should be declared and noted, there is no requirement to exclude individuals from discussions around business case development.

  However, where a business case has been developed and requires sign-off by a Committee or by the ICB Board, any interests should be declared and managed. It would be best practice for the case to be withheld from the member in question, or at the very least they should be issued with a version which has commercial information/strategy redacted to ensure no allegations of competitive advantage can be made.

  In addition to this, the individual should be excluded from the discussion and decision-making in relation to the case.

  Interests in services and sectors should be declared, either via the Register of Interests or within the relevant meeting. Where interests are declared, these need to be formally minuted and the relevant individual excluded from both the discussion and the decision. Ideally the case should not be shared with those with a CoI; if the case is shared with individuals with a CoI, this should be a redacted version only.

- **Define Procurement Approach**
  The approach to any given procurement will be decided upon in line with the ICB Procurement Policy, based on market analysis and intelligence, the complexity and value of the service being procured, and the prevailing legislation in place at the time.

  The recommended procurement vehicle for a given service will be decided based on discussions between the Director of Contracting, Chief Transformation Officer, AGEM Procurement advisors and the Deputy Chief Financial Officer. The annual procurement plan will then be presented to the ICB Finance and Investment Committee for approval, in line with the ICB Scheme of Delegation.

  All members of the Finance and Investment Committee are required to declare interests which are included within the ICB Register of Interests. Where an interest is thought to exist, advice should be sought from the Head of Governance about the action to be taken, although it would be normal practice for any papers pertaining to the interest to be withheld from the individual concerned and for them to be excluded from the discussion and decision.

  In addition, at the start of all meetings, declarations of interest are sought for items on the agenda where interests have not been previously declared. It is the responsibility of committee members to read papers prior to the meeting to establish whether any CoI does exist and ensure these are declared. Where interests are declared, the declaration must be minuted. It is the role of the Chair to confirm the treatment of the individual but it would be expected that the individual declaring the interest be excluded from any discussions and decisions. If the individual concerned is the Chair of the meeting, the Vice-Chair will need to undertake the chairing of this part of the meeting.

  It is important to note that the procurement plan will focus on services rather than providers (since we procure services and not contracts). On this basis interests should be declared where individuals have interests in specific sectors/services even where there is no direct interest in an existing provider.

The annual procurement plan, which includes the proposed vehicles to be used will be shared with the Finance and Investment Committee, in line with the Scheme of Delegation. Interests in services and sectors should be declared, either via the Register of Interests or within the relevant meeting. Where interests are declared, these need to be formally minuted and the relevant individual excluded from both the discussion and the decision.

- **Undertake Competitive Procurement**

  Should it be agreed that an opportunity will be issued to the market under either a restricted or an open procurement process, a multi-disciplinary team will be established to develop the final specification, the evaluation questions and weighted scoring matrix, the contract type, and other formal documentation/background to be shared as part of the procurement. The selection and management of this team will follow a number of rules, these including:

  - All individuals will be required to declare any interests prior to any information relating to the procurement being shared. Where interests are declared, these will be discussed with the procurement SRO and if they cannot be managed, the individual will be asked to withdraw from the process;
  - There should be no conversations between evaluators regarding the output of the bids before moderation; and
  - No evaluator will see the whole bid; evaluators only see the elements of the bid that they are required to score so no-one can second-guess the outcome or score to skew the overall scoring.

  Once a procurement 'goes live' and is released to the market, the ICB Board should refrain from any discussion around potential outcomes and/or the status of the procurement itself. Any discussions in relation to that procurement should only be held through formal procurement routes and should be only in writing. Any questions or comments received during this period will be logged and released to the market, to ensure all providers have the same information at the same time. Conversely, any discussions which take place outside of this process could jeopardise the safety of the procurement, and in a worst case, providers may be disqualified from bidding. During this stage therefore, members of the ICB Board should refrain from discussing any open procurements unless this is part of the formal clarification process. Any discussions which do come to light out with this process will be raised with the ICB Audit and Risk Assurance Committee.

  When pulling together documentation for procurements, there will be a strict separation of duties and a very clear process around declarations and conflicts of interest.

  In their role as ICB Board members, individuals must not discuss procurements once they are live. Individuals and their organisations may raise questions during the time in which a procurement is 'live', but these must ONLY be raised through the formal clarification process which is overseen by the ICB procurement advisors. Any deviation from this process will be reported and may lead to providers being excluded from bidding.

- **Implement and Award**

  Once the procurement has closed to the market, the evaluation period will begin, following the rules above. Once an evaluation period has been completed, a formal contract award report will be written by the ICB procurement advisors and shared with the project Senior Responsible Officer (SRO). Depending on the value of the contract, this will be submitted for approval to the appropriate individual/committee in line with the ICB Standing Financial Instructions (SFIs).

Before the report is submitted to the relevant officers, CoIs again need to be considered. When a report is submitted, the Register of Interests needs to be checked, and where a conflict of interest exists, this needs to be managed effectively. No reports should be shared with anyone with an interest in the relevant services.

Where a report needs to be shared with a Committee or with the ICB Board, the paper needs to be withheld from any individuals identified as having a CoI, and they should be excluded from any discussion or decision in relation to the paper; if it is the Chair of the meeting who has the interest, this element of the meeting will need to be chaired by the Vice-Chair. Their exclusion should be minuted.

Once a contract award report has been approved, the awarding of the contract will take place, with formal notification sent to the market and all bidders. Where tenders require it, a ten-day standstill period will begin at this point. This period allows the market to digest and respond to the outcome of the procurement and lodge any challenges. During this period, no action can be taken by either the body awarding the contract, or the organisation who has been successful. This includes any communication with partners regarding the successful bidder and any discussions regarding mobilisation of the new service.

Contract award reports should be only shared with those who have no interest in the relevant service. Where interests exist, these should be managed, with reports being withheld from the individuals concerned. Individuals with relevant interests should be excluded from any discussion or decision-making in relation to the contract award. During the ten-day standstill period, there should be no communication with partners regarding the successful bidder or the mobilisation of the new service. No information on successful or unsuccessful bidders should be shared beyond the individual/group responsible for awarding the contract.

Conclusions

The management of CoIs in procurement is vital to ensure the process cannot be challenged successfully. If members and officers of the ICB Board and its sub-committees follow the processes above, this will mitigate risk of challenge in this area.

3. Are there any options?

N/A

4. Key Risks and Issues

The overarching risk is that procurement decisions may be compromised by not managing conflicts of interest effectively. The approach outlined above should minimise this risk by ensuring conflicts of interest are recorded and managed.

Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☐	No ☒

Risk is already recorded via Corporate Governance team

5. Are there any financial implications or other resourcing implications, including workforce?

No direct consequences – although should conflicts not be managed appropriately there may be costs in relation to procurement and legal challenge, and abandonment of procurements.
6. How will / does this work help to address the Green Plan Commitments? Click to view Green Plan
Sound procurement will enable us to seek additional green plan commitments from bidders and therefore from contracts.
7. How will / does this work help to address inequalities?
Through delivery of our strategic objectives
8. Next steps:
The ICB Board is asked to agree the content herein and confirm the direction of travel.
9. Appendices
Appendix A – Summary of Board Member Responsibilities
10. Background reading

Appendix A

Managing Conflicts of Interest in Procurements
Summary of Board Member Responsibilities

- Individual Board members should never approach service leads in an unsolicited manner to discuss service needs
- ICB Board members can share views, expertise and experience as stakeholders within a formal stakeholder engagement programme.
- Members should avoid individual and unsolicited conversations which may be construed as seeking to unfairly benefit their own organisations and/or the services they provide.
- Interests in services and sectors should be declared, either via the Register of Interests or within the relevant meeting.
- Where interests are declared, these need to be formally minuted and the relevant individual excluded from both the discussion and the decision.
- Ideally the case should not be shared with those with conflicts of interest; if the case is shared with individuals with conflicts of interest, this should be a redacted version only.
- In their role as ICB Board members, individuals must not discuss procurements once they are live.
- Individuals and their organisations may raise questions during the time in which a procurement is 'live', but these must ONLY be raised through the formal clarification process which is overseen by the ICB procurement advisors. Any deviation from this process will be reported and may lead to providers being excluded from bidding.

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Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Board of the Integrated Care Board (ICB)
14. 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	13 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:
The Primary Care Commissioning and Assurance Committee will receive this paper on 17 March 2023 (after Board papers are submitted).

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 (POD) contracting from NHS England to the ICB from 01 April 2023;
B) **Approve** a recommendation from Primary Care Commissioning and Assurance Committee (PCCAC) to accept delegation from 01 April 2023;
C) **Note** the outstanding risks and view of internal audit, and support the recommendation of a side letter to the Delegation Agreement which sets out the ICB's 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; and
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 ICB Board 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 NHS England (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 (HWE) 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 NHSE.
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 PCCAC has considered the progress made at its meeting on 17 March 2023 and is making a recommendation to Board to approve the delegation of these services, at which point 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; and
- 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 and 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 Board

Since the last paper presented to the Board in its private session on 27 January 2023 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 robust processes are established. 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:

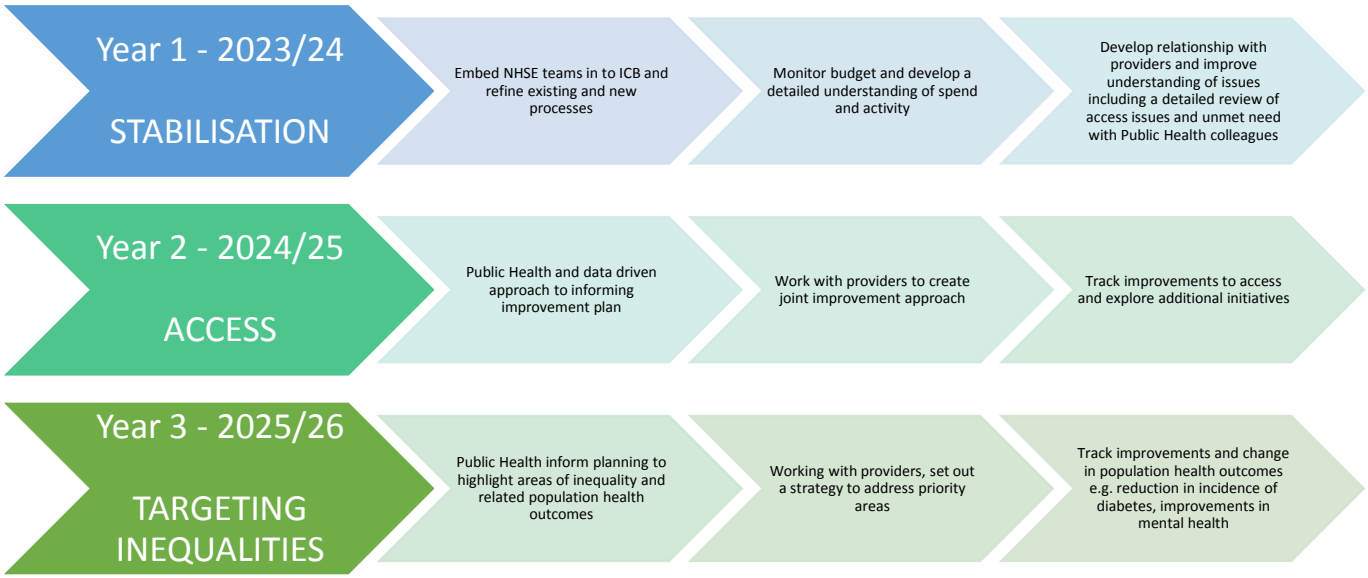
- 159 Community Pharmacy contracts;
- 86 Optometry contracts; and
- 148 Dental contracts (including 2 acute hospitals and 2 community services).

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 486 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.

Collaborative working with Public Health has started, and this includes working together to understand the impact of the closure of three Lloyds pharmacies in Central Bedfordshire. The Public Health Consultant will support the ICB by undertaking a revised local Pharmaceutical Needs Assessment (PNA) to determine if additional pharmacy provision is required. This is an example of where collaborative system working can support more responsive planning and provision of community pharmacy and dental services across BLMK.

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 into account in a review of the risks that remain in place and they have been included on relevant risk registers for ongoing management.

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 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.	Letter of Comfort from NHSE setting out limited requirement for quality intervention. Consideration for 8a Quality Assurance role to review and implement an effective system.	£85,343 incl. 25% on costs [Recurrent issue]	H
Complaints Workforce			
The current East of England (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

Gap Identified	Mitigation	Possible Financial Impact	Likelihood of risk materialising (H/M/L)
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

Gap Identified	Mitigation	Possible Financial Impact	Likelihood of risk materialising (H/M/L)
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, 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 Assurance Committee on 03 March 2023, and the full report, along with management responses and the current position on outstanding risk,s will be presented to their next meeting.

4. Governance structure

As previously shared with the Board, 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 and revised PCCAC Terms of Reference will be shared with the Board 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 Board 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 has been signed by Felicity Cox on behalf of the ICB. PCCAC has considered the points that should be highlighted as concerns to NHSE, and these will be set out in a formal side letter to the delegation agreement as agreed at Board on 17 March 2023.

7. Recommendation from PCCAC on 17 March 2023

At its meeting on the 17 March 2023, the PCCAC will receive the information contained within this report and will be asked whether the Committee supports making a recommendation to Board to sign off the planned delegation as of 01 April 2023. It is expected that this will be the case, but a verbal update will be provided to Board at its meeting due to Board papers being required before the PCCAC meets.

8. 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 from Primary Care Commissioning and Assurance Committee (PCCAC) to accept delegation from 01 April 2023 ;
C) **Note** the outstanding risks and view of internal audit, and support the recommendation of a side letter to the Delegation Agreement which sets out the ICB's 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; and
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 14 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 **Error! Reference source not found.**); 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 **Error! Reference source not found.** 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 **Error! Reference source not found.** 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 **Error! Reference source not found.** 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 **Error! Reference source not found.**, **Error! Reference source not found.**, 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 **Error! Reference source not found.** 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 **Error! Reference source not found.** 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 **Error! Reference source not found.** (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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V0.05		

Reviewers

This document must be reviewed by:

Reviewer name	Title/responsibility	Date	Version
Jackie Bidgood	Senior Contract Manager	14.09.2021	V3
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Approved by

This document must be approved by:

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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

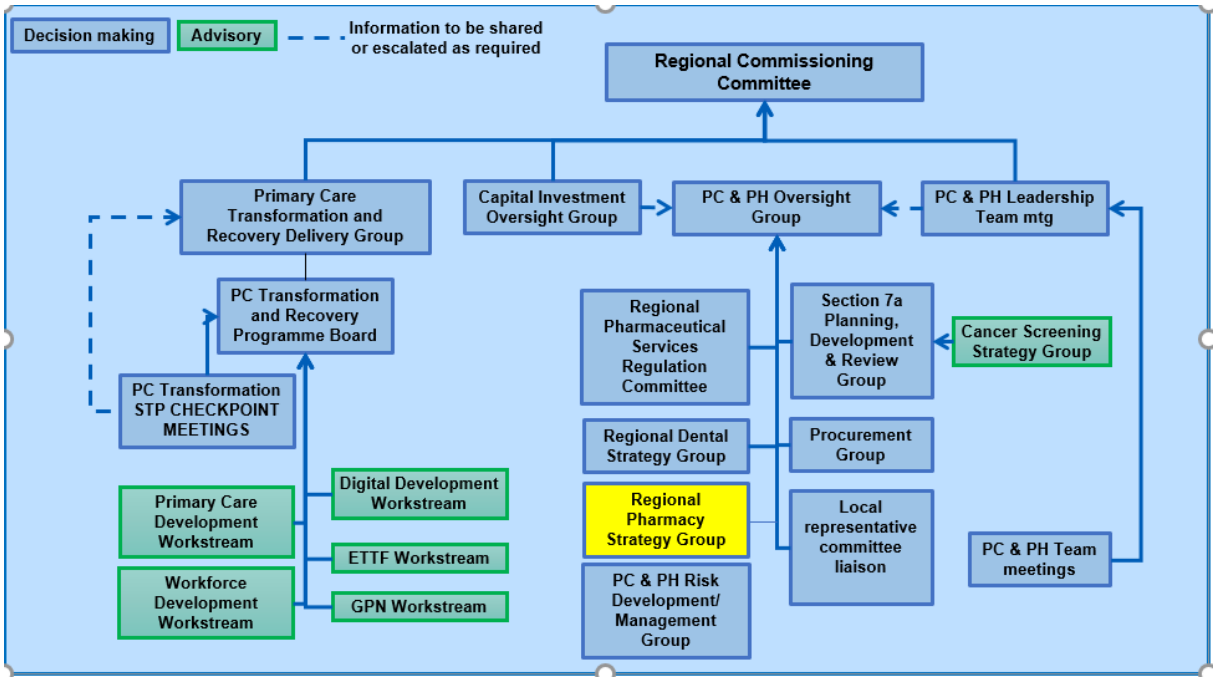
NHS England and NHS Improvement has delegated decision making to each PSRC in relation to matters under the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (the "Regulations") listed in Chapter 3 of the Pharmacy Manual, where the decision maker is listed as the PSRC and in accordance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

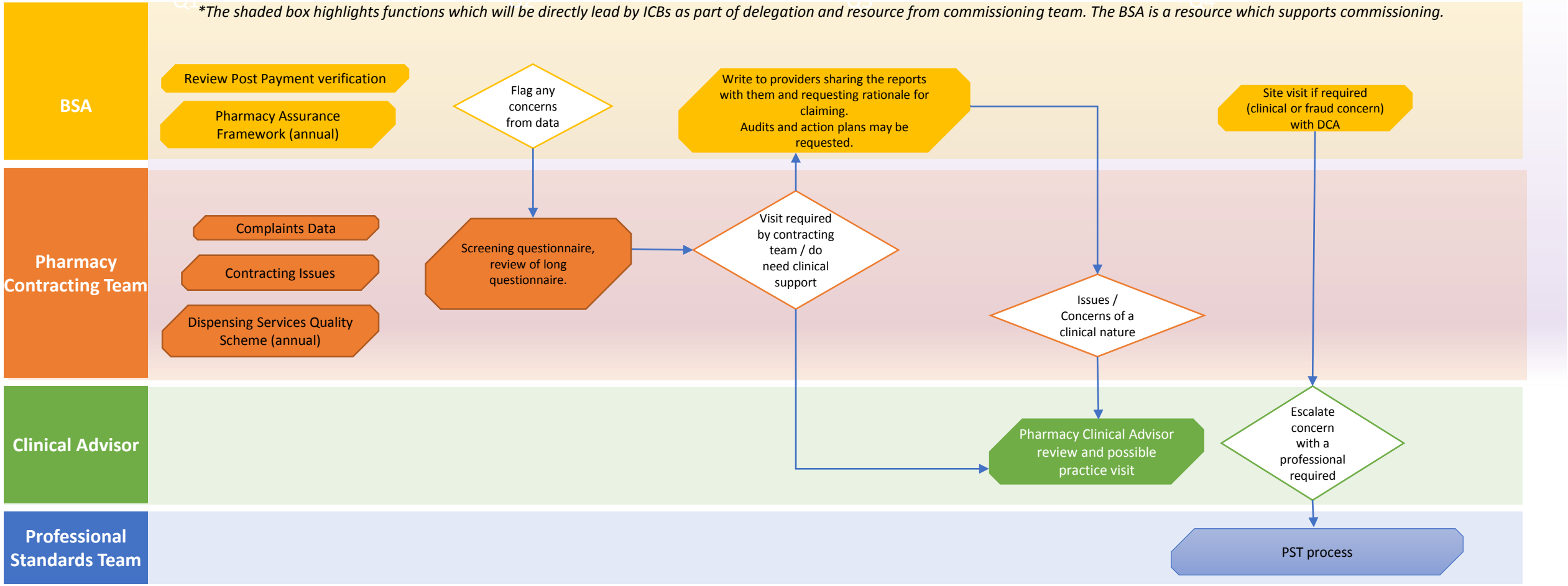
I confirm that the information I have given in Part 1 and Part 2 is to the best of my knowledge and if this changes I will update this immediately by informing the commissioning lead (or nominated deputy) as soon as I am aware. I have read and understood Part 2 and Part 3 and sign below to show my agreement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

Name:

Signature:
Date:

Pharmacy Quality Review and Audits

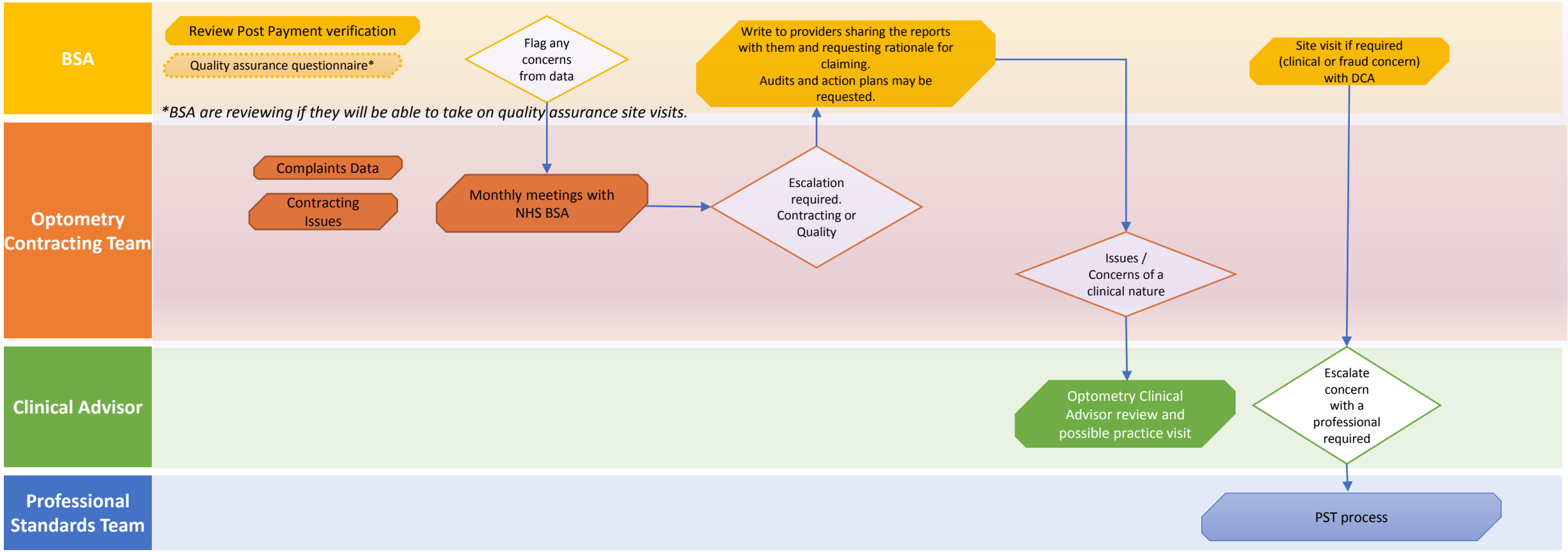
- Pharmacy quality in terms of contractual, clinical and professional are monitored by Contracting and BSA team, utilising the clinical advice and professional standards team review process where escalation is required.
- Direct Commissioning Nursing and Leadership Team sit on Professional Standards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

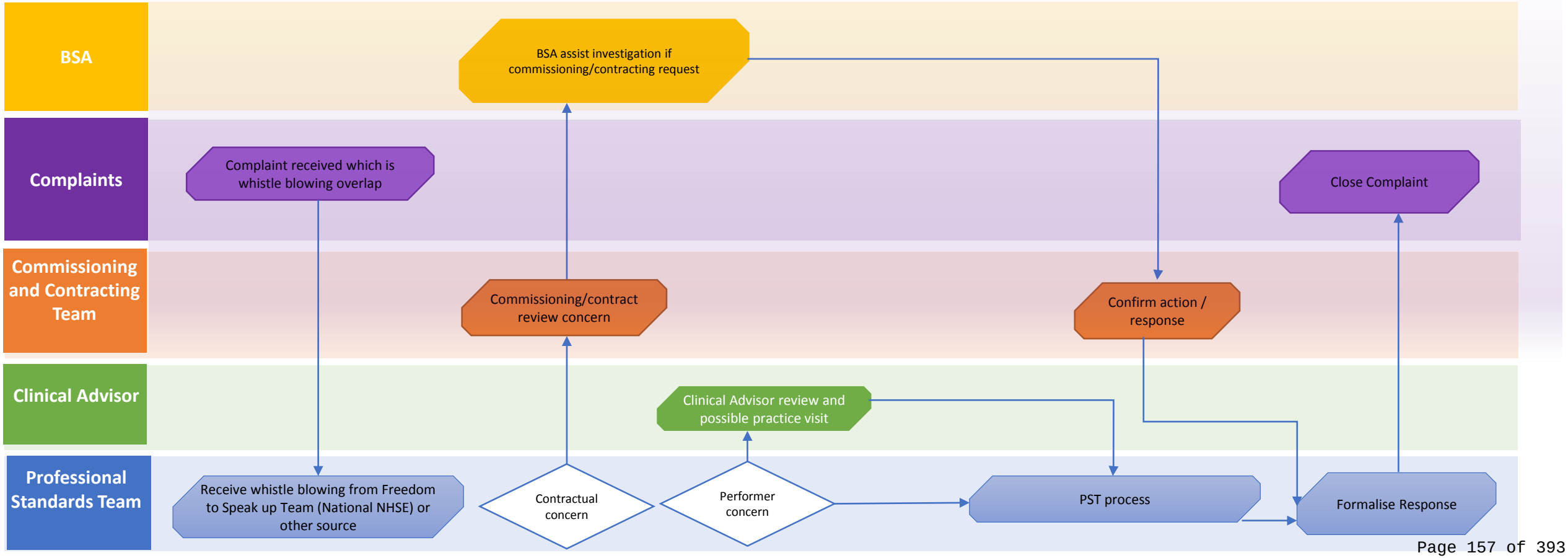
**The shaded box highlights functions which will be directly lead by ICBs as part of delegation and resource from commissioning team. The BSA is a resource which supports commissioning.*



Whistle Blowing

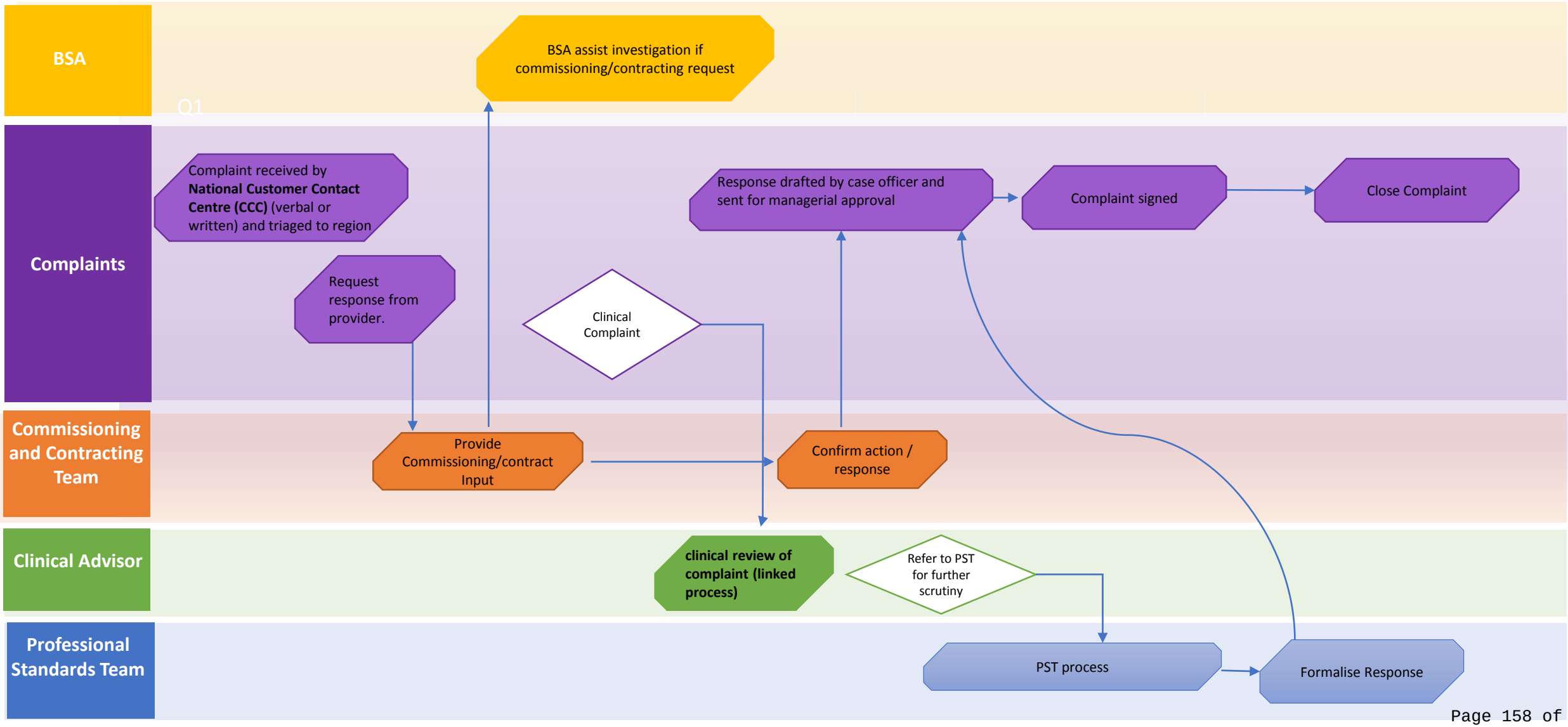
- National Freedom to Speak Up remains in place, Professional standards team who deals with these remain at region. Interface with POD Commissioning required and complaints.

**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.*



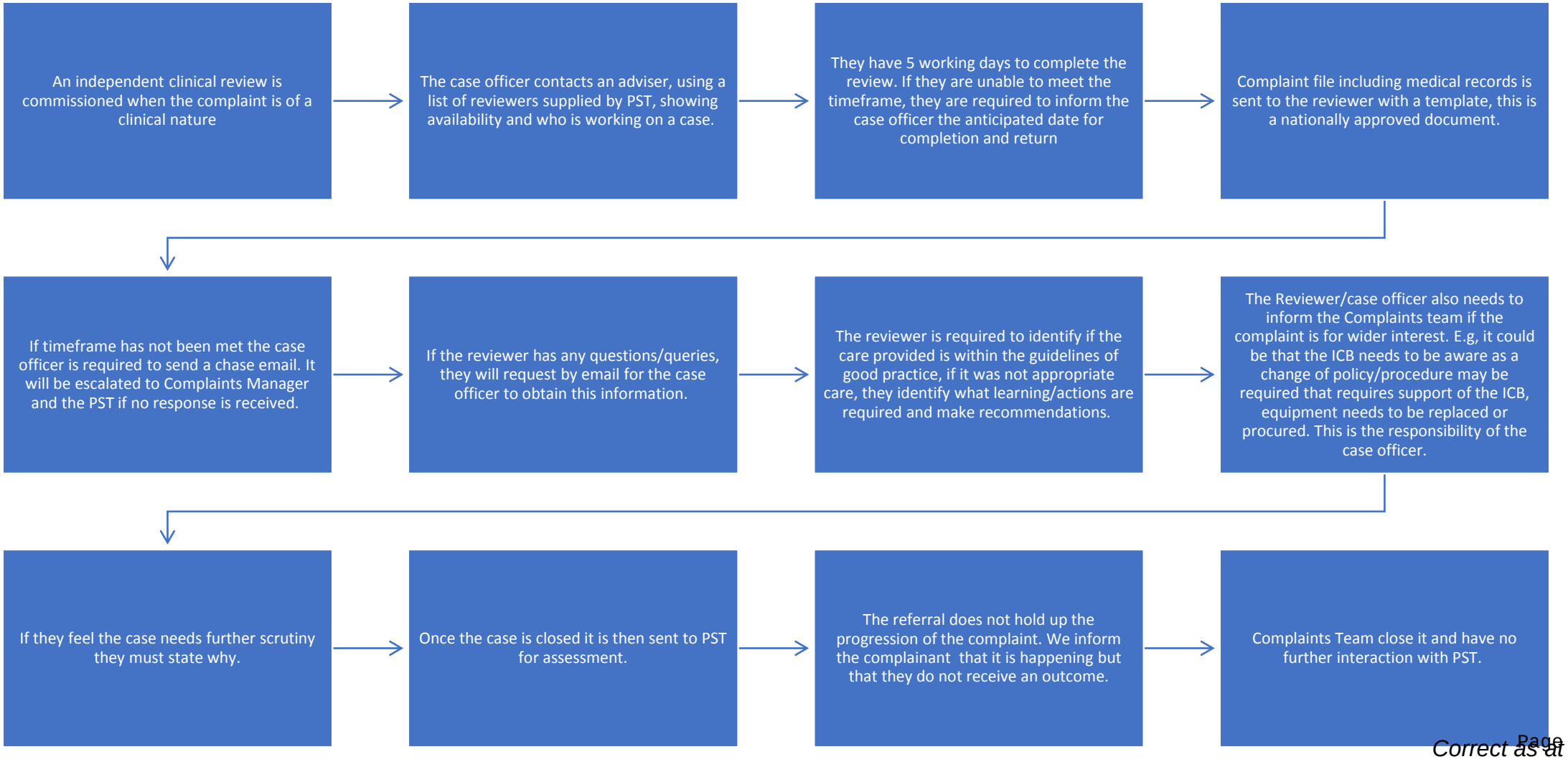
Complaints

**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.

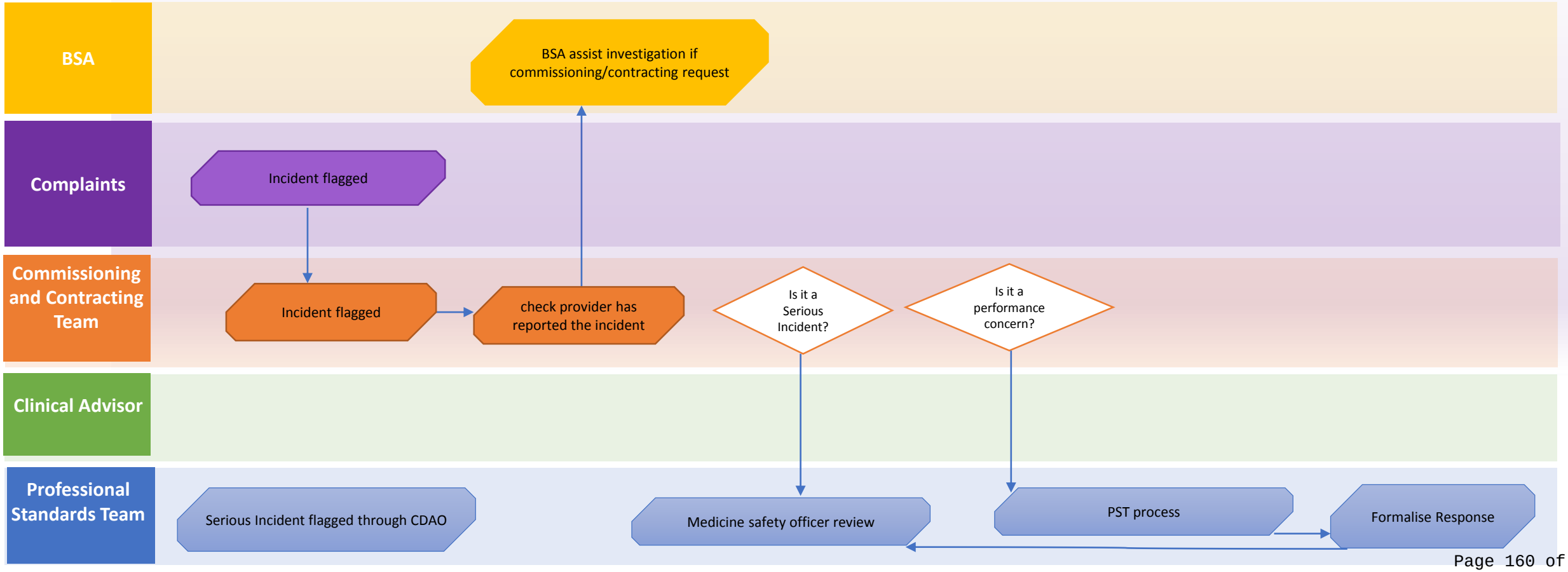


Correct as at 18/10/2022

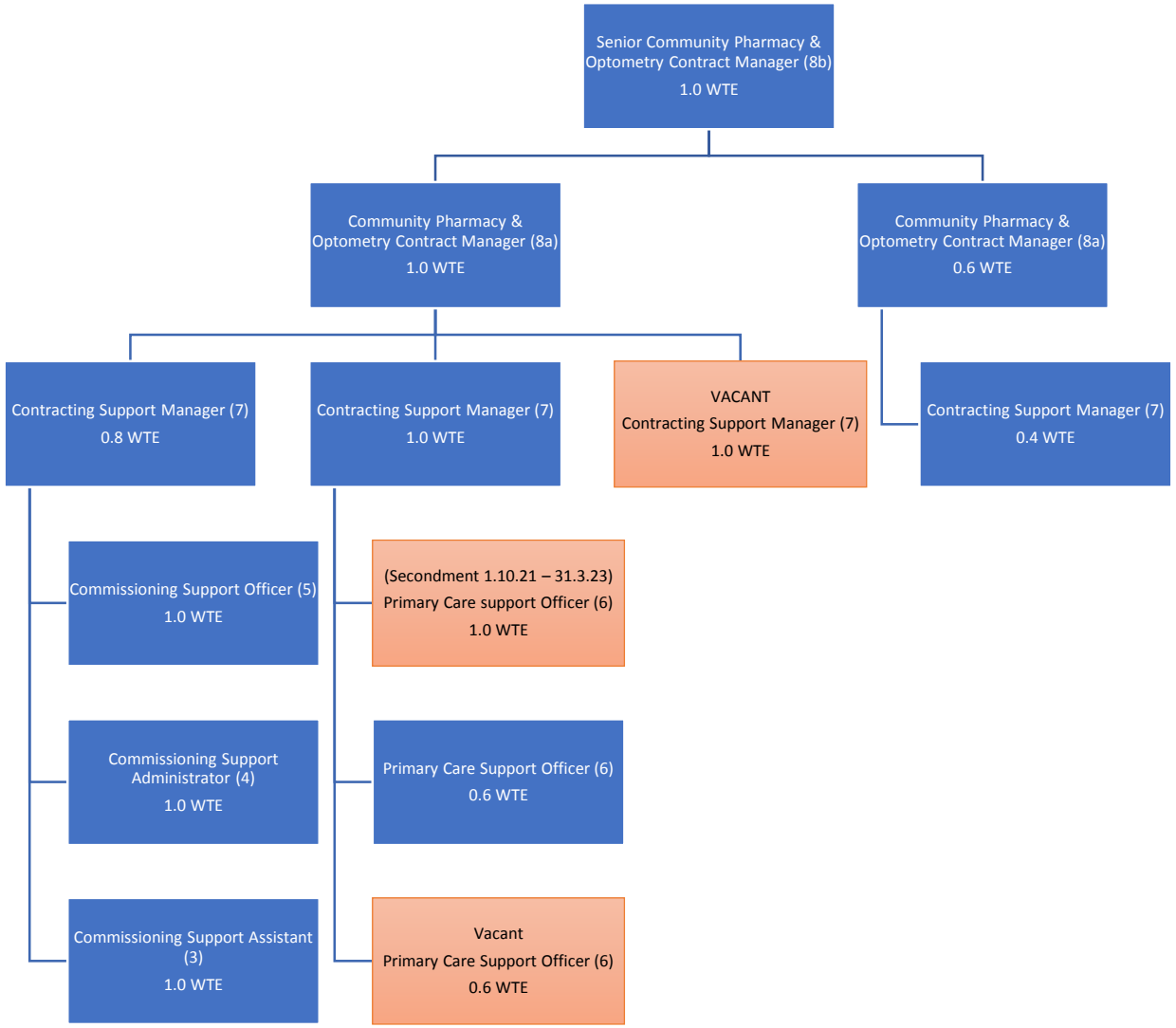
Serious Incident

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 (*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 *(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 (*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

12.3

12.4

12.5 **SCHEDULE 8** (*Deployment of NHS England Staff to the* ICB) shall apply.

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

12.7 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 12.6 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 **Error! Reference source not found.**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

17.8 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 **Error! Reference source not found.** (*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 **Error! Reference source not found.**A (*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;

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;

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.

17.9 **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

28.2.9 SCHEDULE **3**

Reserved Functions

13. Introduction

13.1 In accordance with clause 8.4 of this Agreement, all functions of NHS England other than those defined as Delegated Functions are Reserved Functions.

13.2 This **Error! Reference source not found.** (*Reserved Functions*) sets out further provision regarding the carrying out of the Reserved Functions.

13.3 The ICB will work collaboratively with NHS England and will support and assist NHS England to carry out the Reserved Functions.

14. Management of the national performers list

14.1 Subject to Paragraph 2.2, NHS England will continue to perform its functions under the National Health Service (Performers Lists) (England) Regulations 2013.

14.2 The ICB will carry out administrative tasks in respect of the Performers Lists as described at:

14.2.1 Paragraph 9 of Part 2, Schedule 2A;

14.2.2 Paragraph 9 of Part 2, Schedule 2B; and

14.2.3 Paragraph 6 of Part 2, Schedule 2C.

14.3 NHS England's functions in relation to the management of the national performers list include:

14.3.1 considering applications and decision-making in relation to inclusion on the national performers list, inclusion with conditions and refusals;

14.3.2 identifying, managing and supporting primary care performers where concerns arise; and

14.3.3 managing suspension, imposition of conditions and removal from the national performers list.

14.4 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.

14.5 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.

14.6 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.

15. Management of the revalidation and appraisal process

15.1 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).

15.2 All functions in relation to GP appraisal and revalidation will remain the responsibility of NHS England, including:

15.2.1 the funding of GP appraisers;

15.2.2 quality assurance of the GP appraisal process; and

15.2.3 the responsible officer network.

15.3 Funding to support the GP appraisal is incorporated within the global sum payment to Primary Medical Services Provider.

15.4 The ICB must not remove or restrict the payments made to Primary Medical Services Provider in respect of GP appraisal.

15.5 Appraisal arrangements in respect of all other primary care practitioner groups shall also be Reserved Functions.

16. Administration of payments and related performers list management activities

16.1 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.

16.2 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.

16.3 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.**A (*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.

17. Section 7A and Capital Expenditure Functions

17.1 NHS England retains the Section 7A Functions and will be responsible for taking decisions in relation to the Section 7A Functions.

17.2 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.

17.3 NHS England retains the Capital Expenditure Functions and will be responsible for taking decisions in relation to the Capital Expenditure Functions.

17.4 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.

18. Such other ancillary activities that are necessary in order to exercise the Reserved Functions

18.1 NHS England will continue to comply with its obligations under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

18.2 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.

18.3 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.

18.4 The ICB CD Lead must, in relation to the Delegated Functions:

18.4.1 on request provide NHS England's CDAO with all reasonable assistance in any investigation involving the Delegated Functions;

18.4.2 report all complaints involving controlled drugs to NHS England's CDAO;

18.4.3 report all incidents or other concerns involving the safe use and management of controlled drugs to NHS England's CDAO;

18.4.4 analyse the controlled drug prescribing data available; and

18.4.5 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.

19. Reserved Functions – Primary Medical Services

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

19.1.1 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;

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

19.1.3 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;

19.1.4 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;

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

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

19.1.6.1 Payments;

19.1.6.2 Pensions;

19.1.6.3 Patient Registration;

19.1.6.4 Medical Records;

19.1.6.5 Performer List;

19.1.6.6 Supplies;

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

19.1.6.8 Pharmacy Market Management.

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

20. Reserved Functions – Primary Dental Services

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

20.1.1 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;

20.1.2 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;

20.1.3 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;

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

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

20.1.5.1 Payments;

20.1.5.2 Pensions;

20.1.5.3 Performer List; and

20.1.5.4 Market Management.

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

21. Reserved Functions – Primary Ophthalmic Services

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

21.1.1 the Primary Ophthalmic Services Contracts policy and associated documentation;

21.1.2 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

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

21.1.3.1 Payments;

21.1.3.2 Performers List;

21.1.3.3 Market Management/Entry; and

21.1.3.4 Contract management, assurance and post-payment verification.

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

22. Reserved Functions – Pharmaceutical Services and Local Pharmaceutical Services

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

22.1.1 publication of Pharmaceutical Lists;

22.1.2 functions of NHS England as a determining authority in relation to pharmaceutical remuneration under Part 12 of the Pharmaceutical Regulations;

22.1.3 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;

22.1.4 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;

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

22.1.6 administration of the pharmacist pre-registration training grant scheme.

23. Reserved Functions – Primary Dental Services

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

23.1.1 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;

23.1.2 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;

23.1.3 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;

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

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

23.1.5.1 Payments

23.1.5.2 Pensions

23.1.5.3 Performer List

23.1.5.4 Market Management.

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

24. Reserved Functions - Prescribed Dental Services

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

24.1.1 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;

24.1.2 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;

24.1.3 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;

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

24.1.5 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):

24.1.5.1 Payments

24.1.5.2 Pensions

24.1.5.3 Performer List

24.1.5.4 Market Management.

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

28.2.10 **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 **Error! Reference source not found.** (*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

[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.

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;
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 **Error! Reference source not found.** *(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 10 (*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 12 (*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 **Error! Reference source not found.** 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 **Error! Reference source not found.**);

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 **Error! Reference source not found.** 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 **Error! Reference source not found.** of this Schedule;
Designated Commissioner	has the meaning given to that term at paragraph **Error! Reference source not found.** 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 **Error! Reference source not found.** 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 **Error! Reference source not found.**. 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 **Error! Reference source not found.**, **Error! Reference source not found.**, 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 **Error! Reference source not found.** and **Error! Reference source not found.** 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 **Error! Reference source not found.**.

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:

[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

2.1.7.1 their Terms of Service and identifying and investigating breaches, including possible breaches, of those terms;

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];

[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

2.1.22 preparing and maintaining Dispensing Doctor Lists[13];

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;

[13] Regulation 46 of the Pharmaceutical Regulations
[14] Schedule 3 of the Pharmaceutical Regulations
[15] Regulation 94 of the Pharmaceutical Regulations

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

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 **Error! Reference source not found.** 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 **Error! Reference source not found.** 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)

[16] Regulation 114 of the Pharmaceutical Regulations

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

25. Introduction

25.1 In accordance with clause 8.4 of this Agreement, all functions of NHS England other than those defined as Delegated Functions are Reserved Functions.

25.2 This **Error! Reference source not found.** (*Reserved Functions*) sets out further provision regarding the carrying out of the Reserved Functions.

25.3 The ICB will work collaboratively with NHS England and will support and assist NHS England to carry out the Reserved Functions.

26. Management of the national performers list

26.1 Subject to Paragraph 2.2, NHS England will continue to perform its functions under the National Health Service (Performers Lists) (England) Regulations 2013.

26.2 The ICB will carry out administrative tasks in respect of the Performers Lists as described at:

26.2.1 Paragraph 9 of Part 2, Schedule 2A;

26.2.2 Paragraph 9 of Part 2, Schedule 2B; and

26.2.3 Paragraph 6 of Part 2, Schedule 2C.

26.3 NHS England's functions in relation to the management of the national performers list include:

26.3.1 considering applications and decision-making in relation to inclusion on the national performers list, inclusion with conditions and refusals;

26.3.2 identifying, managing and supporting primary care performers where concerns arise; and

26.3.3 managing suspension, imposition of conditions and removal from the national performers list.

26.4 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.

26.5 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.

26.6 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.

27. Management of the revalidation and appraisal process

27.1 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).

27.2 All functions in relation to GP appraisal and revalidation will remain the responsibility of NHS England, including:

27.2.1 the funding of GP appraisers;

27.2.2 quality assurance of the GP appraisal process; and

27.2.3 the responsible officer network.

27.3 Funding to support the GP appraisal is incorporated within the global sum payment to Primary Medical Services Provider.

27.4 The ICB must not remove or restrict the payments made to Primary Medical Services Provider in respect of GP appraisal.

27.5 Appraisal arrangements in respect of all other primary care practitioner groups shall also be Reserved Functions.

28. Administration of payments and related performers list management activities

28.1 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.

28.2 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.

28.3 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.**A (*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.

29. Section 7A and Capital Expenditure Functions

29.1 NHS England retains the Section 7A Functions and will be responsible for taking decisions in relation to the Section 7A Functions.

29.2 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.

29.3 NHS England retains the Capital Expenditure Functions and will be responsible for taking decisions in relation to the Capital Expenditure Functions.

29.4 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.

30. Such other ancillary activities that are necessary in order to exercise the Reserved Functions

30.1 NHS England will continue to comply with its obligations under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

30.2 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.

30.3 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.

30.4 The ICB CD Lead must, in relation to the Delegated Functions:

30.4.1 on request provide NHS England's CDAO with all reasonable assistance in any investigation involving the Delegated Functions;

30.4.2 report all complaints involving controlled drugs to NHS England's CDAO;

30.4.3 report all incidents or other concerns involving the safe use and management of controlled drugs to NHS England's CDAO;

30.4.4 analyse the controlled drug prescribing data available; and

30.4.5 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.

31. Reserved Functions – Primary Medical Services

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

31.1.1 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;

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

31.1.3 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;

31.1.4 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;

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

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

31.1.6.1 Payments;

31.1.6.2 Pensions;

31.1.6.3 Patient Registration;

31.1.6.4 Medical Records;

31.1.6.5 Performer List;

31.1.6.6 Supplies;

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

31.1.6.8 Pharmacy Market Management.

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

32. Reserved Functions – Primary Dental Services

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

32.1.1 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;

32.1.2 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;

32.1.3 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;

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

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

32.1.5.1 Payments;

32.1.5.2 Pensions;

32.1.5.3 Performer List; and

32.1.5.4 Market Management.

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

33. Reserved Functions – Primary Ophthalmic Services

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

33.1.1 the Primary Ophthalmic Services Contracts policy and associated documentation;

33.1.2 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

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

33.1.3.1 Payments;

33.1.3.2 Performers List;

33.1.3.3 Market Management/Entry; and

33.1.3.4 Contract management, assurance and post-payment verification.

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

34. Reserved Functions – Pharmaceutical Services and Local Pharmaceutical Services

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

34.1.1 publication of Pharmaceutical Lists;

34.1.2 functions of NHS England as a determining authority in relation to pharmaceutical remuneration under Part 12 of the Pharmaceutical Regulations;

34.1.3 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];

34.1.4 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;

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

34.1.6 administration of the pharmacist pre-registration training grant scheme.

35. Reserved Functions – Primary Dental Services

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

35.1.1 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;

35.1.2 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;

35.1.3 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;

35.1.4 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)

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

35.1.5.1 Payments

35.1.5.2 Pensions

35.1.5.3 Performer List

35.1.5.4 Market Management.

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

36. Reserved Functions - Prescribed Dental Services

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

36.1.1 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;

36.1.2 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;

36.1.3 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;

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

36.1.5 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):

36.1.5.1 Payments

36.1.5.2 Pensions

36.1.5.3 Performer List

36.1.5.4 Market Management.

36.2 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

1.2 SCHEDULE **3**

Reserved Functions

37. Introduction

37.1 In accordance with clause 8.4 of this Agreement, all functions of NHS England other than those defined as Delegated Functions are Reserved Functions.

37.2 This **Error! Reference source not found.** (*Reserved Functions*) sets out further provision regarding the carrying out of the Reserved Functions.

37.3 The ICB will work collaboratively with NHS England and will support and assist NHS England to carry out the Reserved Functions.

38. Management of the national performers list

38.1 Subject to Paragraph 2.2, NHS England will continue to perform its functions under the National Health Service (Performers Lists) (England) Regulations 2013.

38.2 The ICB will carry out administrative tasks in respect of the Performers Lists as described at:

38.2.1 Paragraph 9 of Part 2, Schedule 2A;

38.2.2 Paragraph 9 of Part 2, Schedule 2B; and

38.2.3 Paragraph 6 of Part 2, Schedule 2C.

38.3 NHS England's functions in relation to the management of the national performers list include:

38.3.1 considering applications and decision-making in relation to inclusion on the national performers list, inclusion with conditions and refusals;

38.3.2 identifying, managing and supporting primary care performers where concerns arise; and

38.3.3 managing suspension, imposition of conditions and removal from the national performers list.

38.4 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.

38.5 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.

38.6 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.

39. Management of the revalidation and appraisal process

39.1 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).

39.2 All functions in relation to GP appraisal and revalidation will remain the responsibility of NHS England, including:

39.2.1 the funding of GP appraisers;

39.2.2 quality assurance of the GP appraisal process; and

39.2.3 the responsible officer network.

39.3 Funding to support the GP appraisal is incorporated within the global sum payment to Primary Medical Services Provider.

39.4 The ICB must not remove or restrict the payments made to Primary Medical Services Provider in respect of GP appraisal.

39.5 Appraisal arrangements in respect of all other primary care practitioner groups shall also be Reserved Functions.

40. Administration of payments and related performers list management activities

40.1 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.

40.2 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.

40.3 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.**A (*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.

41. Section 7A and Capital Expenditure Functions

41.1 NHS England retains the Section 7A Functions and will be responsible for taking decisions in relation to the Section 7A Functions.

41.2 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.

41.3 NHS England retains the Capital Expenditure Functions and will be responsible for taking decisions in relation to the Capital Expenditure Functions.

41.4 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.

42. Such other ancillary activities that are necessary in order to exercise the Reserved Functions

42.1 NHS England will continue to comply with its obligations under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

42.2 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.

42.3 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.

42.4 The ICB CD Lead must, in relation to the Delegated Functions:

42.4.1 on request provide NHS England's CDAO with all reasonable assistance in any investigation involving the Delegated Functions;

42.4.2 report all complaints involving controlled drugs to NHS England's CDAO;

42.4.3 report all incidents or other concerns involving the safe use and management of controlled drugs to NHS England's CDAO;

42.4.4 analyse the controlled drug prescribing data available; and

42.4.5 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.

43. Reserved Functions – Primary Medical Services

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

43.1.1 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;

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

43.1.3 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;

43.1.4 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;

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

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

43.1.6.1 Payments;

43.1.6.2 Pensions;

43.1.6.3 Patient Registration;

43.1.6.4 Medical Records;

43.1.6.5 Performer List;

43.1.6.6 Supplies;

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

43.1.6.8 Pharmacy Market Management.

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

44. Reserved Functions – Primary Dental Services

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

44.1.1 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;

44.1.2 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;

44.1.3 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;

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

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

44.1.5.1 Payments;

44.1.5.2 Pensions;

44.1.5.3 Performer List; and

44.1.5.4 Market Management.

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

45. Reserved Functions – Primary Ophthalmic Services

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

45.1.1 the Primary Ophthalmic Services Contracts policy and associated documentation;

45.1.2 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

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

45.1.3.1 Payments;

45.1.3.2 Performers List;

45.1.3.3 Market Management/Entry; and

45.1.3.4 Contract management, assurance and post-payment verification.

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

46. Reserved Functions – Pharmaceutical Services and Local Pharmaceutical Services

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

46.1.1 publication of Pharmaceutical Lists;

46.1.2 functions of NHS England as a determining authority in relation to pharmaceutical remuneration under Part 12 of the Pharmaceutical Regulations;

46.1.3 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;

46.1.4 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;

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

46.1.6 administration of the pharmacist pre-registration training grant scheme.

47. Reserved Functions – Primary Dental Services

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

47.1.1 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;

47.1.2 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;

47.1.3 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;

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

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

47.1.5.1 Payments

47.1.5.2 Pensions

47.1.5.3 Performer List

47.1.5.4 Market Management.

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

48. Reserved Functions - Prescribed Dental Services

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

48.1.1 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;

48.1.2 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;

48.1.3 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;

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

48.1.5 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):

48.1.5.1 Payments

48.1.5.2 Pensions

48.1.5.3 Performer List

48.1.5.4 Market Management.

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

1.3 **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.

1.4 References in this

1.5 SCHEDULE **3**

Reserved Functions

49. Introduction

49.1 In accordance with clause 8.4 of this Agreement, all functions of NHS England other than those defined as Delegated Functions are Reserved Functions.

49.2 This **Error! Reference source not found.** (*Reserved Functions*) sets out further provision regarding the carrying out of the Reserved Functions.

49.3 The ICB will work collaboratively with NHS England and will support and assist NHS England to carry out the Reserved Functions.

50. Management of the national performers list

50.1 Subject to Paragraph 2.2, NHS England will continue to perform its functions under the National Health Service (Performers Lists) (England) Regulations 2013.

50.2 The ICB will carry out administrative tasks in respect of the Performers Lists as described at:

50.2.1 Paragraph 9 of Part 2, Schedule 2A;

50.2.2 Paragraph 9 of Part 2, Schedule 2B; and

50.2.3 Paragraph 6 of Part 2, Schedule 2C.

50.3 NHS England's functions in relation to the management of the national performers list include:

50.3.1 considering applications and decision-making in relation to inclusion on the national performers list, inclusion with conditions and refusals;

50.3.2 identifying, managing and supporting primary care performers where concerns arise; and

50.3.3 managing suspension, imposition of conditions and removal from the national performers list.

50.4 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.

50.5 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.

50.6 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.

51. Management of the revalidation and appraisal process

51.1 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).

51.2 All functions in relation to GP appraisal and revalidation will remain the responsibility of NHS England, including:

51.2.1 the funding of GP appraisers;

51.2.2 quality assurance of the GP appraisal process; and

51.2.3 the responsible officer network.

51.3 Funding to support the GP appraisal is incorporated within the global sum payment to Primary Medical Services Provider.

51.4 The ICB must not remove or restrict the payments made to Primary Medical Services Provider in respect of GP appraisal.

51.5 Appraisal arrangements in respect of all other primary care practitioner groups shall also be Reserved Functions.

52. Administration of payments and related performers list management activities

52.1 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.

52.2 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.

52.3 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.**A (*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.

53. Section 7A and Capital Expenditure Functions

53.1 NHS England retains the Section 7A Functions and will be responsible for taking decisions in relation to the Section 7A Functions.

53.2 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.

53.3 NHS England retains the Capital Expenditure Functions and will be responsible for taking decisions in relation to the Capital Expenditure Functions.

53.4 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.

54. Such other ancillary activities that are necessary in order to exercise the Reserved Functions

54.1 NHS England will continue to comply with its obligations under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

54.2 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.

54.3 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.

54.4 The ICB CD Lead must, in relation to the Delegated Functions:

54.4.1 on request provide NHS England's CDAO with all reasonable assistance in any investigation involving the Delegated Functions;

54.4.2 report all complaints involving controlled drugs to NHS England's CDAO;

54.4.3 report all incidents or other concerns involving the safe use and management of controlled drugs to NHS England's CDAO;

54.4.4 analyse the controlled drug prescribing data available; and

54.4.5 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.

55. Reserved Functions – Primary Medical Services

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

55.1.1 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;

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

55.1.3 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;

55.1.4 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;

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

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

55.1.6.1 Payments;

55.1.6.2 Pensions;

55.1.6.3 Patient Registration;

55.1.6.4 Medical Records;

55.1.6.5 Performer List;

55.1.6.6 Supplies;

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

55.1.6.8 Pharmacy Market Management.

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

56. Reserved Functions – Primary Dental Services

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

56.1.1 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;

56.1.2 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;

56.1.3 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;

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

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

56.1.5.1 Payments;

56.1.5.2 Pensions;

56.1.5.3 Performer List; and

56.1.5.4 Market Management.

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

57. Reserved Functions – Primary Ophthalmic Services

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

57.1.1 the Primary Ophthalmic Services Contracts policy and associated documentation;

57.1.2 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

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

57.1.3.1 Payments;

57.1.3.2 Performers List;

57.1.3.3 Market Management/Entry; and

57.1.3.4 Contract management, assurance and post-payment verification.

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

58. Reserved Functions – Pharmaceutical Services and Local Pharmaceutical Services

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

58.1.1 publication of Pharmaceutical Lists;

58.1.2 functions of NHS England as a determining authority in relation to pharmaceutical remuneration under Part 12 of the Pharmaceutical Regulations;

58.1.3 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;

58.1.4 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;

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

58.1.6 administration of the pharmacist pre-registration training grant scheme.

59. Reserved Functions – Primary Dental Services

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

59.1.1 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;

59.1.2 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;

59.1.3 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;

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

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

59.1.5.1 Payments

59.1.5.2 Pensions

59.1.5.3 Performer List

59.1.5.4 Market Management.

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

60. Reserved Functions - Prescribed Dental Services

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

60.1.1 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;

60.1.2 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;

60.1.3 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;

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

60.1.5 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):

60.1.5.1 Payments

60.1.5.2 Pensions

60.1.5.3 Performer List

60.1.5.4 Market Management.

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

1.6 **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.

1.7 This Schedule and the Data Sharing Agreements entered into under this Schedule are designed to:

1.7.1 provide information about the reasons why Relevant Information may need to be shared and how this will be managed and controlled by the Parties;

1.7.2 describe the purposes for which the Parties have agreed to share Relevant Information;

1.7.3 set out the lawful basis for the sharing of information between the Parties, and the principles that underpin the exchange of Relevant Information;

1.7.4 describe roles and structures to support the exchange of Relevant Information between the Parties;

1.7.5 apply to the sharing of Relevant Information relating to Delegated Functions in respect of

1.7.5.1 Primary Care Providers and Primary Care Provider Personnel; and

1.7.5.2 Dental Services Providers and their personnel;

1.7.5.3 All other providers of Delegated Functions.

1.7.6 apply to the sharing of Relevant Information whatever the medium in which it is held and however it is transmitted;

1.7.7 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;

1.7.8 apply to the activities of the Parties' personnel; and

1.7.9 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

6.4 SCHEDULE **3**

Reserved Functions

61. Introduction

61.1 In accordance with clause 8.4 of this Agreement, all functions of NHS England other than those defined as Delegated Functions are Reserved Functions.

61.2 This **Error! Reference source not found.** (*Reserved Functions*) sets out further provision regarding the carrying out of the Reserved Functions.

61.3 The ICB will work collaboratively with NHS England and will support and assist NHS England to carry out the Reserved Functions.

62. Management of the national performers list

62.1 Subject to Paragraph 2.2, NHS England will continue to perform its functions under the National Health Service (Performers Lists) (England) Regulations 2013.

62.2 The ICB will carry out administrative tasks in respect of the Performers Lists as described at:

62.2.1 Paragraph 9 of Part 2, Schedule 2A;

62.2.2 Paragraph 9 of Part 2, Schedule 2B; and

62.2.3 Paragraph 6 of Part 2, Schedule 2C.

62.3 NHS England's functions in relation to the management of the national performers list include:

62.3.1 considering applications and decision-making in relation to inclusion on the national performers list, inclusion with conditions and refusals;

62.3.2 identifying, managing and supporting primary care performers where concerns arise; and

62.3.3 managing suspension, imposition of conditions and removal from the national performers list.

62.4 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.

62.5 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.

62.6 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.

63. Management of the revalidation and appraisal process

63.1 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).

63.2 All functions in relation to GP appraisal and revalidation will remain the responsibility of NHS England, including:

63.2.1 the funding of GP appraisers;

63.2.2 quality assurance of the GP appraisal process; and

63.2.3 the responsible officer network.

63.3 Funding to support the GP appraisal is incorporated within the global sum payment to Primary Medical Services Provider.

63.4 The ICB must not remove or restrict the payments made to Primary Medical Services Provider in respect of GP appraisal.

63.5 Appraisal arrangements in respect of all other primary care practitioner groups shall also be Reserved Functions.

64. Administration of payments and related performers list management activities

64.1 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.

64.2 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.

64.3 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.**A (*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.

65. Section 7A and Capital Expenditure Functions

65.1 NHS England retains the Section 7A Functions and will be responsible for taking decisions in relation to the Section 7A Functions.

65.2 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.

65.3 NHS England retains the Capital Expenditure Functions and will be responsible for taking decisions in relation to the Capital Expenditure Functions.

65.4 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.

66. Such other ancillary activities that are necessary in order to exercise the Reserved Functions

66.1 NHS England will continue to comply with its obligations under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

66.2 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.

66.3 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.

66.4 The ICB CD Lead must, in relation to the Delegated Functions:

66.4.1 on request provide NHS England's CDAO with all reasonable assistance in any investigation involving the Delegated Functions;

66.4.2 report all complaints involving controlled drugs to NHS England's CDAO;

66.4.3 report all incidents or other concerns involving the safe use and management of controlled drugs to NHS England's CDAO;

66.4.4 analyse the controlled drug prescribing data available; and

66.4.5 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.

67. Reserved Functions – Primary Medical Services

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

67.1.1 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;

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

67.1.3 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;

67.1.4 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;

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

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

67.1.6.1 Payments;

67.1.6.2 Pensions;

67.1.6.3 Patient Registration;

67.1.6.4 Medical Records;

67.1.6.5 Performer List;

67.1.6.6 Supplies;

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

67.1.6.8 Pharmacy Market Management.

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

68. Reserved Functions – Primary Dental Services

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

68.1.1 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;

68.1.2 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;

68.1.3 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;

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

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

68.1.5.1 Payments;

68.1.5.2 Pensions;

68.1.5.3 Performer List; and

68.1.5.4 Market Management.

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

69. Reserved Functions – Primary Ophthalmic Services

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

69.1.1 the Primary Ophthalmic Services Contracts policy and associated documentation;

69.1.2 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

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

69.1.3.1 Payments;

69.1.3.2 Performers List;

69.1.3.3 Market Management/Entry; and

69.1.3.4 Contract management, assurance and post-payment verification.

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

70. Reserved Functions – Pharmaceutical Services and Local Pharmaceutical Services

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

70.1.1 publication of Pharmaceutical Lists;

70.1.2 functions of NHS England as a determining authority in relation to pharmaceutical remuneration under Part 12 of the Pharmaceutical Regulations;

70.1.3 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;

70.1.4 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;

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

70.1.6 administration of the pharmacist pre-registration training grant scheme.

71. Reserved Functions – Primary Dental Services

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

71.1.1 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;

71.1.2 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;

71.1.3 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;

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

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

71.1.5.1 Payments

71.1.5.2 Pensions

71.1.5.3 Performer List

71.1.5.4 Market Management.

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

72. Reserved Functions - Prescribed Dental Services

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

72.1.1 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;

72.1.2 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;

72.1.3 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;

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

72.1.5 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):

72.1.5.1 Payments

72.1.5.2 Pensions

72.1.5.3 Performer List

72.1.5.4 Market Management.

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

6.5 **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.

6.6 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.

6.7 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.

6.8 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 **Error! Reference source not found.** (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 (*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 (*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 (*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 (*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.

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to Board of the Integrated Care Board (ICB)
15. Proposed Approach: BLMK ICB Joint Forward Plan

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	Hilary Tovey, Interim Director of Strategy, ICB
Date to which the information this report is based on was accurate	1st March 2023
Senior Responsible Owner	Anne Brierley Chief Transformation Officer, BLMK ICB

The following individuals were consulted and involved in the development of this report:
BLMK Integrated Care Board Members, Directors of Public Health, BLMK Associate Directors of Transformation and Primary Care, BLMK System Strategy Group, BLMK Joint Forward Plan Task and Finish Group (membership includes public health and integration leads at place plus senior BLMK ICB enabler leads), BLMK Health and Care Partnership (at a formal on meeting 7th March).
This report has been presented to the following board/committee/group:

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

ICB Board members are asked to:

- **Review** the proposed approach to the BLMK development of our Joint Forward Plan, comment, and approve (pending adjustments identified);
- **Consider** options to mitigate risk on timescales for Health & Well-being Board engagement (required) given the local elections;
- **Commit** to an action to confirm governance/ approval within sovereign organisations (Councils and Trusts) before multi-agency review at Place Boards/ Health & Well-being Boards/ Provider Collaborative Boards; and
- **Commit** to proposed targeted public engagement work to ensure we have a comprehensive and consistent approach to ensuring residents, including our VCSE community, have the opportunity to contribute to the development of the final Joint Forward Plan.

Executive Summary

This paper sets out the proposed approach to the development of the BLMK ICS Joint Forward Plan.

NHSE guidance (for summary see Annex A) requires ICS's to develop a joint plan, spanning a minimum of 5 years, which reflects:

- partnership / collaborative plans at place to deliver the 4 core requirements of the ICB; and
- the need to deliver NHS commitments across all domains of healthcare (primary care, urgent & emergency care, cancer, children and young people's services, diagnostics and elective recovery, mental health & learning disabilities) into the medium term.

It is expected that this plan will build on existing plans at place to make real the ambitions for our residents which we set out in our system strategy.

NHSE has asked for draft plans to be published on or before the 31st March, with final plans to be shared on the 30th June 2023. For BLMK this first publication will comprise a draft outline to be shared in the public papers for the Board of the ICB (due to be published on the 17th March) to inform discussion and agreement at this board regarding next steps and the work to develop this outline into a final, agreed, plan by the 30th June.

Overview of proposed approach

Our ambition for the BLMK Joint Forward Plan is that it will support the ICB and the wider Health and Care Partnership to operate as an adaptive system, building the infrastructure and capability to identify and agree the priority issues for our population, and clarity around the approaches we will use to address these.

The Joint Forward Plan will aim to move us towards tackling these issues in an integrated way, that acknowledges the variety of factors which influence health (and life) outcomes and recognises the interconnectedness of our health, care and wider public sector ecosystem.

Our approach to developing the Joint Forward Plan is to focus on our people rather than our existing service lines.

The Joint Forward Plan will build on medium term Place Plans and emerging Place-based 'Deals' and NHS operational plans.

We are therefore looking to develop a plan which will support us to:

- **reflect the expected rapid expansion in our population to 2040** and beyond, and the changing demographic in each Borough over this period;
- **focus on shared 'wicked' issues to improve health outcomes and tackle inequalities** in local communities where only a collaborative and innovative approach can meet rising population need and demand within workforce and affordability constraints; and
- **focus on the wider determinants of health and well-being**, maximising prevention and enabling community assets (including the voluntary sector) to enable our communities to thrive.

It is expected that Joint Forward Plans will be updated annually. The level of detail included in the first iteration will naturally reflect the current maturity of our partnership. It is expected that that the June submission will capture the key actions and timelines, where this is known, but will focus on agreeing a shared methodology and timeline for development and implementation over years 1-3 of the Plan.

Over time, the plan will evolve to host the Gantt chart of the critical milestones for delivery, and identify where 'tipping points' in population growth and need at place will require a new approach to support tackling inequalities and access to health services, and bring together our sovereign responsibilities to enable our communities to thrive.

Dedicated work will be undertaken in Q1 2023/24 to confirm the Place Plans' and Provider Collaboratives' items for inclusion in the Joint Forward Plan and ensure that the Joint Forward Plan is aligned to and compliments these emerging plans. ICB members will also be asked to undertake specific activity to ensure all partners have the opportunity to contribute to the development of the final Joint Forward Plan.

NHSE guidance requires systems to undertake close engagement with a range of partners, and we are developing our plans to undertake this engagement between Apr - June. This work will involve not just those for whom the ICB has a core responsibility, as per the NHSE guidance, but involve providers, VCSE organisations and people and communities across BLMK. It will build upon and benefit from existing public and patient engagement exercises, including with minority groups.

1. Options to Deliver

The minimum and proposed options to develop and deliver the Joint forward Plan are summarised above.

2. Key Risks and Issues

Key risks are:

1. The timescales currently set out in the NHSE requirements do not allow for sufficient time for engagement with Place Health & Well-being Boards due to scheduled local elections;
2. Further clarity is required to confirm governance/ approval within sovereign organisations (Councils and Trusts) before multi-agency review at Place Boards/ Health & Well-being Boards/ Provider Collaborative Boards;
3. Current estimates around projected population growth and/or demographic shift, which will have a significant impact on how we need to prepare and plan to tackle inequalities and improving health outcomes into the longer term. Without this, the Joint Forward Plan will not be able provide assurance as to whether the proposed Plan will deliver our strategic objectives for all BLMK residents; and
4. Options that are deliverable and affordable to address any gaps in the Plan may be limited.

Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☐	No ☒

Defined risks, mitigations, controls and residual unmitigated risks will be specified as the Plan is developed and added to the ICB Board Assurance Framework for ongoing oversight.

3. Are there any financial implications or other resourcing implications, including workforce?

Financial and workforce implications will be picked up through the development of the Plan.

4. How will / does this work help to address the Green Plan Commitments?

Click to view Green Plan

This is a clearly defined priority in the Plan.

5. How will / does this work help to address inequalities?

This is a clearly defined priority in the Plan.

6. Next steps:

Next steps:

1. Mapping P**lace plans and priority populations** against our current understanding of key system wicked issues and proposed approach to tackling these.
2. Land methodology around **inequalities** and our **end to end clinical pathway reviews**
3. Scope **priority areas for 23/24**, building on work to map expected population growth and how we need to organise ourselves around health and care to respond to this, including:
    - Expanding our **one estate** to include our public sector estate and private sector estate which is being used to deliver public services;
    - Developing a **strategic workforce plan** – including boosting employment and training, and how to grow specific areas of our workforce to meet changing need; and
    - Identifying the **key macroeconomic opportunities and constraints** which are likely to inform our planning into the medium term.
4. **Engaging our partners - b**uild on proposed targeted public engagement work to ensure we have a comprehensive and consistent approach to ensuring all partners, including our VCSE community, have the opportunity to contribute to the development of the final Joint Forward Plan.

1. Appendices

Appendix A – Proposed JFP outline
Appendix B – Summary of NHSE guidance on preparation of joint forward plan

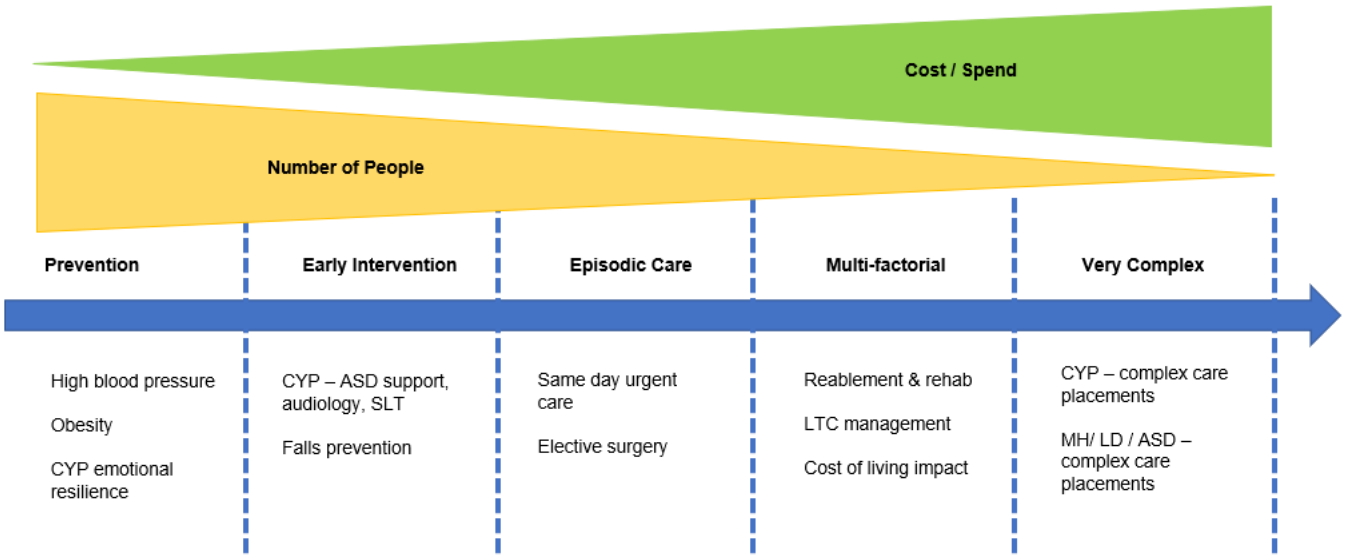
2. Background reading

- BLMK system strategy
- BLMK summary strategy
- NHS England Operational Planning guidance 23/24
- NHS England guidance on developing Joint Forward Plans

APPENDIX A: BLMK Joint Forward Plan: Proposed outline

The purpose of our Joint Forward Plan is to focus on the needs of our population and how we can build an adaptive, integrated, system across the NHS, local authorities and our wider system partners who are working to improve the health and wellbeing of our population.

This first iteration of the Plan will look at how we can grow our partnership working and build on the principle of subsidiarity in such a way that we can identify and focus our efforts on those priority populations identified at place and shifting the balance of our collective attention and spend away from the current focus on episodic and multifactorial health and care challenges to allow us to commit more resource to improving prevention, early intervention and the disruptive innovation required to support people with the most complex needs within our population.



In seeking to change the current way we approach our delivery challenges we will develop an approach which considers, in the context of our growing population and likely demographic population shift, how we can move to planning from the perspective of the resident, including:

- Developing a **consistent approach** to framing and investigating our 'wicked issues', with a focus on defining our target population, supporting co-production and personalisation, using collective resources to tackle these issues, and ensuring we are consistently and transparently measuring the impact of our actions;

- Ensuring our **interventions are evidence based** and challenge us to achieve and sustain top decile performance, systematically promoting research and innovation, and learning from best practice; and

- Taking an **adaptive approach to improvement**, measuring outcomes as well as activity and considering the impact of our actions/failure to act on the whole health and care ecosystem, embedding a Quality Improvement approach that is locally owned and driven, and paying attention to operational process optimisation, making it easier for our teams to do the right thing for the resident or patient first time.

The Plan will also include detail of the approach, timelines and milestones (where relevant) of how we are currently organising ourselves around the above issues, with a focus on:

- Building 'Fuller' Neighbourhood Teams – to meet the changing needs of care at a locality/neighbourhood level to address improve our primary care and same day urgent care offer, integrating community and social care pathways to support people with frailty and long term conditions and the opportunities from Pharmacy, Optometry and Dentistry (POD) specialised commissioning delegation;

- Developing 'Place Deals' and driving planning and delivery at place and how this links in with the universal ICB offer and the wider system health and care ecosystem;
- Complex care pathways – including children's continuing care and complex Mental Health and/or Learning Disabilities and neurodiversity;
- Programmes based around specific population cohorts – to include children and young people, people with long term conditions, MDLDA, Frailty and Urgent Emergency Care pathways;
- Clinical services strategy – taking an end to end pathway approach to reviewing high risk clinical speciality reviews, community diagnostic centre capacity, and exploring opportunities for standardised order sets, delegation of specialised commission, reducing unwarranted variation in pathology/clinical consumables and opportunities for clinical support infrastructure; and
- Technology and data to support population health driven decision making, performance reporting, a QI approach to tackling inequalities and digital tools and services to support better outcomes and improve efficiency/productivity.

APPENDIX B: Summary of NHS England Guidance on developing the Joint Forward Plan

The guidance aims to set out a flexible framework for Joint Forward Plans to build on existing system and place strategies and plans in line with the principle of subsidiary. It also states specific statutory requirements that plans must meet.

The minimum requirements for the ICB Joint Forward Plan (JFP) are centred on 3 principles:

- **Principle 1:** the plan is aligned with the ambitions of the wider system partnership;
- **Principle 2:** the plan supports subsidiarity, building on existing local strategies (including Joint Strategic Needs Assessments and Health and Wellbeing strategies) and reflect universal NHS commitments; and
- **Principle 3:** the Plan is delivery-focused, including specific objectives and milestones as appropriate.

At a minimum the JFP should describe how the ICB and its Partner Trusts intend to arrange and/or provide NHS services to meet their population's physical and mental health needs. This should include delivery of:

- Universal NHS commitments (set out in operational planning guidance and the NHS Long Term Plan (LTP));
- The ICS's four core purposes; and
- Legal requirements (specifically those set out in the NHS Act 2006, the Public Sector Equality Duty, second 149 of the Equality Act 2010).

The minimum legislative requirements for content are:

- Link to ICB Mandate, Integrated Care Strategy, Joint Strategic Needs Assessments, Joint local health and wellbeing strategies and system capital plans;
- Plans for system governance, financial duties and efficiencies;
- An integrated workforce plan;
- Action to reduce inequalities, promote personalised care, research and innovation, and deliver a net zero NHS;
- Our approach to integration and addressing the triple aim; and
- Specifically, how we plan to address the need of **children and young people** and **victims of abuse.**

Close engagement with partners is essential to the development of JFPs. This includes working with:

- the ICP (BLMK Health and Care Partnership);
- Primary Care providers;
- Local Authorities and each relevant HWB;
- other ICBs in respect of providers whose operating boundary spans multiple ICSs;
- NHS collaboratives, networks and alliances;
- the voluntary, community and social enterprise sector (VCSE); and
- people and communities that will be affected by specific parts of the proposed plan, or who are likely to have a significant interest in any of its objectives.

ICBs and their Partner Trusts must involve relevant HWBs in preparing or revising the JFP. This includes sharing a draft with each relevant HWB, and consulting relevant HWBs on whether the JFP takes proper account of each relevant Joint Local Health and Wellbeing Strategy (JLHWS).

ICBs and their partner trusts should agree processes for finalising and signing off the JFP. The final version must be published, and ICBs and their Partner Trusts should expect to be held to account for its delivery – including by their population, patients and their carers or representatives – and in particular through the ICP, Healthwatch and the Local Authorities' health overview and scrutiny committees. JFPs must be re-viewed and, where appropriate, updated before the start of each financial year.

Legislative requirement	Description	Implications for the JFP
Describing the health services for which the ICB proposes to make arrangements	The plan must describe the health services for which the ICB proposes to make arrangements in the exercise of its functions.	The plan should set out how an ICB will meet the health needs of its population and this will include primary, community and acute care.
Duty to improve quality of services	Each ICB must exercise its functions with a view to securing continuous improvement in: • the quality of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness. • outcomes including safety and patient experience.	The plan should contain a set of quality objectives that reflect system intelligence. It should include clearly aligned metrics (on processes and outcomes) to evidence successful and sustained delivery. Quality priorities should go beyond performance metrics and look at outcomes, preventing ill-health and use the Core20PLUS5 approach to ensure inequalities are considered. Plans should align with the National Quality Board principles.
Duty to reduce inequalities	Each ICB must have regard to the need to (a) reduce inequalities between persons with respect to their ability to access health services, and (b) reduce inequalities between persons with respect to the outcomes achieved for them by the provision of health services. There is also a duty to have regard to the wider effects of decisions on inequalities. The duty to promote integration requires consideration of securing integrated provision where this would reduce inequalities in access to services or outcomes achieved.	The plan should set out how the ICB intends to deliver on the national vision to ensure delivery of high-quality healthcare for all, through equitable access, excellent experience and optimal outcomes.
Duty to promote involvement of each patient	Each ICB must promote the involvement of patients, and their carers and representatives (if any), in decisions which relate to (a) the prevention or diagnosis of illness in the patients, or (b) their care or treatment.	The plan should describe actions to implement the Comprehensive Model for Personalised Care which promotes the involvement of each patient in decisions about prevention, diagnosis and their care or treatment.
Duty as to patient choice	Each ICB must act with a view to enabling patients to make choices with respect to aspects of health services provided to them.	The plan should describe how ICBs will ensure that patient choice is considered when developing and implementing commissioning plans and contracting arrangements and delivering services.
Duty to obtain appropriate advice	Each ICB must obtain appropriate advice to enable it to effectively discharge its functions from persons who (taken together) have a broad range of professional expertise in (a) the prevention, diagnosis or treatment of illness, and (b) the protection or improvement of public health.	The plan should outline the ICB's strategy for seeking any expert advice it requires, including through formal governance arrangements and broader engagement.
Duty to promote innovation	Each ICB must promote innovation in the provision of health services (including innovation in the arrangements made for their provision).	The plan should set out how the ICB will promote local innovation and work with partners, including AHSNs, to support adoption and spread.
Duty in respect of research	Each ICB must facilitate or otherwise promote (a) research on matters relevant to the health service, and (b) the use in the health service of evidence obtained from research.	The plan should set out how the ICB will promote research and support collaboration across local NIHR research infrastructure and systematically utilise the evidence generated through research.
Duty to promote education and training	Each ICB must have regard to the need to promote education and training for the persons mentioned in section 1F(1) so as to assist the Secretary of State and Health Education England in the discharge of the duty under that section.	The plan should describe how the ICB will apply education and training as an essential lever of an integrated workforce plan that supports the delivery of services in the short, medium and long term. The plan should articulate the role of education and research in securing healthcare staff supply and responding to changing service models, as well as the role of trainees in service delivery.
Duty to promote integration	Each ICB must exercise its functions with a view to ensuring that health services are delivered in an integrated way and that the provision of health services is integrated with the provision of health-related or social care services, where this would: • improve quality of those services	Plans should describe how ICBs will integrate health services, social care and health-related services to improve quality and reduce inequalities. This could include organisational integration (e.g. provider collaboratives), functional integration (e.g. non-clinical functions), service or clinical integration (e.g. through shared pathways, multi-disciplinary teams, clinical assessment processes).

	• reduce inequalities in access and outcomes	This must include delivery on integration ambitions described in the relevant integrated care strategy and joint local health and wellbeing strategies.
Duty to have regard to wider effect of decisions	In making decisions about the provision of health care an ICB must consider the "triple aim" of (a) better health and wellbeing of the people of England (including by reducing inequalities with respect to health and wellbeing) (b) better quality of health care services for the purposes of the NHS (including by reducing inequalities with respect to the benefits obtained by individuals from those services) (c) more sustainable and efficient use of resources by NHS bodies,	The plan should articulate how the triple aim was considered in its development. It may also describe approaches to ensure the triple aim is embedded in decision-making and evaluation processes.
Duty as to climate change etc	Each ICB must have regard to the need to (a) contribute towards compliance with (i) section 1 of the Climate Change Act 2008 (UK net zero emissions target), and (ii) section 5 of the Environment Act 2021 (environmental targets), and (b) adapt to any current or predicted impacts of climate change identified in the most recent report under section 56 of the Climate Change Act 2008.	The plan should describe how the ICB and its partner NHS trusts and foundation trusts will deliver against the targets & actions in the Delivering a NZ NHS report.
Public involvement by integrated care boards	ICBs and NHS trusts and foundation trusts have a duty to involve people and communities in decisions about the planning, development and operating of services commissioned and provided.	The plans should describe how: • the public and communities were engaged in development of the plan • the ICB and NHS trusts and foundation trusts will work together to build effective partnerships with people and communities, particularly the people who face the greatest health inequalities, working with wider ICS stakeholders to achieve this. • how activity at neighbourhood and place informs decisions taken by the system
Addressing the particular needs of children and young persons	The plan must set out any steps that the ICB proposes to take to address the particular needs of children and young persons under the age of 25.	The plan must set out steps that the ICB proposes to take to address the particular needs of children or young people. This could include using data and gathering insights to ensure the plan identifies and sets steps for delivery of the longer-term priorities and ambitions for the ICB's population of children, young people and families.
Addressing the particular needs of victims of abuse	The plan must set out any steps that the ICB proposes to take to address the particular needs of victims of abuse (including domestic abuse and sexual abuse, whether of children or adults).	The plan must set out steps that the ICB proposes to take to address the particular needs of victims of abuse. This could include ensuring implementation of appropriate governance, processes, training, data, systems and evaluation to address the needs of victims and survivors of abuse, and, where required, tackle perpetrators.
Implementing any joint local health and wellbeing strategy	The plan must set out the steps that the ICB proposes to take to implement any joint local health and wellbeing strategy to which it is required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007.	The plan must set out steps the ICB will take to deliver on ambitions described in any relevant joint local health and wellbeing strategies, including identified local target outcomes, approaches and priorities.
Financial duties	The plan must explain how the ICB intends to discharge its financial duties	The plan must describe how the financial duties under Sections 223GB to 223N of the NHS Act 2006 will be addressed. This includes ensuring that the expenditure of each ICB and its partner NHS trusts and NHS foundation trusts in a financial year (taken together) does not exceed the aggregate of any sums received by them in the year, and complying with NHSE financial objectives, directions and expenditure limits. It should also set out how the efficiency of NHS services will be improved in line with the core purpose to 'enhance productivity and value for money'.

		This should include the key actions the ICB will take to ensure that the collective resources of the health system are used effectively and efficiently. This could include specific plans to support the effectiveness of financial governance and controls, address unwarranted variation and strengthen understanding of the cost of whole care pathways, maximise consolidation and collaboration opportunities across corporate services, unlock efficiency through capital investment, and improve utilisation of NHS estate.

Appendix A: BLMK draft Joint Forward Plan
March 2023

Joint Forward Plan Required Content

NHSE guidance expects Joint Forward Plans to be drafted on the basis of the principle that it:

1: is aligned with the ambitions of the wider system partnership.

2: supports subsidiarity, building on local strategies (including JSNA and LHWBS) and reflects universal NHS commitments.

3: is delivery-focused, including specific objectives and milestones as appropriate.

1. Legislative content (must do)

- System governance
- **Financial responsibilities**, including our emerging approach to efficiencies, five year planning and our capital plan
- **People strategy** – building BLMK as an excellent place for people to work, learn and volunteer
- Plans to tackle **inequalities**, develop **personalised care**, and link to **research and innovation**
- **Our green plan** and approach to reaching **net zero**
- How we will support **children and young people**
- How we will work together to support **victims of abuse**

2. Other NHSE recommended content

- Current **performance** against operational planning targets for 2023/24
- A summary of our **digital/data** strategies and plans
- How we are developing our **One Estate** approach
- Our plans for **Population Health Management**
- Supporting wider **social and economic development** in the context of our Growth priority

ICBs must involve Health & Well-Being Boards:

- Joint forward plans for the ICB and its partner NHS trusts and NHS foundation trusts must set out any steps that the ICB proposes to take to implement any JLHWS
- ICBs and their partner NHS trusts and NHS foundation trusts must involve each relevant HWB in preparing or revising their forward plans
- The HWB must be provided with a draft of the forward plan, and the ICB must consult with the HWB on whether the draft takes proper account of each relevant JLHWS
- Following consultation, any HWB within the ICB's area has the right to respond to the ICB and may give its opinion to NHS England
- Within the ICB's forward plan, it must include a statement from the HWB as to whether the JLHWS has been taken proper account of within the forward plan

Summary Overview: the BLMK Plan for our Joint Forward Plan

It is an NHS England requirement for every ICB to produce a 5-year Joint Forward Plan, which complements the ICB Strategy and NHS 1-year Operating Plan to set how we will:

- Use our ICB to deliver the Place Plans in the medium-term, supported by our Provider Collaboratives, and focused on local population need (JSNA)
- Outline our approach to deliver the ICB's responsibilities ('4 pillars' of tackling inequalities, improving health outcomes, providing value for money, and supporting growth and sustainability)

The Joint Forward Plan (JFP) is due for submission from ICBs on June 30th 2023. However, NHS England have required all ICBs to submit a draft together with our 2023-4 NHS Operational Plan submission at the end of March.

This paper sets out the proposed BLMK approach to developing our JFP by June 30th – it is a Plan for Our Plan.

ICB members are asked to review the outline draft, provide responses to specific questions detailed in the cover sheet, and – pending adoption of feedback – approve this approach to creating the BLMK Joint Forward Plan.

SECTION ONE: Joint Forward Plan Introduction

The Joint Forward Plan does not require new content – it is the medium-long term view of how we deliver the aims and objectives of our Place Plans in partnership. Key to this medium-long term view is not just how we meet population growth and changing needs within our resources – but how we collaborate to tackle our most 'wicked' issues to support our communities to thrive.

The BLMK Joint Forward Plan will focus on those areas where collaboration at Place is required to achieve this. Specifically, our Joint Forward Plan will:

- **Focus our collaborative long-term plan on meeting the changing needs of our population** (not individual organisations or service lines)
- Develop our **processes and partnerships to build an adaptive, integrated system** which can respond to local population need sustainably within our resources
- **Develop & deliver infrastructure strategies** to tackle inequalities, improve health outcomes AND reduce avoidable cost

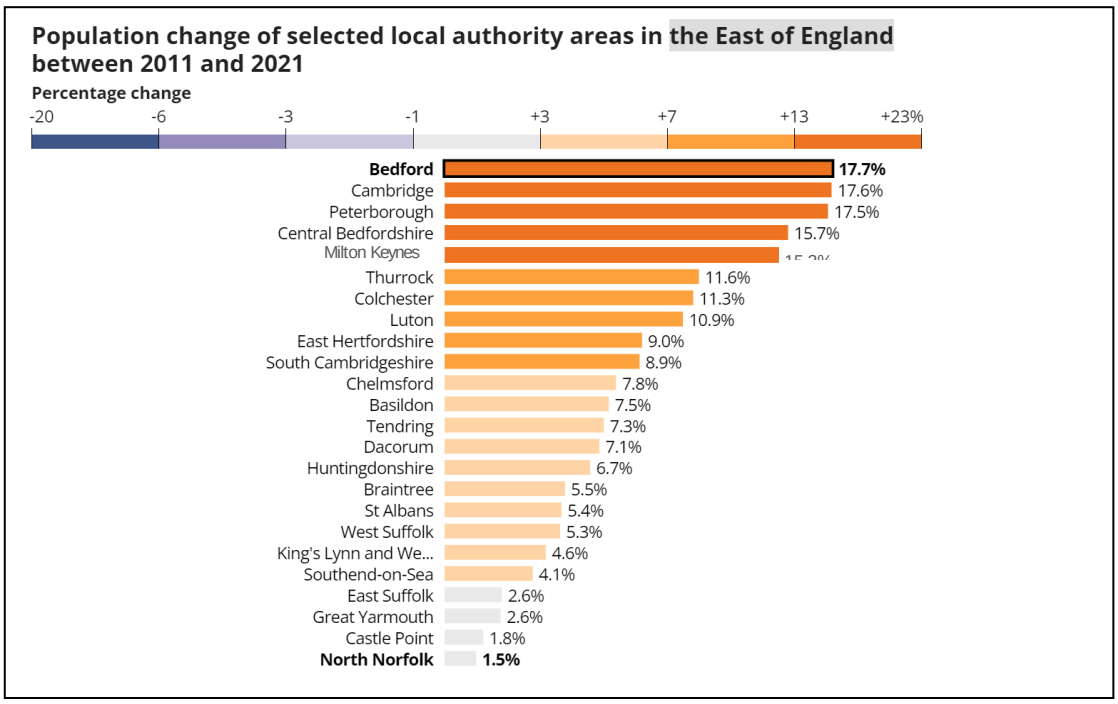
These plans are the long-term/ strategic delivery plan for Place Plans. Where Provider Collaboratives span multiple Places, and Place Plan actions are best delivered at scale, Provider Collaboratives (for example, the Bedfordshire Care Alliance) will work across multiple Places to deliver a consistent delivery model across the constituent Places.

Our Population

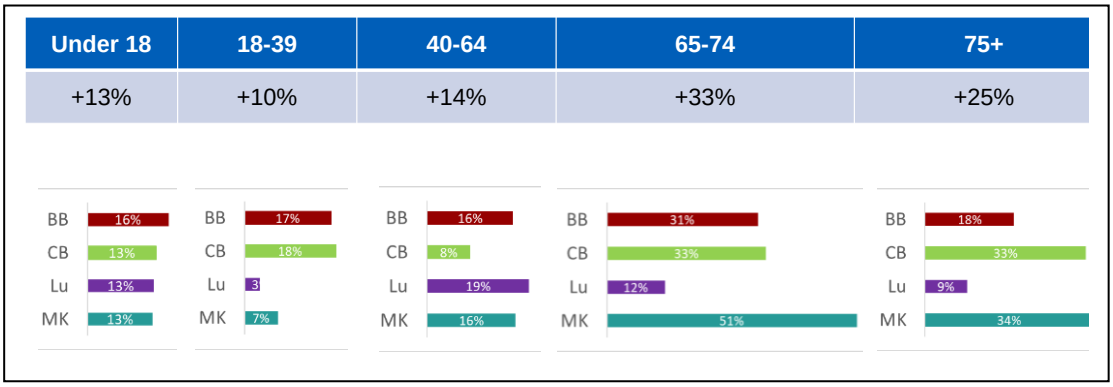
The Boroughs within BLMK ICB are diverse with a rapidly growing population.

Over the last ~10 years, roughly 5,000 homes were completed per year across BLMK (CBC > MK > BBC > Luton). Local Plans / housing strategies suggest around 6,000 new homes will be built across BLMK per year over the next ten years. This is significantly more than National (ONS) population projections assume a growth of c.2,400 homes per year across BLMK.

The ONS new housing projections for BLMK are out by a factor of 2.5, as BLMK is one of the fastest growing populations in the UK, and this trend is expected to continue.



Not only will there be more residents in the area over the next 15-20 years, but the demography, health needs and demand of our population will also change significantly.

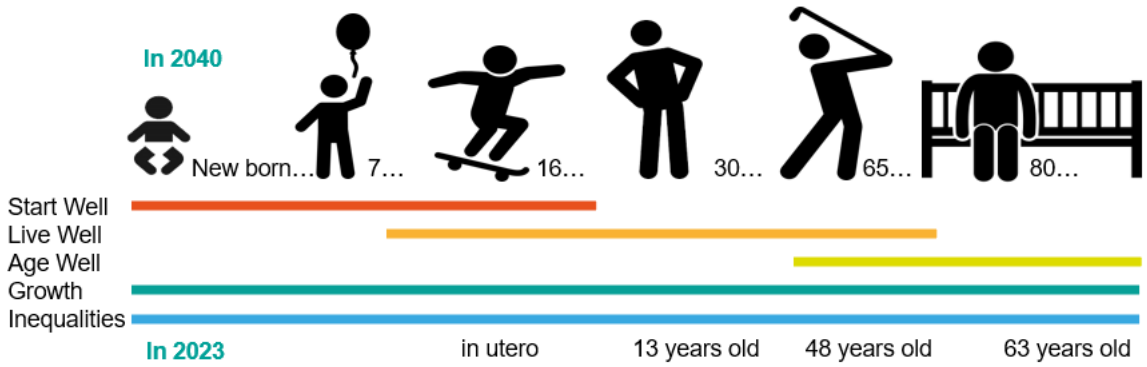


All of our Boroughs have strong plans to grow housing, employment opportunities and prosperity in a sustainable way, focused on the needs of specific communities within each Borough.

[examples from each Place to be added]

The BLMK Joint Forward Plan recognises that we cannot do more of the same with our resources (workforce, infrastructure such as estates and digital and finance) to meet this growing and changing population need.

The Plan aligns to our strategic priorities and the recognition that the actions that we take now will have a significant impact on our ability to improve the health and outcomes for our population in the future.



Given the variation in inequalities and health outcomes, people across BLMK hit the thresholds for start well, live well and age well at different ages across their life.

The known wicked issues for BLMK are:

- Rapid population growth and demographic shifts (specific to each Borough)
- Challenges accessing core primary care (including GP and dental services)
- Inequalities experienced by communities within BLMK
- Impact of COVID on residents
    - Deconditioning of people with frailty
    - Increased safeguarding and mental health issues for children and young people
    - Delays in accessing routine elective surgery
- Cost of living crisis affecting families
- Poor health of the population
    - Obesity
    - Long term conditions

SECTION TWO: Medium Term Affordability

[NHS & LA headlines – to be added for June submission]

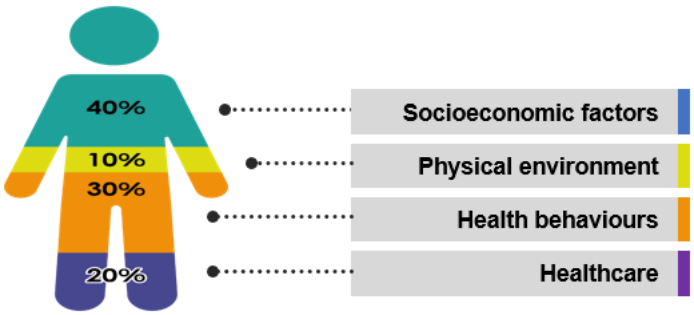
SECTION THREE: Our Strategy

Our system strategy sets out our ambition for improving health outcomes and reducing inequalities so that everyone in our city, towns, villages and communities can **live a longer, healthier life**. This means increasing the **number of years people spend in good health and reducing the gap between the healthiest and the least healthy in our community**.

Our strategy set out three questions which we aim to answer by working in partnership:

1. Are we doing the right things to improve health outcomes and tackle inequalities for our residents?
2. Are we making the best use of partnerships between public services, VCSE partners and local communities?
3. Are we working with our people and communities to understand what matters to our residents and co-designing and co-producing sustainable solutions.

The benefit of working in partnership is the opportunity this affords us to look at all of the factors that affect our changes of living a longer, healthier life.



Our system strategy builds on our health and wellbeing strategies at Place and our understanding of what matters to our residents.

Our Joint Forward Plan will also be firmly grounded in this understanding of what matters to our people and communities, our Joint Strategic Needs Assessments, Health and Wellbeing Strategies and emerging priorities at Place.

SECTION FOUR: A Joint Approach – Maximising Benefit to Residents

Our Joint Forward Plan highlights the shared 'wicked issues', where an innovative and collaborative approach is needed to deliver the Boroughs' Place Plans and the NHS targets for access and outcomes for all residents sustainably to 2040 and beyond.

As such the BLMK Joint Forward Plan is built on a strong shared ethos between all partners in the ICB as to how best to achieve this sustainably:

1. **Prevention and earlier intervention**

2. **Locally configured interventions that meet the needs of residents at a Neighbourhood, Place or System-level**

3. **Getting It Right First Time**, especially for those residents who have the
    a. Worst outcomes / highest risk factors / greatest inequalities
    b. Highest and most complex needs/ unmet needs driving high volumes of interaction with health, care and public sector services, including police, fire and criminal justice systems
    c. Voice least often heard/ face the most barriers to access
    d. High volume, low complexity demand for health care (elective and same day urgent care)

4. **Co-production with local communities**

5. **Leverage the inter-dependencies and interfaces across health and care services** to
    a. make every contact count – build opportunistic prevention & support to self-care into existing pathways of care
    b. reduce low value and repetitive interventions for residents and our teams
    c. optimise use of resources (workforce, estates, finance)

6. **Optimise the operating environment for health, care and civic services** – across traditional service and organisational boundaries with co-ordinated actions to:
    a. Tackle inequalities

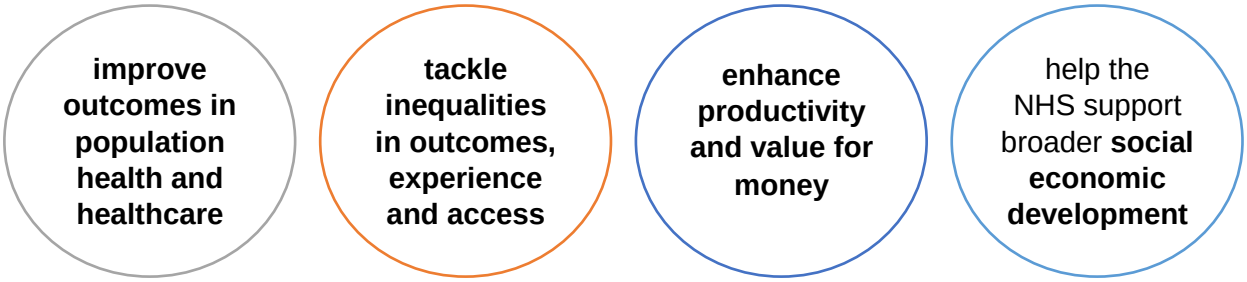
b. Stimulate local employment and economic development
c. Sustainability and green agenda
d. Long-term workforce development,
e. Market management
f. Strategic investment and utilisation of digital and estates assets

The key differences between existing Local Authority and NHS planning approaches are:

- NHS focused on short-term delivery (3-year funding cycle, 1-year operating plan) / LA plans for infrastructure and population growth are over a generation (15-20 year plans)
- NHS operating objectives are focused on the standards that clinical services must achieve for the patients who access them / LA considers the whole population living in a specific geography

All health and LA partners in ICBs have a shared responsibility to the populations they serve in their use of public money:

The four pillars of an ICS are to:



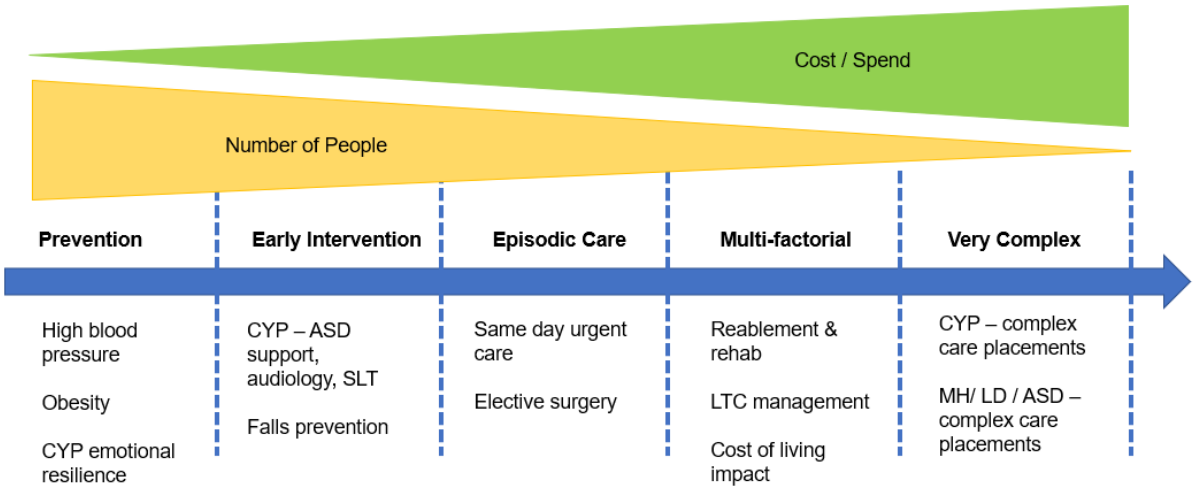
The BLMK Joint Forward Plan will therefore:

1. Focus on the needs of all residents at Place (not service lines / public sector institutions)
2. Extend to 2040
3. Identify the methodology by which we will:
   - Understand the growth, changing demographic and needs of our populations at Place to 2040
   - Outline key milestones and critical delivery points based on population size and need, incorporating existing 'wicked issues' and known changes in the operating environment (for example, devolution of specialised commissioning, or the creation of new towns in BLMK Boroughs)
   - Confirm the methodology for systematic review and strategic planning across key domains where a joint intervention between NHS and LA is required, utilising benchmarking, the evidence-base and innovation / research, applied through quality improvement methodology co-produced with local residents
   - Outline the key enabling strategic plans for workforce, infrastructure (estates and digital), and management of the operational environment (e.g. market management)

SECTION FIVE: The BLMK Approach

The purpose of the Joint Forward Plan is to determine how best we will work in partnership to address these known 'wicked issues' to the benefit of residents; and how these actions will enable sustainable delivery of NHS services to the standards set out in the NHSE Operating Plan.

Addressing these twin challenges will require a systemic and stratified approach, as depicted below:



Based on local JSNAs and Place Plans, the Joint Forward Plan will highlight those areas where a collaborative and different approach is required.

This will shift our focus from 'what can we afford to do?' to

'Can we afford NOT to do it?'

This latter question focuses on the needs and outcomes of the population, and how best we tackle inequalities and improve health outcomes to enable our communities to thrive AND deliver sustainable public sector services within resources.

This innovative and collaborative approach will involve:

- Developing a consistent approach to framing and investigating our 'wicked issues', with a focus on defining our target population, supporting co-production and personalisation, using collective resources and focusing on how we apply our different 'routes to Thrive'.
- Ensuring interventions are evidence based and challenge ourselves to achieve and sustain top decile performance, drawing on and contributing to research and innovation, and applying learning from best practice.
- Taking an adaptive approach to improvement, measuring outcomes as well as activity and considering the impact of our actions/failure to act on health and care (and wider society).

Examples of this approach could include:

a) Earlier intervention for children and young people who would benefit from:

- Speech and language help at a younger age / lower threshold of need
- Autism spectrum disorder support and diagnosis at a lower threshold of need
- Occupational therapy input for children identified above to support communication and social interaction at home and school

The underpinning rationale for this earlier intervention is to support children to meet their earlier developmental and education milestones, rather than delay intervention until the SEND threshold is met later in childhood.

Not only is this better for the individual child but also reduces higher system costs in SEND and (often) mental health support as children become aware of their 'difference' and struggle to keep up at school.

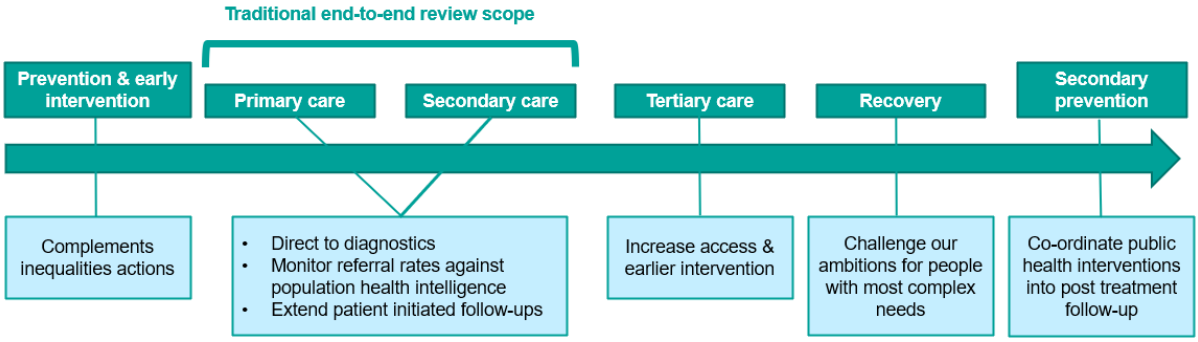
b) Local integrated offer for people with complex mental health and/ or learning disability needs, whose placement needs are currently met through contracting with independent sector providers. This could encompass:

- Creation of sufficient bespoke Supported Independent Living accommodation within Boroughs to meet local need
- Extended capacity to bring crisis support to the individual at times of highest need, reducing Emergency Department attendances / acute psychiatric admission unless clinically required
- Recovery approach that supports the individual to tackle root causes / manage distressing emotions and achieve their potential

This population are some of the most disadvantaged in our society, and this approach sets out a whole-system to tackle these inequalities and support these residents to thrive. This approach is also likely to drive better quality and more financially sustainable support.

c) Elective clinical pathways review

'End-to-end' clinical pathways review typically span the course of the pathway from primary care to secondary (acute) care and the return to primary care for residents who do access healthcare. Adopting a truly end-to-end clinical pathway review could better tackle inequalities and improve health outcomes, as depicted below:



Anchored in Places, this approach will:

- Identify populations whose risk profile / barriers to access indicates they require, using risk stratification at Neighbourhood / ward level
- Provide bespoke engagement (health promotion and uptake of screening programmes)
- Provide oversight for Place partners – giving a clear view (and feedback loop) on managing unwarranted variation not least in:
    - Over-referral that does not convert into increased diagnosis
    - Under-referral / late referral impacting on health outcomes
- Reduce bureaucracy for GPs in referral processes: encouraging greater autonomy for acute providers to determine the right clinical pathway based on diagnostic results
- Inform decision-making on how best to target current under-utilisation of BLMK residents for tertiary (specialised) clinical pathways, including earlier preventative interventions and/ or bespoke local pathways with tertiary providers
- Optimise public health interventions into post-treatment follow-up to maximise health outcomes

The outcomes sought from this approach are two-fold:

1. to ensure timely access that maximises health outcomes for all residents regardless of their barriers to accessing health and care
2. to manage demand and cost through more effective (targeted) interventions based on population need

d) Partnership in Fuller Neighbourhoods to support residents to tackle the root causes of their need (not solely manage symptoms). This approach goes beyond social prescribing to locally-determined offers that:

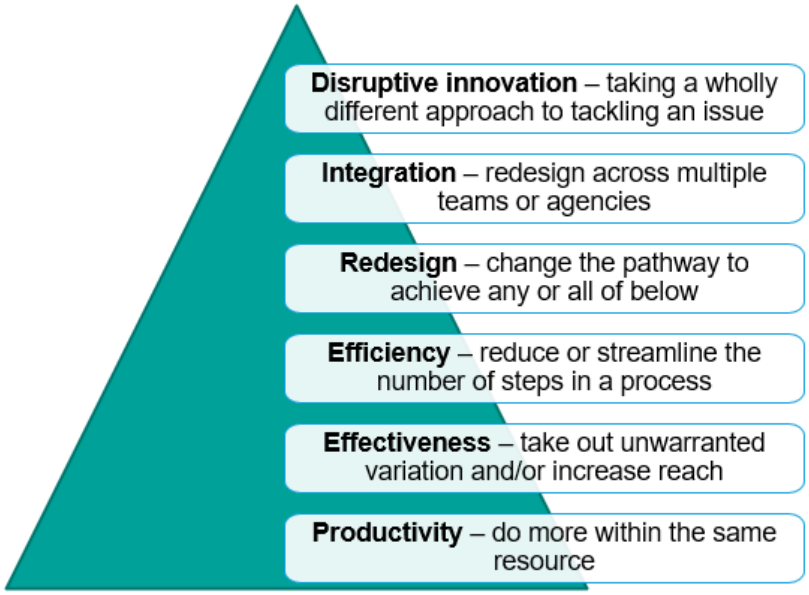
- Simplifies access to support, reducing the multiplicity of 'front doors'
- Draws on local communities' own assets and those of the VCSE to support people to thrive
- Offers co-ordinated support across civic, care and health partners reflecting residents' needs (not our service configuration and referral processes)

These examples demonstrate how, when we collaborate to the benefit of specific residents, we can improve outcomes for the individual and reduce avoidable cost across the public sector. In this way the plan will aim to move us away from the traditional focus on episodic and siloed care to:

- Define our goals by the needs of our population (at Place) rather than episodes of care or care pathways
- Drive the 'left shift', by moving resource to improving prevention and early intervention (to benefit residents and reduce future need and cost)
- Focus our collective attention on where disruptive innovation is required to meet complex need and high demand within resources
- Challenge ourselves to take a long-term view (outcomes & cumulative cost) wherever possible

We will deliver this through Quality Improvement interventions that are locally owned and driven to make it easier for our teams to do the right thing for the resident, first time.

Based on population growth and need we will deploy a range of actions in delivery of the elements of the Joint Forward Plan:



SECTION SIX: preparing the Joint Forward Plan

There will be several phases to the delivery of our Joint Forward Plan

- **Preparation phase** – establishing population-focused intelligence and delivery structures to inform and enable ICB core objectives for residents at neighbourhood and Place.
- Delivery of **Place and Provider Collaborative plans** – to meet local population need sustainably and within resources
- **Delivering the 'left shift'** – with a consistent focus on high volume/low-cost prevention and low volume/high-cost and complex interventions to maximise impact within resource
- **Building tomorrow** – building prosperity for our communities
- Achieving and **sustaining top decile** – getting ahead of the curve to drive sustainable excellence

Phase 1: Preparation for the Joint Forward Plan July 2022 – March 2024

Establish population-focused intelligence and delivery structures to inform & enable ICB core objectives to residents at Neighbourhood and Place

Population modelling	**Model our expected population changes at Neighbourhood and Place,** including growth, demographic shift and the changes in need/demand which will inform our Joint Forward Plan	Data-based intelligence on scope, size, timing and prioritisation of JFP actions, linked to populations
Place Deals & Provider Collaboratives	**Optimise Place Deals and Provider Collaboratives to integrate health, care and civic interventions around specific populations to reduce inequalities and improve outcomes:** • Deliver Fuller Neighbourhoods to meet local population need • Co-ordinate LA primary prevention and NHS secondary prevention interventions at place and patient cohort • Integrate community and social care pathways to support people with frailty and long term conditions (Home First & Stay Well At Home, including Virtual Ward & SDEC) • VCSE as an embedded partner	Multi-professional, multi-agency partnerships configured around specific resident cohorts to: • Maximise prevention & early intervention • Improve outcomes for residents • Drive effectiveness & efficiency through integration
Population health, public health & tackling inequalities	**Bring together public health and population health management resources to form a Population Health Intelligence Unit to**: • Provide consistent population baseline data and reporting on impact to specific populations • Ensure that population health and inequalities are highlighted in NHS activity, performance and quality reporting at Place / Neighbourhood • Develop data scientist analytics capacity and capability • Roll out a shared QI approach on inequalities, including exemplar 360º Thrive programmes for agreed specific populations, i.e. Learning Disabilities	Population-focused analytics at place and Neighbourhood to provide: • Integrated health, care & civic population intelligence • Outcome metrics to measure impact to specific populations • Consistent application of QI
One Estate	**Bring together estates assets at Place to develop all Partners Estates Strategy at Place** • All public sector partners • Opportunities within commercial & social enterprise facilities • Strategy aligned to projected population growth at Neighbourhood & Place	• Key enabler for new models of care • Supports population growth • Reduce avoidable long term costs

Phase 2a: Delivery of Place & Provider Collaborative Plans July 2022 – 2040

To meet local population need sustainably within resources

Fuller Neighbourhood Teams	**To meet changing needs of local residents at a locality/neighbourhood level:** • Engage with local communities to co-design future scope of Fuller Neighbourhoods • Holistic offers of support to tackle root causes (life improvement) • Increase same day urgent care capacity as population grows • Innovate models of continuity of care/complex care management • Reduce high volume/ low benefit clinical support activity primary care (e.g. straight to test/self refer) • Determine opportunities from POD specialised commissioning delegation • Estates strategy aligned to predicted population growth at Neighbourhood agreed with each Place	• Optimise health & well-being based on local need • Access to meet local population need / growth
Clinical services strategy	**End to end reviews for high risk/high opportunity clinical speciality pathways:** • Prevention / early intervention / primary care / secondary care (tertiary care) / secondary prevention • Optimising pathways (left shift, i.e. 'tertiary' functions into acute settings as population growth allows, acute functions into Place • Pathway productivity & efficiency (straight to test/standardised order sets incl. new CDC capacity) • Reduce unwarranted variation in access – missing patients & over-referral • Models of delivery (including strategic partnerships) • Capital investment strategy (diagnostics, digital, estates) • Long term strategy for key services lines delegated from specialised commissioning	• Top decile clinical pathways • High value for money • No-one left behind
'Thrive' programmes	**Civic & Health Inclusion around specific population cohorts, e.g.:** Children and young people, Learning Disabilities and Autism Spectrum disorder (ASD), Offenders, Veterans, Traveller communities and people experience homelessness.	• Cross-cutting interventions to reduce inequalities & improve outcomes

Phase 2b: Delivering the Left Shift April 2024 – March 2040

Consistent focus on high volume/ low-cost prevention AND low volume/ high cost & complexity to maximise impact within resources

Maximising Prevention & Earlier Intervention	**Identify which civic, care & health interventions, for what population and when will:** • Improve outcomes for the individual • Reduce long-term cost across public sector partners • Utilise co-production with specific communities to deliver • Learn & adapt to maximise outcomes & value for money	• Improve individual outcomes • Reduce avoidable long-term cost
Complex Needs: Thrive not just Survive	**New models of care (including local delivery) for residents with the highest complexity of needs – Children & Young People, Mental Health, Learning Disabilities & Neurodiversity** • Multi-agency proactive identification of people with escalating complex need • 24/7 crisis pathways / support in community settings (multi-agency) • Recovery-focused pathways • Local infrastructure based on local need (placements, partnerships) • Support levels flex aligned to need, not person moves through multiple settings	• Improve individual outcomes • Reduce avoidable long-term cost

Phase 2c: Building Tomorrow July 2022 – 2040

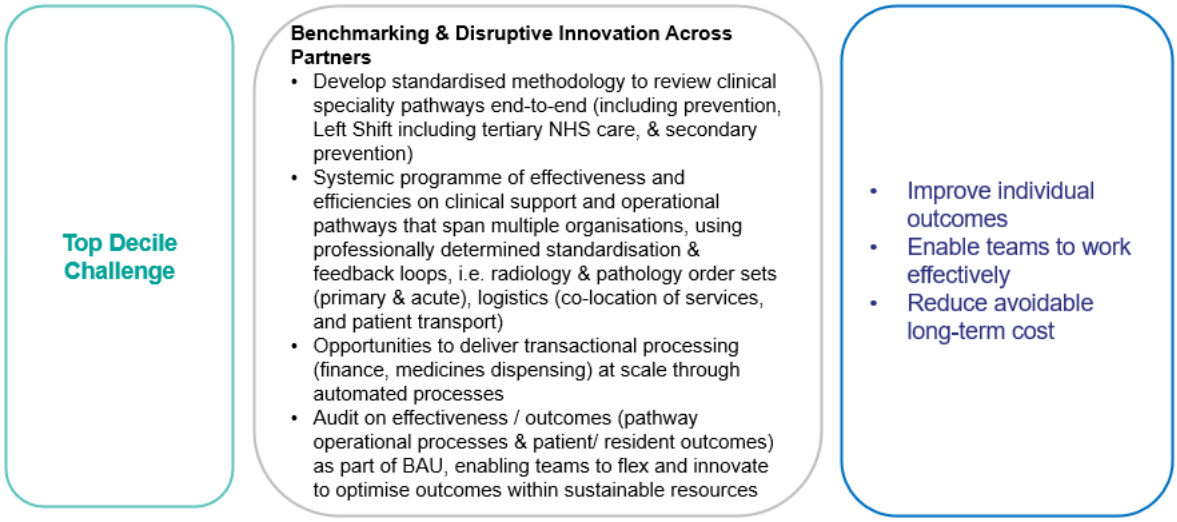
Building Prosperity for our Communities

Sustainability	**Achieving net zero across the system by 2035, ensuring we work in harmony with the environment and remain within the 'ecological ceiling':** • Improved models of care to support the circular economy – focusing on fuel poverty and improving food and nutrition • Remote and digital strategies to reduce carbon footprint • Review of medicines and supply chain with a focus on supplier carbon reduction plan and e.g. inhaler replacement. • Travel and transport 'modal shift' to improve air quality, supported by an ICS Clean air framework and system wide adaptation plan. • Embedding sustainability planning and decision making across organisations, supported by increased capability and capacity, carbon literacy and intelligence, governance assurance to underpin delivery	• Building a 'circular economy' • People stay well & make best use of resources • Better physical and natural environment
Opportunities for prosperity	**Improving opportunities for prosperity in all our population now and in the future:** • Promoting sustainable procurement and use of our public sector estate – aligning procurement policies and procurement pipeline • Aligning our long term estate plan with LA population growth projections • Developing the BLMK research and innovation strategy and networks	• Use of public sector assets • Local investment • Promoting research
Building our workforce	**Taking a strategic approach to workforce development in line with population projections:** • Focus on improving the uptake of health and care roles amongst the local population, • Growing our own future workforce, taking advantage of our education and research institutions	• Well-resourced public services • Increased employment
Social value	**Making sure our work contributes to our whole society, ensuring everyone has the chance of a decent standard of living 'above the social foundation'** • Keeping people healthy in their homes and communities • Focus on alleviating the effects of the cost of living crisis • Nurturing partnerships with VCSE partners and local employers • Developing our anchor institutions	• Keeping people healthy • Nurturing local partnerships

Phase 3: Achieving & Sustaining Top Decile July 2022 – 2040

Getting ahead of the curve to drive sustainable excellence

Transformation through technology & data	**Digital Integration Drives Optimised Outcomes** • Develop a single source of the truth – integrated data functionality • Report NHS performance at place/patient cohort level • Build our strategic data platform • Systemic use of artificial intelligence, robotics & automated data collection • Use digital to maximise independence through self-access (patient portal) • Enable care at Place (point of care diagnostics, remote monitoring) • Digital feedback loops to drive quality & effective use of resources, for example inventory management • Automated Robotic Processes to standardise & optimise processes	• Inform holistic professional decision-making across organisations • Reduce avoidable cost • Enable teams to work effectively



SECTION SEVEN: Place and Provider Collaborative Key Objectives

[for completion ahead of Health and Wellbeing Boards]

Each of the four Places in BLMK have been developing Place plans, identifying local priorities that partners can work collectively on to improve the health and wellbeing of local residents.

[Note – text below is place holder only – requires Place partners' engagement to complete – to include wicked medium/long term issues that we need to address in partnership at Place and Provider Collaboratives]

Bedford Borough

Bedford Borough's vision is to thrive as a Place that people are proud of, want to live in and move to. Local plans recognise a growing and strong local economy and an active response to climate change as two important factors in achieving this. From this foundation residents will be able to thrive and realise their potential, supporting and celebrating Bedford Borough's diverse and inclusive communities.

The Bedford Borough Place plan has been developed by the Health and Wellbeing Board and commits to:

- Understanding our communities
- Promoting prevention and health promotion
- Transforming care with primary care and VCSE

The priority partnership actions identified in Bedford Borough are:

- Tackling obesity
- Improving access to primary care

Central Bedfordshire

The Central Bedfordshire Place Plan includes three over-arching ambitions set out below:

- **Promoting fairness and social inclusion** – identifying and tackling underlying inequalities in social and wider determinants of health, promoting better equitable access to services.
- **Living Well** – so everyone has the right and opportunity to live their best life, with the required support and infrastructure to make healthy choices and maximise wellbeing.

- **Ageing well** – to provide support and services required to meet the needs of an ageing population, adapting to changing demands and new models of care.

Given the breadth of the ambition, the board has identified 5 initial priorities of focus which are:

1. **Cancer** – prevention, early detection and reducing premature mortality.
2. **Children and Young People's Mental Health** – delivering the ambitions to promote positive mental health and wellbeing
3. **Mental health, learning disability and autism** – reducing stigma, improving the experience of care and physical health of people with these conditions and access in crises.
4. **Primary care access, including dentistry** – developing the fuller plan for integrated care and developing new models of care
5. **Developing a one team approach to intermediate care services** – ensuring more joined up and timely care

Luton

By 2040, the vision is for Luton to be a healthy, fair and sustainable town, where everyone can thrive and no-one has to live in poverty, supported by:

- **A town built on fairness** – tackling inequality
- **A child friendly town** – investing in young people
- **A carbon neutral town** – addressing the impact of climate change

The Luton Place Board has developed a Place plan which commits to:

- Giving every child the best start in life
- Sustainable communities, and tackling inequalities
- Reducing frailty and supporting independence

The key priority actions identified to deliver this in Luton are to work in partnership to build:

- **Community hubs** and healthy places
- Improved **mental health services** and interventions to tackle the causes of poor health
- The Luton **digital programme**, connecting health and care services and helping people stay independent at home
- Capacity and capability across the **VCSE sector**

Milton Keynes

The Milton Keynes Health and Care Partnership, has developed and a 'MK Deal' which formalises the commitment of the main local NHS partners in MK and the City Council to work more closely together, with a focus on:

- **Improving system flow** – with a focus on urgent and emergency care services for older and/or frail and/or complex service users.
- **Tackling Obesity** – helping people lose weight and maintain a healthy weight through easily accessible weight management programmes, use of technology, pharmacological therapies and education/prevention work.
- **Children & Young People's Mental Health** – recognising that good mental health in children and young people helps build resilience, develop healthy relationships and lays the foundation for better mental and physical health and wellbeing throughout their whole lives. Early intervention is key for lifelong wellbeing: 75% of adult mental health issues are present by the age of 24.
- **Complex Care** – focussing on improving the planning, assessment, commissioning, and case management for people who have the most complex needs

Bedfordshire Care Alliance

The Bedfordshire Care Alliance is a provider collaborative which aims to ensure that where scale and complexity requires us to standardise care across the three Bedfordshire boroughs.

The Alliance has agreed a focus on four priority areas:

- **Supported discharge** – improving rehab reablement and recovery outcomes
- **Alternatives to acute admission** – stay well at home
- **Digital infrastructure** – to enable integrated pathways of care across Bedfordshire
- Support to Places to optimise **care closer to home**

Mental health, Learning Disabilities and Autism Collaborative

The BLMK Mental Health, Learning Disability and Autism Collaborative is a collaboration of the BLMK ICB, CNWL, ELFT the Bedfordshire Care Alliance, Milton Keynes Health and Care Partnership and Place based partnerships to improve outcomes, quality, value and equity for people in BLMK.

The initial vision of the Collaborative, which will be developed with input from service users, carers and system partners, will put service user voice and a focus on Place at its heart, refocusing efforts on addressing inequalities and unwarranted variation, and working at scale where it makes sense to do so.

Specific areas where the Collaborative will add value will include:

1. **Workforce** – training a new generation of mental health professionals
2. **Emotional wellbeing for young people** – responding to the increase in referrals since the pandemic
3. **Support for adults with autism** – so that even those without a formal diagnosis can get access to the support they need.

SECTION EIGHT: Sustainable delivery of NHS Operating Plan Targets

[to be updated following submission of the 2023/24 Operational plan]

Our approach to planning, transformation and contracting will look to address wicked issues which relate to our ways of working and operational realities, including:

These issues include:

- Vulnerabilities highlighted through winter pressures and the need to promote **admission avoidance and supported discharge** – workforce is a significant issue in this regard.
- **End of life care**, and in particular the need to develop a Place based delivery model
- Long waits in **elective care**, with a focus on ophthalmology, ENT, cardiology and MSK, and links to theatre productivity and vulnerabilities in paediatric surgery provision.
- **Diagnostics** including the development of community diagnostic hubs and refurbishments required to support endoscopy pathways.
- Ongoing pressures on **cancer services** including increased demand and complexity of cancer presentations and impacts on recovery of services, and the need to balance this with a push for early referral and diagnosis of cancer.
- Support for **children and young people** – especially those with the most complex needs, and to improve the experience of transition between services
- Improving uptake of **childhood vaccinations**, improving mental health and tackling obesity in children and young people.
- Recruitment and retention within the **maternity workforce** and addressing inequalities in experience and outcomes for our residents.
- Increased demand across all ages **autism, ASD and ADHD** pathways, and the need to find alternative solutions to the delays in care associated with long waits for formal diagnoses.
- Cost pressures and increased demand on **section 117** services, and variation in access and provision across the system.
- Capacity across **primary and same day urgent care** – including workforce, IT and estates.
- Capacity and capability to develop **multidisciplinary working across primary and secondary care** based around population need.
- An agreed system approach to **prevention** – including long-term sustainable investment – ensuring this is developed in partnership with the VCSE.

[place holder – additional content on known milestones including Community diagnostic centres, MKUH new hospital build, Mount Vernon re-provision to be added ahead of final submission in June]

SECTION NINE: Summary of key risks *[to be expanded for June submission]*

Principle risks, controls and mitigations are detailed in in the ICBs Board Assurance framework.

Key risks which are likely to impact our ability to deliver our Joint Forward Plan are summarised below:

1) insufficient capital/CDEL will be available to meet increased population growth/need.
2) insufficient impact on population wellbeing of left shift interventions – failure to deliver this will result in unaffordable need and cost
3) a gap or delay in resourcing as population growth/need increases
4) head space to lead transformation (operational pressures)
5) workforce transformation required

[Question - where are we holding/assuring Joint Forward Plan risks at Place and Provider Collaboratives?]

APPENDICIES *[to be added for June submission]*

a) Strategic Workforce Plan

Linked to

- population growth and demographic shift
- planned job creation in Boroughs
- LA and NHS workforce long term needs

b) Estates and capital strategy

c) Digital & Inequalities/ Health Intelligence Strategy

d) Joint sustainability & Green Plan

e) Medium Term Financial Plan

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Board of the Integrated Care Board (ICB)
16. Update - BLMK ICS 2023/24 Financial and Operating Plan

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	Anne Brierley ICB Chief Transformation Officer
Date to which the information this report is based on was accurate	9 March 2023
Senior Responsible Owner	Anne Brierley ICB Chief Transformation Officer

The following individuals were consulted and involved in the development of this report:
All partners have been involved in the planning process.
This report has been presented to the following board/committee/group:
This report provides an update on the previous report to Board in January. The financial plan has been presented to the Finance and Investment Committee on 10 March 2023. An update on operational planning was provided to the Quality and Performance Committee on 3 March 2023.

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

In a paper to the 27 January 2023 meeting of the Board of the Integrated Care Board (ICB), members were informed of the receipt of NHS England (NHSE) Operational Planning guidance for 2023/2024. This paper provides an update on the process for, and progress in, developing a BLMK Operational Plan.

The paper highlights the not inconsiderable time constraints imposed for this process and outlines the governance process being used to ensure that the Plan represents the aspiration and capability of the wider system.

Against a requirement for the final Plan to be submitted to NHSE by no later than noon on 30 March 2023, the paper asks agreement of the Board for the final, submitted Plan to be approved by the ICB Chief Executive Officer, following a meeting of system CEOs on 29 March 2023.

Members are asked to:

- **NOTE** progress with the development of the operational plan 2023/24 and
- **AGREE** for the final, submitted, Plan to be approved by the ICB Chief Executive Officer following a meeting of system CEOs on 29 March 2023.

1. Brief background / introduction:

In a paper to the 27 January 2023 ICB Board meeting, members were informed of the receipt of NHSE Operational Planning guidance for 2023/2024. This paper provides an update on the process for, and progress in, developing a BLMK Operational Plan.

Objectives, Priorities and Targets for 2023/24

The Operational Plan requirements have broadly the same remit as those for the Joint Forward Plan but focus on differing time scales; the immediate operational delivery of integrated health and care at Place and Collaborative (including delivery of the mandated NHSE operating plan requirements); and the medium-term focus on developing and executing our strategic objectives to meet our ICB vision to support all our communities to thrive. While the Operational Plan is short term and deals with immediate priorities it can therefore be viewed as the first step towards our more considered 5 year Joint Forward Plan.

The core planning requirements for 2023/24 cover expectations and targets for:

- Recovery and productivity/ efficiency;
- Delivery of the NHS Long Term Plan and transformation; and
- Local empowerment and accountability.

Recognising the shift to local decision-making at ICBs and Place, NHS England has tasked systems with a more streamlined, though still stretching, suite of 32 specific objectives and targets for this period. These cover key areas of health care:

1. Improve ambulance responses and accident and emergency (A&E) waiting times;
2. Reduce elective long waits and cancer backlogs and improve core diagnostic performance;
3. Ensure easier access to primary care services especially General Practice;
4. Improve access to mental health for all age groups;
5. Maximise preventative interventions, such as managing hypertension ;
6. 3 key diagnostic targets (cancer and non-cancer) to support earlier diagnosis; and
7. Health inequalities lens on all – reaching the patients with the poorest access / health outcomes.

An initial draft plan was submitted to NHSE by the required deadline of **23 February 2023**. Finalised Plans must be signed off and returned to NHS England by **30 March 2023.**

2. Summary of key points:

Format and Content of the Plan

The format of the Operational Plan is prescribed and takes the form of a number of numerical returns plus an accompanying narrative document:

- The numerical returns are spreadsheet templates covering three aspects (finance, activity/ performance and workforce) that demonstrate how the system will fund, resource and deliver the levels of activity required of it to achieve the targets expected for our area; and
- The narrative document that provides answers to a range of NHSE-specified questions, and so contextualises the numerical spreadsheets and any risks or assumptions therein.

Taken together, these quantify and articulate the approach and plans of the BLMK system at Place, Collaborative and System level to deliver the national ambition. It is also expected that, where not already covered by the national ambition, the Operational Plan will address the priority maximum impact interventions identified within updated Place Plans which was presented to the Health and Care Partnership Board on 7 March 2023.

Community and Mental Health service providers contracted to provide services in BLMK have their main offices in other systems and so are formally part of the Plan returns for those systems. However, and while the focus of the Plan is largely built around, and judged against, acute activity, such providers have been asked to contribute to BLMK area spreadsheets outlining staffing, turnover and recruitment figures relevant to their contract services within BLMK.

The Development Process

As facilitator the ICB is leading on coordinating the development of the Plan between and across partners:

- Day to day development of the Plan is being led and coordinated by a core Operational Plan Working Group drawn from ICB subject matter experts as system facilitators and SPOCs (specific points of contact) for partners;
- ICB SPOCs have been engaging with peers in partner organisations to consider the objectives, activity and targets;
- Progress is overseen through fortnightly meetings of the ICB-chaired Performance and Delivery Group, which includes representation from system partners;
- Key subject-specific fora such as the People Board and meetings of Chief Finance Officers are being used to enable strategic subject-specific discussion and agreement between and across partners;
- Partners are expected to lead discussions on their contributions within their own organisations;
- An extra-ordinary meeting of system Chief Executives was convened on 21 February 2023 to consider and give approval to the draft Plan due for submission to NHSE on 23 February 2023. The meeting was also able to 'triangulate' between the pillars of the Plan and identify key sticking points and inter-dependencies to be addressed prior to finalisation of the Plan; and
- Progress on the further development of the Plan is scheduled to be reported to the ICB Board on 24 March 2023 – this paper.

Progress To Date

At this drafting stage, the System is not yet able to demonstrate a fully compliant plan, and so negotiation and amendment is expected before the final version. Initial triangulation has taken place to understand interdependencies, so that anomalies or risks can be escalated as appropriate.

The System has very recently received feedback from NHSE on the draft Plan and is prioritising this against issues already identified locally and at the Chief Executives meeting. Key issues at this point include:

- Bridging a funding shortfall that currently necessitates identifying efficiency cost reductions across the system;
- Capacity to deliver the levels of recovery activity needed to achieve the BLMK target of 109% of 2019/20 activity (i.e., pre-COVID level);
- The plans, activity and funding necessary to manage hospital flow and discharge and meet targets for urgent elective care and winter planning; and

- Ambitious recruitment and retention levels to provide the necessary workforce to deliver activity and service.

3. Are there any options?

All partner organisations within BLMK ICB are subject to the mandatory and statutory planning requirements and own governance relevant to the scope of their health or care provision. As such they are best placed on an individual / Place basis to make use of discretionary opportunities ('head-room') created by strong performance and delivery to date.

However, strong and sustained delivery of all such mandated requirements, including financial balance, will provide the requisite 'licence to practice' for the ICB, enabling headroom and autonomy to deliver innovation and transformation.

4. Key Risks and Issues

To date, the System has been unable to submit a compliant Plan. The key risk in the delivery of our strategy through our short timescale Operational Plan is that current urgent and emergency care pathway operational pressures are constraining our clinical capacity for elective recovery. Ongoing planning is underway to deliver the best outcomes within our resources.

Building focus on impact / outcomes to specific populations within our communities into our 'business as usual' performance and quality oversight is essential to ensure that we make progress in tackling inequalities and improve health outcomes for all our residents.

Our operational and strategic planning will factor in the risks and opportunities from delegated specialised commissioning for BLMK residents; Pharmacy, Optometry and Dentistry (POD) from April 2023 and planned devolution of 66 specialised commissioning services lines, including cancer, neuro-rehabilitation and specialist dental (all ages) from April 2024.

Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☒	No ☐

The principal risks are captured in the BLMK ICB Board Assurance Framework (BAF).

5. Are there any financial implications or other resourcing implications, including workforce?

Our operational delivery plan and Joint Forward Plan will need to ensure that we use our resources effectively to achieve maximum benefits for our population. Key to this will be new workforce models and commitment to 'grow our own' through training and apprenticeships, as well as innovative investment in our collective infrastructure to meet the increasing needs and volume of the BLMK population.

6. How will / does this work help to address the Green Plan Commitments?

Click to view Green Plan

Growth and sustainability are a key strategic objective in the Health and Care Partnership Integrated Strategy for BLMK, and consideration of benefits / impact of both operational delivery and development of the medium-term plan will need to include these issues as core to all delivery by the ICB.

7. How will / does this work help to address inequalities?

This is fundamental to sustainable delivery of health and care in BLMK, and to enable us to achieve our ambition to support all communities to thrive. Consideration for addressing health inequalities is a key expectation of the planning guidance and forms part of our narrative plan response.

8. Next steps:

BLMKs providers and ICB leads will continue to liaise with local NHSE leads and subject matter experts to identify opportunities to improve levels of activity and expected performance within the Plan.

The emerging Plan is also subject to ongoing discussion between senior provider leads for each of work-force, finance and activity/operational delivery. A meeting of the Chief Executives from across the system is scheduled to take place on 29 March 2023 before the submission of the final plans so that the balance between finance, workforce and activity can be considered, understood and agreed.

The outstanding development still needed, together with the submission deadline of 30 March 2023, pre-clude the final Plan being brought to this meeting of the ICB Board for approval. Under these circumstances the Board is asked to agree for the final, submitted, Plan to be approved by the ICB Chief Executive and following the meeting with System CEOs on 29 March 2023.

9. Appendices

None

10. Background reading

“2023/24 priorities and operational planning guidance” – published by NHS England, 23 December 2022

“Update on Strategy and Planning” - Report to the Board of the Integrated Care Board, 27 January 2023

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Integrated Care Board

Report to the Board of Integrated Care Board (ICB)
17. Place Plans, Health and Wellbeing Board Updates and guidance for Health and Wellbeing Boards and Integrated Care Boards

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

Report Author	Maria Wogan, Chief of System Assurance and Corporate Services and Link Director for Milton Keynes BLMK ICB Sarah Stanley, Chief Nursing Officer and Link Director for Bedford Borough, BLMK ICB Anne Brierley, Chief Transformation Officer and Link Director for Central Bedfordshire, BLMK ICB Nicky Poulain, Chief Primary Care Officer and Link Director for Luton, BLMK ICB
Date to which the information this report is based on was accurate	10 March 2023
Senior Responsible Owner	Felicity Cox, Chief Executive BLMK ICB

The following individuals were consulted and involved in the development of this report:

ICB Place Link Directors
This report has been presented to the following board/committee/group:
Not applicable

Purpose of this report - what are members being asked to do?
The members are asked to **note** the following: A) The Place Plans for Bedford Borough, Central Bedfordshire, Luton and Milton Keynes; B) The reports from the Health and Wellbeing Boards; and C) The implications of the Health and Wellbeing Board guidance issued on 22 November 2022 and agree to take action as appropriate at place.

Executive Summary Report

1. Brief background / introduction:

1.1. Place Plans

Each of the four Places in BLMK have been developing Place plans, identifying local priorities that partners can work collectively on to improve the health and wellbeing of local residents.

1.1.1 Bedford Borough

Bedford Borough's vision is to thrive as a place that people are proud of, want to live in and move to. Local plans recognise a growing and strong local economy and an active response to climate change as two important factors in achieving this. From this foundation residents will be able to thrive and realise their potential, supporting and celebrating Bedford Borough's diverse and inclusive communities.

The Bedford Borough Place Plan has been developed by the Health and Wellbeing Board and commits to:

- Understanding our communities;
- Promoting prevention and health promotion; and
- Transforming care with primary care and VCSE.

1.1.2 Central Bedfordshire

The Central Bedfordshire Place Plan was agreed at the Health & Wellbeing Board and outlines the ambitions for Central Bedfordshire to 2025. The Plan has three over-arching ambitions set out below:

- **Promoting fairness and social inclusion** – by identifying and tackling underlying inequalities in social and wider determinants of health, to give everyone the best opportunity to live a healthy life and promote better, equitable access to services, across community, acute and primary care;
- **Living Well** – everyone should have the right and opportunity to live their best life, with the required support and infrastructure to make healthy choices and maximise wellbeing; and
- **Ageing well** – continue to provide support and services required to meet the needs of our aging population, while adapting to changing demands and new models of care, through both the formal service offer and supporting and developing community based services.

Measures of success have been identified for each of the priorities and progress will be monitored by the Health and Wellbeing Board.

1.1.3 Luton

By 2040, the vision is for Luton to be a healthy, fair and sustainable town, where everyone can thrive and no-one has to live in poverty, supported by:

- A town built on fairness – tackling inequality;
- A child friendly town – investing in young people; and
- A carbon neutral town – addressing the impact of climate change.

The Luton Place Board has developed a Place Plan which commits to:

- Giving every child the best start in life;
- Sustainable communities, and tackling inequalities; and
- Reducing frailty and supporting independence.

1.1.3.1.Luton At Place Board Update:

- The Luton Place Board membership has expanded iteratively over the last year, ensuring we have the right people around the table including the six PCN clinical directors for the collective agenda. Specialist partners are invited when tabling specific agenda items.
- The Board works in connectivity with the Fuller Report and Marmot Town recommendations, both reports are central to the Board's programme of work. In addition the Board works in tandem with dependent Boards; the Inequalities Board & the Children's Trust Board. Whole system collaboration is central to the working ethos, including our critical relationships with the Voluntary and Community Sector. Members are currently working to strengthen connectivity with the Fire Service & exploring new collaborative opportunities.
- The strategic approach, objectives and priorities are supported by an integrated programme of work. Members are currently working with Luton Borough Council (LBC) Business Intelligence team towards a dashboard of measures which will evidence the impact of the individual priorities and workstreams. The dashboard will consist of a core group of high level measures, sitting above a more expansive set of measures for deep dives into impact and issues arising in specific workstreams, ensuring the workstreams are on track to achieving the ambitions of the Board.
- In 2022 Board members signed a Memorandum of Understanding and a Mutual Accountability Framework, setting out members' commitment to One Voice – One Luton and working collectively as one team towards the agreed strategic ambitions and priorities. A review of the approach is currently underway, with the aim to establish a 'Luton Deal'. Further updates will be provided once the work is ready to be tabled.
- Key workstreams under the spot light at the moment are:
    - the Community Hubs, currently in the planning & development phase to support Priority 3 – Empowering Local People to become resilient increasing people's sense of control to manage their own health and wellbeing. The workstream interconnects with the Luton Family Hubs, the Warm Spaces Charter, the Healthy Places Framework, the principles of 'A place to go, a place to talk, a place to do', the Fuller Recommendations & Neighbourhood teams & Luton Core20Plus5. Further updates can be provided as the planning phase progresses;
    - the BLMK Mental Health Provider Collaborative presented an update to members in January and reflected on key opportunities across the footprint, in particular in response to the Fuller Recommendations. The update provided a platform for informative discussions around interconnectivity at Place level, the draft Luton Mental Health Strategy and the mental health workstream, Priority 1 of the Place Board programme; Early intervention and Prevention Services tackling the cause of poor health and wellbeing. The draft Luton Mental Health

Strategy is currently being socialised and following due governance process, with an action plan in development;

- the Digital workstream in Priority 3; Empowering Local People to become resilient increasing people's sense of control to manage their own health and wellbeing, is a preventative workstream supporting care provider connectivity with health services and enabling effective care within the community. The Digital Programme, tabled in January, holds a number of collaborative projects across the BLMK footprint, with the Luton Place Board programme holding a sub workstream for Luton. A new ICB funded Artifical Intelligence (AI) project, Miicare, has gone live, with Luton delivering the first stage roll out. Miicare is a digital tool to support families, carers, and care agencies, who care for vulnerable adults within their own homes (not care homes). The digital offer ensures that the person within their care can remain in their own home, safely and for as long as possible, whilst providing insights into behaviours that are able to inform proactive care and support when required and prevent admissions or increase in care package provision; and
- the Voluntary Sector Alliance has been established and presented to the Board in February, with a focus on how voluntary organisations can link in with partners, strengthen relationships and work collaboratively as one team on the Place priorities and workstreams. Partnerships with the VCS are essential to the Place Board strategic approach and the programme of work. VCS are valued members and contributors to the Board.

1.1.4 Milton Keynes

The Milton Keynes Health and Care Partnership, which has the statutory functions of the Health and Wellbeing Board and also functions as the Place Board, has agreed with the BLMK Integrated Care Board the "MK Deal". It formalises the commitment of the main local NHS partners in MK and the City Council to work more closely together. The priorities in the MK Deal are:

- **Improving system flow** – with a focus on urgent and emergency care services for older and/or frail and/or complex service users;
- **Tackling Obesity** - which is focused on helping people lose weight and maintain a healthy weight through easily accessible weight management programmes, use of technology, pharmacological therapies and education/prevention work;
- **Children & Young People's Mental Health** – recognising that good mental health in children and young people helps build resilience, develop healthy relationships and lays the foundation for better mental and physical health and wellbeing throughout their whole lives. Early intervention is key for lifelong wellbeing: 75% of adult mental health issues are present by the age of 24; and
- **Complex Care** - is focused on the improving the planning, assessment, commissioning, and case management for people who have the most complex needs (workstream not initiated yet).

Key metrics have been agreed for the three workstreams that have been initiated and progress is reported to the MK Health and Care Partnership Meetings.

1.2 Updates from Health and Wellbeing Board Meetings

1.2.1 Central Bedfordshire Health and Wellbeing Board 18 January 2023

- The Board noted that the initial Health and Care Strategy had been agreed last month at the Integrated Care Partnership meeting and it had been published on the BLMK ICB website;
- National pressures of the result of covid, flu and Strep A were highlighted to the Board;
- The Board, Members of the Council and Health Colleagues discussed the Integrated Health and Care Hubs and the insufficient capital funds to fund the hubs. There was hope that a collaboration

of partners could see the continuation of the Hubs. The ICB's response was that all stakeholders would be receiving a briefing to prevent any further confusion surrounding them;

- The Director of Public Health presented this year's annual report on excess weight and the ambitions in place to address it. The Board agreed the recommendations;
- The final version of the Place Plan was shared with the Board. The intention would be for the Place Plan to be the delivery model of the Health and Wellbeing Strategy; and
- The Board received a presentation on the Leisure Facilities Strategy in Houghton Regis. This covered the strategy's overarching aims to provide new, protect existing, and enhance existing facilities as well as the new leisure centre due to open in Houghton Regis in 18 months to 2 years' time.

1.2.2 Luton Health and Wellbeing Board (HWB) 14 February 2022

- ICB Public Health reported on an application by Lloyds Pharmacy Ltd to close their branch at Bramingham Park Sainsbury's, Quantock Rise and consolidate services at their branch in Marsh Farm Shopping Centre, Luton, which HWB commented on.
- Public Health reported on the draft Luton Tobacco Control Strategy 2023-2028 and received feedback from the HWB for consideration in finalising the strategy. An update on progress was requested in due course.
- The Chief Primary Care Officer and the Head of Cancer Network of the BLMK ICB reported on the work being undertaken to improve prevention and early cancer diagnosis in Luton, which was noted and supported by the HWB. An update on the review of Mount Vernon Cancer Centre services, including some of the challenges facing the services and Luton patients was also provided and noted by the HWB.
- Public Health gave an update on the Luton Sexual Health Needs Assessment commissioned by Luton Council, Public Health and its NHS partners, which HWB commented on and approved.
- A joint report of Luton Council's Corporate Director, Population Wellbeing and the ICB's Chief Primary Care Officer on the Better Care Fund 2023-2024 was presented to the HWB for oversight and to ask for approval of the 2023-2024 allocations for the Better Care Fund and the Improved Better Care Fund, which was given.
- The Luton Director of Public Health gave a presentation on the refresh of the Luton Population Wellbeing draft strategy for discussion and comments. The strategy was well received, particularly the short version and different format in which it was presented. The strategy refresh will strengthen further the direction of work across the Place Board and the other sub boards. An update on progress was requested in 6 months' time.
- A joint report of Luton Director of Adult Social Services and the ICB Chief Primary Care Officer provided the HWB with an oversight of the Adult Social Care Hospital Discharge Grant, the agreed allocations and the Deed of Variation to be added to the Luton S75 Agreement. HWB ratified the approval of the allocations of the grant and the Deed of Variation given by the Chair outside the meeting due to the tight submission deadline to Government in December 2022.
- HWB agreed to receive an update report at its next meeting on 5 April 2023.

1.2.3 Milton Keynes (MK) Health and Care Partnership 22 February 2022

- The Partnership received a report from the Director of Public Health on the stop smoking service and agreed actions to reduce smoking prevalence as partners.
- The Director of Public Health presented her report on tackling excess weight in MK and the partnership had an extensive discussion on the topic and how all partners could support actions on this agenda, the ambitions in the report were endorsed.
- The Integrated Care Partnership (ICP) and ICB report was received, including noting the BLMK Health and Care Strategy and the next steps in planning and other updates on ICB work programmes including the VCSE Memorandum of Understanding, the Health Impacts of the Green Plan and the planned procurement of Muscloskeletal Services.
- The Partnership reviewed progress with the MK Deal and agreed that the priority on Children and Young People's Mental Health should 'go live' on 1 April. The fourth priority on complex care was still being developed and would be considered at the next meeting of the Partnership.

- The proposal to pilot locality/neighbourhood working in one or two areas in MK was supported and the Joint Leadership Team was asked to develop this workstream as a potential firth priority for the MK Deal for the next Partnership meeting.

1.2.4 Bedford Borough Health and Wellbeing Board 15 March 2023

Bedford Borough Health and Wellbeing Board is taking place on 15 March 2023. Papers for the meeting had not been published when this agenda went to print.

1.3 Health and Wellbeing Board guidance 22 November 2022

Non-statutory Health and Wellbeing Board (HWB) guidance was published in November 2022, following a consultation on draft guidance in July and August 2022. Health and wellbeing boards – guidance - GOV.UK (www.gov.uk).

The guidance document is designed to support Integrated Care Board (ICB) and Integrated Care Partnership leaders (in BLMK this is the Health and Care Partnership), local authorities and HWBs to understand how they should work together to an ensure effective system and place-based working.

The Health and Care Act 2022 did not change the statutory duties of Health and Wellbeing Boards as set out by the Health and Social Care Act 2012. It places an expectation that all place-based arrangements will build on and work with existing forums such as HWBs as key existing place-based forums for driving integration.

The following is a summary of key points from the guidance:

Role and purpose of HWBs

- Membership to include member of ICB and should be reviewed following the establishment of ICBs and ICPs.
- Joint Local Health and Wellbeing Strategies (JLHWS) should directly inform joint commissioning, co-ordination of NHS and Local Authority (LA) commissioning, including Better Care Fund (signing off plan and providing governance for fund).
- HWBs remain a committee of the local authority to provide a forum to improve health and wellbeing of local population and look to reduce health inequalities.
- Deliver Joint Strategic Needs Assessment (JSNA) and JLHWS.
- Can be the forum for discussion about strategic and operational co-ordination of commissioned services.
- Pharmaceutical Needs Assessment (PNA) remains a requirement for HWBs.

JLHWS and JSNA

- Local authorities, ICBs and NHS England must have regard to these where relevant to exercising their functions.
- In developing JSNAs, HWBs should involve communities and representative organisations and consider broader issues e.g. disadvantage, vulnerable groups, wider impacts.
- HWBs should consider where there is a lack of evidence and identify research needs which could be met by ICBs, LAs and NHS England as they research (for Local authorities relates to health of children and any other health functions).
- Must consider if the JLHWS needs refreshing when receive the Integrated Care Strategy from the ICP – **action for Health and Wellbeing Boards.**
- HWBs should be 'active participants' in the development of the IC Strategy.
- Integrated Care Strategy should build on JLHWSs and identify where needs could be better met at system level; and should identify learning from across the system to drive innovation and improvement.
- JSNAs should be digitised and accessibility improved for a range of users.

Changes

- HWBs, ICBs, ICPs and other place-based partnerships work together to determine the integrated approach to delivering streamlined care and prevention work, including action on wider determinants (building on local work).
- Local authorities and ICBs to jointly establish an ICP (statutory joint committee). In BLMK this is the Health and Care Partnership.

All partners HWBs, ICBs and ICPs to adopt a set of principles in developing relationships, including:

- building from the bottom up;
- following the principles of subsidiarity;
- having clear governance, with clarity at all times on which statutory duties are being discharged;
- ensuring that leadership is collaborative;
- avoiding duplication of existing governance mechanisms; and
- being led by a focus on population health and health inequalities.

These principles are not currently in the Health and Care Partnership Terms of Reference (TOR) but will be included when the TORs are next reviewed.

Care Quality Commission (CQC) inspections of Integrated Care Systems will assess provision of NHS care, Public Health and Adult Social Care within the area including:

- How well the ICB, Local authority and CQC-registered providers discharge their care functions;
- How the system works as a whole, including the role of the ICP; and
- The CQC is required to publish a report, providing an independent assessment of the health and care in integrated care systems.

Integrated care strategy:

- HWBs are required to consider revising their JLHWS following the development of the integrated care strategy for their area but are not required to make changes.
- Expectation that HWBs and ICPs work collaboratively and iteratively in the preparation of the system-wide integrated care strategy.
- ICPs to ensure collective input to their strategic priorities, and that sufficient time is provided for this.
- ICPs should use the insight and data held by HWBs in developing the integrated care strategy.

The Health and Care Strategy was agreed by the Health and Care Partnership in December 2022 and was informed by the Health and Wellbeing strategies and Place priorities. The strategy can be found BLMK ICP Strategy (blmkhealthandcarepartnership.org)

ICB:

- The ICB has a duty to share with HWBs, the ICB and NHS Trust and Foundation Trusts their joint capital resource plan outlining their planned capital resource use. This will provide an opportunity to align local priorities and provide consistency with strategic aims and plans**. Action: ICB once capital resource plan is agreed.**

Before the start of each financial year, an ICB and its NHS partners must prepare a joint forward plan (5-year):

- Must set out any steps on how the ICB proposes to implement any JLHWS;
- The HWB must be involved in the preparation or revision of plans and provided with a draft and asked whether it takes account of the JLHWS;
- The HWB has a right to respond to the ICB and may share its opinion with NHS England;

- The plan must include a statement from the HWB about whether the JLHWS has been taken into proper account;
- ICB must consult each relevant HWB as part of their annual review; and
- NHS England must consult each relevant HWB for their views on the ICB's contribution to the delivery of the JLHWS.

The Joint Forward Plan is being built from Place Plans and the Health and Wellbeing Boards (Place Boards) are being involved in the development of it.

Opportunities

- The Local Government Association has revised its support offer to HWB chairs and other lead members focusing on the implications of integrated care systems

2. Summary of key points:

2.1 The four Places in BLMK - Bedford Borough, Central Bedfordshire, Luton and Milton Keynes - have been developing and agreeing the local priorities to work collectively on. Each Place is at different stages of developing action plans for each of the priority areas identified to improve the health and wellbeing of their local residents.

2.2 A summary of discussion from the Health and Wellbeing Boards of Central Bedfordshire, Luton and Milton Keynes is included in the report. Bedford Borough Health and Wellbeing Board is not meeting until 15 March and a summary of discussion will be presented to the next meeting.

2.3 The Health and Wellbeing Board non statutory guidance was published on 22 November 2022. Health and wellbeing boards – guidance - GOV.UK (www.gov.uk). It highlights the new ways of working including that of the ICB and Health and Wellbeing Boards with requirements to consult HWB on the Integrated Care Strategy and share ICB and NHS Trust joint capital plans providing an opportunity to align local strategic aims and plans.

3. Are there any options?

Not applicable

4. Key Risks and Issues

None identified as a result of this report.

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?

None

6. How will / does this work help to address the Green Plan Commitments?

Click to view Green Plan

None

7. How will / does this work help to address inequalities?
Place plan priorities aim to tackle inequalities in the local area.
8. Next steps:
ICB to consider implications of Health and Wellbeing Board guidance
9. Appendices
10. Background reading
None

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to Board of the Integrated Care Board (ICB)
18. Quality and Performance 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	Sarah Stanley - Chief Nurse, Maria Laffan - Deputy Chief Nurse, Maria Wogan, Chief of System Assurance and Corporate Services, Anne Brierley – Chief Transformation Officer
Date to which the information this report is based on was accurate	Latest available national data, predominantly January 2023
Senior Responsible Owner	Sarah Stanley, Chief Nurse and Maria Wogan, Chief of System Assurance and Corporate Services

The following individuals were consulted and involved in the development of this report:
Members of the Performance & Delivery Group. Future reporting in development via the Improving Performance Reporting Task & Finish Group which had its first meeting in February.
This report has been presented to the following board/committee/group:
Quality & Performance Committee, 3rd March 2023

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

The members are asked to:

A) **Note** the ongoing development around performance and quality reporting;

B) **Note** and discuss the areas of improvement and concern raised within the report including the impact of industrial action on elective performance and in particular the 78 week wait target; and

C) **Agree** any additional actions required to manage risk in the system.

1. Brief background / introduction:

A Task and Finish Group has been established to improve how we prioritise and present quality and performance data to the Board, its Committees and system groups. The Board will receive an update on this work and an improved performance and quality report at its next meeting.

This paper summarises key areas of quality and performance across the Bedfordshire, Luton and Milton Keynes (BLMK) system. The focus is on areas of impact to residents/patients and outcomes, safety, safeguarding and experience. Regular performance and quality reports are presented to the ICB Executive Team, the System Performance and Delivery Group and System Oversight and Assurance Group.

2. Summary of key points:

Positive developments since the last report

- Appointments in primary care are 7.35% higher than pre-pandemic with 79% delivered face to face compared with the England average of 68.3%. 44.89% of appointments were booked and delivered on the same day compared to the England average of 48.09%.
- The Evergreen 8 bedded CAMHS unit opened in Luton in February. The new inpatient unit is providing specialist short-term care for ages 13-17 with severe or complex mental health difficulties. The initial focus will be on repatriation of children and young people who are currently placed out of area. The provision has been co-produced with children and young people and the young people will be coming to talk to the Board at a future meeting. Further capacity is still needed across BLMK to meet demand, however Home Treatment Teams are having a positive impact with joint working between the acute Trusts and specialist mental health crisis teams to reduce admission of children and young people in crisis, with 39 emergency mental health admissions in Q3 compared to 60 in Q2.
- Patient Safety Incident response framework implementation is on track.
- Review of Patient Experience on Mental Health Wards - BLMK Quality teams are working closely with main providers East London Foundation Trust (ELFT) and Central & North West London Foundation Trust (CNWL) on establishing a position of assurance regarding safety on inpatient wards. A patient safety leadership and culture shift ambition is clearly a priority for main organisations to support this ongoing assurance piece. A task and finish group is in development for wider areas of provision where people may be placed in other inpatient service including patients under Section117. This is a large piece of work across BLMK and will be updated on a quarterly basis.

Areas of concern/risk:

- Operational pressures and impact on residents – Industrial action has had a significant impact of management capacity across the system and this is impacting quality and performance. The Junior Doctors' industrial action on 13-16 March has had a significant impact and an update on this will be given at the Board meeting.
- Elective waiting list – this report provides a summary of the current position on the elective waiting list for our residents and describes the actions being taken to mitigate harm and delays for residents. The

specialities where residents are waiting the longest are Ophthalmology, Ear, Nose and Throat and Other Medical Services. This area of performance will also be impacted by the Junior Doctors' Industrial Action and in particular will impact the planned reduction to zero of residents waiting 78 weeks or over by the end of March. An update on the position will be provided at the Board meeting.

- NHS 111 - GP Out of Hours Capacity in Bedfordshire and Luton service (HUC). Risk of inadequate provision to meet patient need which may result in inappropriate use of urgent and emergency services or patients failing to seek help.
- Adult Mental Health Admissions - unprecedented levels of people in crisis requiring inpatient stays, lack of move-on accommodation resulting in extended lengths of stay
- Dementia Diagnosis Rate – The ICB is below the planned target levels of 66.02% by end of Q3 with 63.6% in January, predominantly due to a lower rate in Central Bedfordshire of 58.4%. A new specialist dementia diagnosis service for care home residents is being set up by ELFT in Central Bedfordshire as part of a national NHS pilot.
- CQC Maternity Survey – Milton Keynes University Hospital (MKUH) were named as an outlier Trust for the second year in a row in the February 2022 survey results published in January 2023, with worse than expected results. The Quality & Safety meeting will explore with the Trust responses to the results and through a quality improvement lens, look at how the Local Maternity and Neonatal System (LMNS) can support to deliver an improved position in the next survey results. Care Quality Commission (CQC) visited MKUH on 8 and 9 March.
- Severe & Enduring Eating Disorder residential service in Luton Vivre Care – challenge from placing commissioners on ongoing urgent /community support. This is a specialist service (may even be one of a kind nationally) for real tip of peak of complex eating disorder patients – and therefore pathway on responsible clinicians form placing commissioner and model of care delivery to support urgent need (mental health psychology dietetics urgent care) to be worked up. - Current discussions with Kent & Medway regarding 2 complex patients currently placed.

3. Are there any options?

As described in relation to individual items in the paper.

4. Key Risks and Issues

Key risks are included within the report.

Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☒	No ☐

Risks are identified and included on the Board Assurance Framework. The primary risks that relate to this report are as follows:
BAF 1 – Recovery of Elective & Cancer Services – Current risk rating 16
BAF 3 - System Pressures and Resilience – Current risk rating 20

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

There are no specific links to the green plan in this paper. Reporting on performance against the green plan is commencing and will be included in future performance reports.

7. How will / does this work help to address inequalities?

Inequalities will be considered in all aspects of transformational work as a part of the quality agenda, considering if communities are affected adversely using the Equalities Impact Assessment Process.
8. Next steps:
Ongoing work with the Improving Performance Reporting Task & Finish Group
9. Appendices
10. Background reading

1. Managing Urgent and Emergency Care & Planning for Next Winter

We continue to see challenged performance in meeting urgent and emergency care standards, access and quality. Partner organisations across health and care in both the Bedfordshire and MK areas have worked well together to manage the unprecedented demand and acuity levels and to mitigate the risk of patient harm. Our population is experiencing long waits to access emergency care both in our emergency departments and ambulance response times. A&E attendances in January increased by 7.4% on the same time in 2020.

Hospitals have been operating with high levels of bed occupancy (95.8% in December and January and 96.2% in February) and the pressure on hospitals has seen ambulance handover delays. For Bedfordshire Hospitals Trust, the Luton and Dunstable's performance is impacted by diverts from other areas, 'Intelligent Conveyancing' and on occasion, batching of ambulances and Bedford Hospital's performance is linked to challenge around discharge and flow. As an ICB we are reviewing areas of patient harm across our system. Where it is evident that there are other areas of potential impact/harm (e.g. delay in care due ambulance delay/offload) we are planning system review panels to ensure shared system wide learning and areas for improvement.

SYSTEM PRESSURE INDICATORS

Unless otherwise stated, the previous position is for the previous week to the latest data period

	Latest Data Period	Bedford Hospital South Wing			Luton & Dunstable Hospital			Milton Keynes Hospital		
		Same time last week	Latest		Same time last week	Latest		Same time last week	Latest	
Adult G&A Bed Occupancy - system ambition 92%	w/e 05-Mar 7 day avg	97.0%	**98.0%**	⇩	97.1%	**97.3%**	⇩	99.5%	**95.5%**	⇧
Patients with no criteria to reside with LoS 7+ Days - local ambition 22%	w/e 05-Mar 7 day avg	57.5%	**59.3%**	⇩	Figures to the left relate to Bedfordshire Hospitals NHS			35.6%	**35.7%**	⇩
% Beds Occupied by patients with no criteria to reside and LoS 7+ Days - local ambition 22%	w/e 05-Mar 7 day avg	18.73%	**18.79%**	⇩				8.72%	**9.00%**	⇩

		EEAST - Bedfordshire & Luton						SCAS - Milton Keynes		
		Bedford Hospital South Wing			Luton & Dunstable Hospital			Milton Keynes Hospital		
		Same time last week	Latest		Same time last week	Latest		Same time last week	Latest	
Ambulance Hours Lost to Handover delays (after first 15 minutes) (h:mm:ss)	w/e 05-Mar 7 day avg	2:26:20	**6:55:22**	⇩	16:17:29	**20:46:48**	⇩	4:34:26	**5:18:13**	⇩
Ambulance Mean 999 Call Answering Time (seconds) - ambition 10 seconds	w/e 05-Mar 7 day avg	0:04	**0:01**	⇧	Figures to the left relate to the Bedfordshire & Luton System			0:36	**0:36**	⇧
Ambulance - Category 2 Mean Response Time (mm:ss) - ambition 18 minutes	w/e 05-Mar 7 day avg	32:28	**35:49**	⇩				22:04	**23:17**	⇩

		HUC - Bedfordshire & Luton			DHU - Milton Keynes		
		Same time last week	Latest		Same time last week	Latest	
NHS 111 Call Abandonment Rate - local ambition 3%	w/e 05-Mar 7 day avg	12.66%	**12.46%**	⇧	9.20%	**4.02%**	⇧

Key:

Achieving ambition		Within 5% of ambition		More than 5% from ambition	

Key mitigating actions have included admission avoidance schemes, virtual wards, the maximum use of escalation beds in all three hospital trusts which has had an impact on elective activity and patient experience. The impact is more severe in the Bedfordshire system which relies more heavily on elective capacity such as catheterisation labs and endoscopy for escalation space than MKUH which has been able to maintain more elective activity due to the opening of the Maple Unit Same Day Emergency Care unit.

An additional £3.2M funding for BLMK winter operational pressures was announced by the Government on 9 January 2023. This has been allocated to fund additional care at home and intermediate care beds, retention payments to domiciliary care staff, additional mental health acute inpatient capacity and additional therapy capacity.

The MK and Bedfordshire teams are both working to develop winter plans by the end of March to utilise the UEC funding that has been allocated to the UEC recovery plan. The plans include:

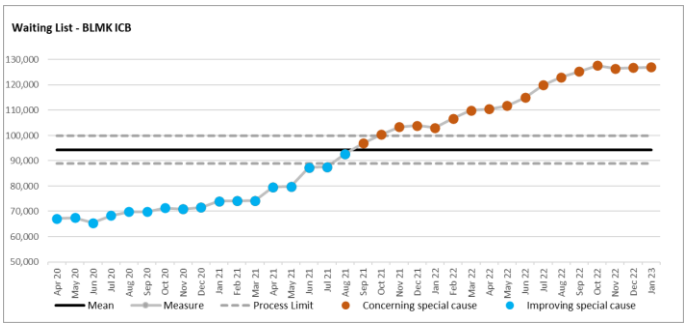
- expand Urgent Community Response, Same Day Emergency Care (SDEC) and virtual ward provision to manage all frailty patients at home who have sub-acute illness;
- increase the established bed capacity at BHT and MKUH (2 additional wards required in each Trust) – this will help to mitigate the impact on elective capacity and improve patient experience ;
- work with wider partners to build up the domiciliary care workforce;
- continuously improve our support for care homes, including expanding rehabilitation and nursing support to care homes for post-acute patients;
- implement the Fuller neighbourhood approach and support primary care in terms of funding, estates and workforce to provide care outside hospital;
- increase our investment in prevention and fully utilise the skills of the voluntary sector to help people stay well at home by tackling the two major determinants of poor health in the elderly (isolation and deconditioning); and
- continue to strengthen place-based working and support the Bedfordshire Care Alliance to integrate services and reduce fragmentation.

The Quality and Performance Committee received a report on the lessons learned from this winter at its meeting on 3rd March and agreed that the necessary actions were being taken to develop a more resilient position for next winter.

2. Elective Care – Reduction of Waiting Times for People

The use of elective capacity to manage system pressures over winter has had an impact on elective performance and prior to these pressures there were some specialities that were particularly challenged in terms of waiting times.

In January there were 126,999 BLMK patients on an Referral to Treatment Time (RTT) waiting list. 73,564 were at Bedfordshire Hospitals, 32,460 at Milton Keynes Hospital and 2,247 at local independent sector providers (Blakelands Hospital, Manor Hospital, Saxon Clinic and SpaMedica Bedford). The top 3 specialties with the highest waiting list are Ophthalmology (17,474), ENT (12,381) and Other Medical Services (11,515). For future reporting the aim is to split the waiting list by adults and children to give a better focus on different age groups.



There has been a 104+ week wait breach at Milton Keynes Hospital in January. The patient was added to the Trauma and Orthopaedics waiting list in 2020 but due to pathway mapping and technical issues this long wait has only come to light. The patient was treated on 11th February. There were a further 4 people waiting more than 104 weeks for treatment at the end of January on Paediatrics Services pathways – 2 at Central North West London (community services provider for Milton Keynes), 1 at Great Ormond Street and 1 at Guy's and St Thomas'.

At the end of January there were 443 people waiting more than 78 weeks for treatment. The top 3 specialties are Ophthalmology (119), Other Medical Services (102) and Trauma and Orthopaedics (89). The ICB and acute provider trusts are required to reduce the number of 78 week waits to zero by 31st March 2023. The 72-hour industrial action by junior doctors is having a significant impact on the planning of care for these long waiters and has put this ambition at risk. The ICB is working closely with both

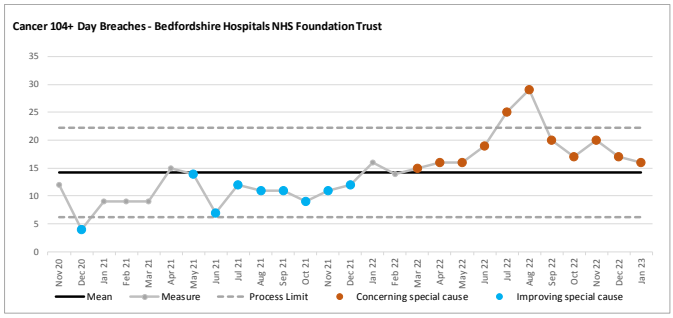
Trusts to address the impact of non-elective pressures on this target, with weekly oversight and assurance processes in place and further initiatives being implemented.

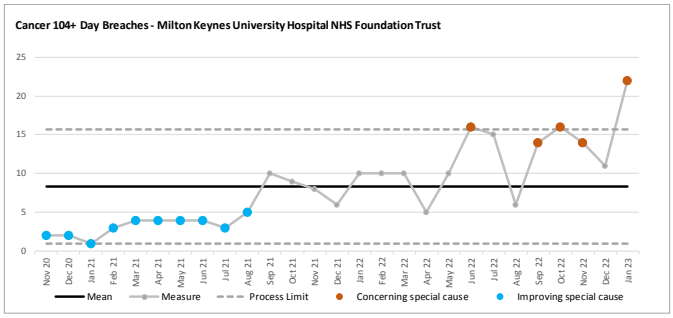
Ophthalmology continues to be the specialty with the highest number of 78+ week waiters with a low % of "To Come In" (TCI – patients due) bookings. As Ophthalmology is less sensitive to non-elective pressures, there is confidence that these patients will be treated by the end of March with additional capacity from the Independent Sector being mobilised in February and March. A longer-term system ophthalmology strategy is being developed ahead of a Getting It Right First Time (GIRFT) deep dive in March and Ophthalmology will be a system priority in 2023/24. The Quality and Performance Committee received a detailed report on the plan for recovering the Ophthalmology position and supported the proposed approach.

Cancer Recovery - The 63-day backlog position deteriorated regionally and nationally over December, and whilst some areas are improving, Bedfordshire Hospitals Foundation Trust (BHFT) have been slower to regain their position against plan.

In January long wait of 104+ days on the 62-day Standard Pathway increased to 43 from 25 in December. Detailed analysis and harm reviews are carried out, and themes are discussed at both Trust Cancer Manager meetings and Board meetings.

Histopathology continues to be one of the most challenging pathways due to capacity and workforce and supporting actions are in place to address these including establishing priority bookings and escalation meetings. In addition, the ICB and Providers are in discussion with the Cancer alliance around additional funding to support histopathology capacity.





Data sources: Weekly Cancer PTL and NHS Digital Cancer Waiting Times Reports

Serious Incidents and patient experience continue to be monitored to ensure that patient safety is considered as a part of our recovery efforts. Progress continues to be made, governance and oversight of performance continues with strong system engagement through the ICS Cancer Board.

Diagnostics - Community Diagnostic Centres (CDC) will help to achieve earlier diagnosis for patients through more direct access to a range of diagnostic tests. The following CDC centres have been approved by the Department of Health and Social Care; North Bedfordshire CDC Hub (Gilbert Hitchcock House), Milton Keynes CDC Spoke (Lloyds Court), Milton Keynes CDC Spoke (Whitehouse Health Centre). The CDC Approval Panel did not approve the proposal for a CDC within Luton on the basis that an exact site location had not been confirmed. A short window opportunity to resubmit an isolated business case covering the Luton CDC is open and work is in progress to address this.

3. System Oversight Framework

The ICB is rated as Single Oversight Framework (SOF) 2 (on a development journey but demonstrates many of the characteristics of an effective ICB).

The table below shows the latest position on our SOF metrics as at 23rd January.

	BLMK ICB	Bedfordshire Hospitals NHS Foundation Trust	Milton Keynes University Hospital NHS Foundation Trust
Total Indicators	73	36	39
Current Ranking			
Highest Quartile	16	9	20
Inter Quartile Range	43	20	12
Lowest Quartile	14	7	7
Changes since last month			
Improvement	23	11	11
No Change	33	18	20
Deterioration	17	7	8

The ICB is working with the regional team to further understand the data driving poor performance in order to develop appropriate improvement plans as a system. The recent improved ICB staff survey results should see an improvement in those SOF indicators.

Indicators where the ICB is ranked in the highest quartile

Aggregation Source	Indicator	Quartile range
ICB	S001a Number of general practice appointments per 10,000 weighted patients	1/42
ICB	S007a Total elective activity undertaken compared with 2019/20 baseline	6/42
Provider	S009c RTT Waiting lists - Total patients waiting more than 104 weeks to start consultant led treatment	1/41
Sub ICB	S009c RTT Waiting lists - Total patients waiting more than 104 weeks to start consultant led treatment	4/42
ICB	S010a Cancer - Total patients treated for cancer compared with the same point in 2019/20	11/42
Provider	S013b Diagnostic activity levels: Physiological measurement	1/42
Sub ICB	S013b Diagnostic activity levels: Physiological measurement	1/42
Provider	S013d Diagnostic Activity Levels - Total	10/42
ICB	S032a Personal Health Budgets	5/42
Sub ICB	S053a % of atrial fibrillation patients with a record of a CHA2DS2-VASc score of 2 or more who are treated with anticoagulation drug therapy	4/42
ICB	S068a Sickness absence rate	8/42
ICB	S74a FTE doctors in General Practice per 10,000 weighted patients	1/42
ICB	S081a Access rate for IAPT Services	3/42
ICB	S084a Number of children and young people accessing mental health services as a % of population	6/42
ICB	S085a Proportion of people with severe mental health illness receiving a full annual physical health check and follow up interventions	10/42
ICB	S107a Percentage of 2-hour Community Response referrals where care was provided within two hours	3/42

Indicators where the ICB is ranked in the lowest quartile

Aggregation Source	Indicator	Quartile range
ICB	S037a Percentage of patients describing their overall experience of making a GP appointment as good	42/42
Provider	S041a Clostridium difficile infection rate	40/42
Sub ICB	S041a Clostridium difficile infection rate	31/36
Provider	S042a E Coli Blood stream infection rate	42/42
Sub ICB	S042a E Coli Blood stream infection rate	34/36
Sub ICB	S047a Proportion of people over 65 receiving a seasonal flu vaccination	35/42
Sub ICB	S050a Cancer – cervical screening coverage: % females aged 25-64 attending screening within the target period	34/42
ICB	S051a Number of people supported through the NHS diabetes prevention programme as a proportion of patients profiled	37/42
Sub ICB	S053b % of hypertension patients who are treated to target as per NICE guidelines	37/42
Sub ICB	S055a Number of GP referrals to NHS digital weight management services per 100k head of population	35/42
ICB	S60a Aggregate score for NHS staff survey questions that measure perception of leadership culture	35/42
ICB	S63c Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public	35/42
ICB	S067a Leaver rate	32/41
ICB	S101a Outpatient follow up activity levels compared with 2019/20 baseline	39/42

4. Quality, Safety and Performance Exception Reports

Serious Incidents (SIs) - 18 SIs reported in December, one of which was a Never Event. This is a slight decrease on the usually reported number of SIs per month but a known end of year trend. 9 SIs, one of which was a Never Event, were reported at Bedfordshire Hospitals, 2 at Milton Keynes Hospital, 2 at East London Foundation Trust and 4 at other providers.

Safeguarding - Children in Care Initial Health Assessment (HIS) and Review Health Assessment (RHA) performance especially for Children placed into area continues to be a challenge, although slowly improving. The ICB is taking part in a national dataset pilot and will review the current data collection dashboard as part of this process. Three GP colleagues in Bedfordshire agreed to conduct assessments with additional GPs to be recruited across Milton Keynes. Review of Domestic Abuse Champions network commenced. Pilot project of face-to-face visits to support GPs in Luton - to be reviewed and rolled out MK and rest of Bedfordshire. There are system pressures with the arrival of 1270 refugees.

South Central Ambulance Service (SCAS) - CQC Inadequate rating - The CQC published an Inspection Report in August following an inspection in May. Key concerns around safety and leadership (Safe and well led) which were rated inadequate. The inspection focussed on core service and the Emergency Operations Centre (EOC) provision with particular attention to performance, triage, safety, safeguarding and staff support/freedom to speak up.

SCAS provides ambulance services to the Milton Keynes population. As host commissioner Hampshire, Southampton & Isle of Wight ICB are overseeing the improvement plan, working closely with SCAS as well as Buckinghamshire Oxfordshire & Berkshire West (BOB) and Frimley ICBs on performance recovery. Tripartite Provider Assurance Meetings are held monthly. The latest meeting confirmed that a new Chief Executive Officer will be in place from 6th March and has already commenced reviewing the SCAS Executive Team portfolio. Non-executive board members have reached a level of confidence in the internal oversight mechanisms and the teams in place to deliver improvements. SCAS's main risk to the improvement plan is balancing the resource required to manage increased operational pressure which draws resource away from progressing/delivering the improvement plan.

Mental Health Crisis Admissions: Mental health services have seen unprecedented levels of people in crisis requiring inpatient stays. The lack of move-on accommodation is an impacting factor that contributes to extended lengths of stay in inpatient units. Work is ongoing around Alternatives for Admission with plans to expand existing provision across BLMK being developed for 2023/24. Crisis café provision is in place across the system however footfall in Bedfordshire and Luton has not been as high as in Milton Keynes as the services are not as integrated into the crisis pathway as in Milton Keynes. Adult Crisis Café provision is being expanded in Central Bedfordshire and young peoples' sanctuaries are being mobilised in Luton and Bedford. A review of crisis services will be undertaken to consider further alternatives to crisis, improved crisis planning and prevention.

Mental Health Nurses are embedded into both Ambulance service control rooms and help triage mental health calls in the control room and support ambulance crews on the ground. We do not have specific data from SCAS or EEAST. The same applies to the Street Triage service with Thames Valley police.

Tier 4 provision CAMHS (Children and Adolescent Mental Health Services) - The new 8-bed inpatient unit in Luton opened in February and is providing specialist short-term care for ages 13-17 with severe or complex mental health difficulties. The initial focus will be on repatriation of children and young people who are currently placed out of area.

Further capacity is still needed across BLMK to meet demand, however Home Treatment Teams are having a positive impact with joint working between the acute Trusts and specialist mental health crisis teams to reduce admission of children and young people in crisis, with 39 emergency mental health admissions in Q3 compared to 60 in Q2.

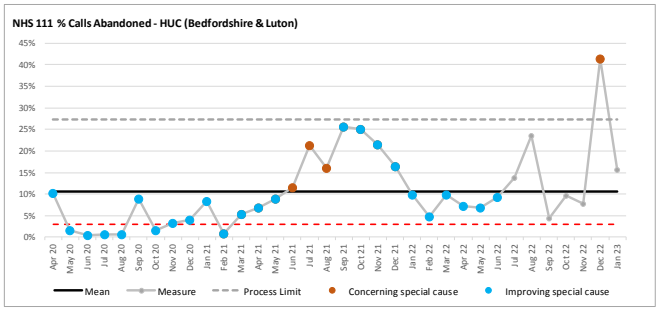
The BLMK Children & Young People (CYP) Clinical Reference Group continues to focus on access to mental health services for children and young people and management of 16–18-year-olds requiring admission to acute settings. Mental Health support teams across BLMK have been expanded and there is focus on increasing the number of Senior Mental Health Leads in schools and colleges.

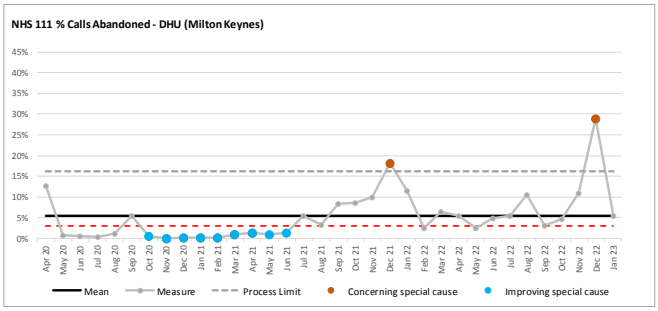
Maternity and Neonatal Services - Progress continues re compliance with the immediate and essential actions from the Ockenden reports. Workforce remains the priority issue in maternity services. Midwifery

workforce remains a risk and this is being mitigated by a number of interventions, including international recruitment which is having a positive impact on vacancy rates at BHFT. Extra support is required for these teams as they begin to commence in post which creates some further pressure on existing practice development midwifery teams.

The CQC maternity survey results February 2022 were published at the end of January and looked at the experiences of women and other pregnant people who had a live birth in early 2022. MKUH were named as an outlier Trust for the second year in a row with worse than expected results. The February Quality & Safety meeting will explore the Trust responses to the results and through a quality improvement lens, look at how the LMNS can support to deliver an improved position in the next survey results. CQC undertook an inspection of MKUH maternity services in the week commencing 6 March 2023.

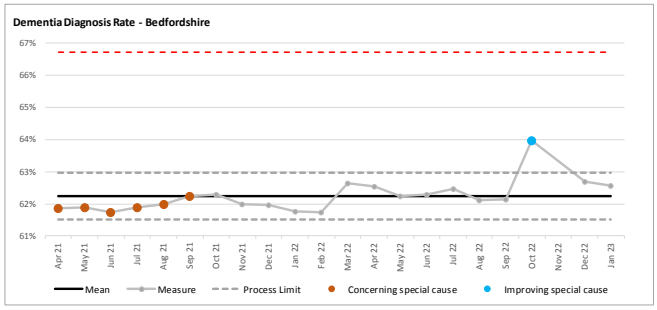
NHS 111 – Abandoned Calls - Local provider data shows that call volumes have now stabilised following a peak in December due to Strep A cases. There is a national ambition for no more than 3% abandonment rate and during February Bedfordshire and Luton had an average of 14% and Milton Keynes 6%. Herts Urgent Care (HUC) - Bedfordshire and Luton service continue to have a challenge around filling GP rotas for the Out Of Hours (OOH) shifts. There is an identified risk of inadequate provision to meet patient need which may result in inappropriate use of urgent and emergency services or patients failing to seek help. HUC have been proactively working to improve relationships with local GPs and there is a programme of actions being progressed to address the root causes of lack of GPs signing up to shifts. Issues identified include personal safety concerns amongst GPs regarding working out of the Luton town centre GP OOH base.

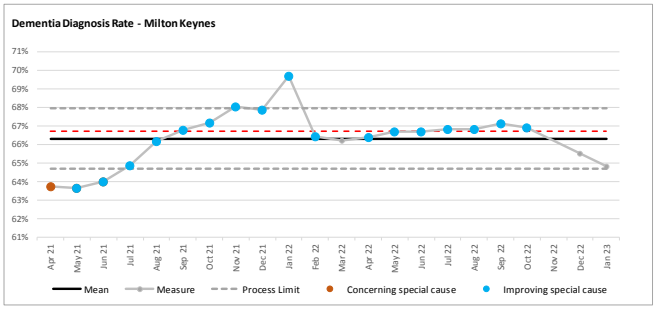




Data source: Integrated Urgent Care Aggregate Data Collection (NHS Statistics)

Dementia Diagnosis - The ICB is below the planned target levels of 66.02% by end of Q3 with 63.6% in January, predominantly due to a lower rate in Central Bedfordshire of 58.4%. A clinician from the DiADeM (Diagnosing Advanced Dementia Mandate) project has been visiting care homes and GP practices in Central Beds to promote the project, aimed at supporting GPs in diagnosing people living with advanced dementia in a care home setting. Referrals are now flowing through and diagnoses being made, with positive feedback.

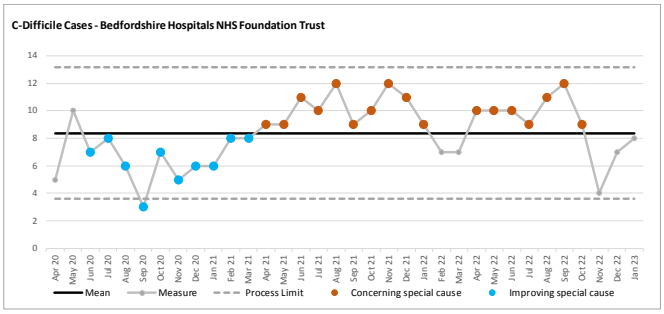


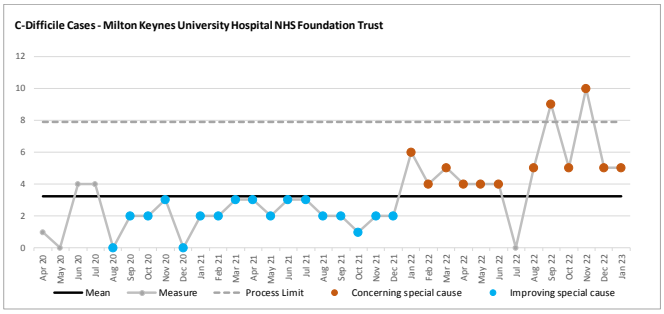


Data source: NHS Digital Primary Care Dementia Data

Infection Prevention and Control - Three ward closures occurred at Bedfordshire Hospitals NHS Foundation Trust in January due to Norovirus and Covid-19. Outbreaks ended and wards re-opened to admissions. National data shows 12 cases of C.difficile were reported for the ICB in January against a ceiling of 12 of which 3 were community associated, 8 were healthcare associated and 1 was unknown, giving a YTD total of 154. Bedfordshire Hospitals Trust - 8 cases of C.difficile were reported by the Trust in January against a ceiling of 5 of which 6 were healthcare associated and 2 were community associated giving a YTD total of 90. Milton Keynes Hospital Trust - 5 cases of C.difficile were reported by the Trust

in January against a ceiling of 1 of which 4 were healthcare associated and 1 was unknown giving a YTD total of 51. There were 2 new cases of MRSA reported for the ICB, giving a YTD total of 20.





Data Source: C Difficile and MRSA – Public Health England

Covid-19 Infections - In the 7 days to 8th March the number of new cases was 275, which is a 24% decrease over the last 4 weeks and a 10% decrease on the previous 7 days.

Mass Vaccinations – between 1st September 2022 and 12th February 2023, more than 245,000 Covid-19 Autumn Booster vaccinations were delivered to residents of BLMK, which represents 90.97% of the expected uptake. The 2022 Autumn Booster campaign ended on 12th February however the evergreen offer will continue as per the published guidelines and a Spring Booster campaign has been announced. ICBs are being asked to develop plans to deliver booster vaccinations between 3rd April and 30th June 2023 with care home residents being vaccinated in the first two weeks. Adults aged 75 and over and individuals aged 5 years and over who are immunosuppressed will be offered the Spring Booster from 17th April. It is also anticipated that an Autumn Booster will be offered from September 2023.

As of 13th February, 89.94% of the expected population had received a flu vaccination. The flu vaccination programme is not impacted by any changes to the Covid programme.

Month 10 – BLMK Performance Summary Report

Area	BLMK ICB	Threshold	Frequency	Latest Data	Achievement	Trend	YTD	Ranking	Regional Average (ICB position vs region)	What does good look like
Elective Recovery	RTT - % Patients Waiting 18 Weeks or less	92%	M	Jan-23	54.18%	⇩	●	5 / 6	55.47%	High is good
	RTT - Number of 104+ Week Waits	n/a	M	Jan-23	5	⇩		2 / 6	9.83	Low is good
	RTT - Number of 78+ Week Waits	n/a	M	Jan-23	443	⇧		1 / 6	785	Low is good
	RTT - Number of 52+ Week Waits	n/a	M	Jan-23	6,992	⇧		3 / 6	8,516	Low is good
	Diagnostics Tests - 6 Week Waits	≥1%	M	Jan-23	32.00%	⇧	●	2 / 6	34.76%	Low is good
Cancer Care	Cancer -2 Week Waits Standard	93%	M	Jan-23	85.72%	⇧	●	2 / 6	75.92%	High is good
	Cancer - 28 Day Faster Diagnosis Standard	75%	M	Jan-23	67.82%	⇩	●	2 / 6	63.92%	High is good
	Cancer - 62 Day GP Referral	85%	M	Jan-23	51.29%	⇩	●	4 / 6	53.07%	High is good
	Cancer - 104+ day waits	0	M	Jan-23	43	⇩	●			Low is good
Urgent Emergency Care	Ambulance - 30 minute Handover Delays (Daily Average)	n/a	M	Feb-23	10.14	⇧				Low is good
	% ED Attendances that result in emergency admission	n/a	M	Feb-23	27.40%	⇧			27.64%	High is good
Primary Care	Appointments in GP Practice - % Face to Face	75%	M	Jan-23	80.32%	⇧	●	1 / 6	73.49%	High is good
Adult Mental Health	72-Hour Follow Ups	80%	M	Dec-23	78.00%	⇩	●			High is good
	SMI Healthchecks	Q3: 4800	Q	Q3 2022/23	4,731	⇧	●			High is good
	Dementia Diagnosis Rate	Q4: 66.61%	M	Jan-23	63.60%	⇩	●	1 / 6	59.64%	High is good
	IAPT Access	Q4: 2331	M	Jan-23	1,510	⇩	●			High is good
	IAPT Moving to Recovery	50%	M	Dec-22	49.67%	⇧	●			High is good
	Early Intervention in Psychosis (EIP)	60%	M	Dec-22	83%	⇧	●			High is good
	Inappropriate Out Of Area Bed Days	Q3: 34	Q	Q3 2022/23	935	⇩				Low is good
Learning Disability & Autism	Learning Disability Healthchecks	Q4: 30.93%	M	Jan-23	49.81%	⇧	●			High is good
Children and Young People (CYP) & Maternity	Number of CYP accessing mental health services	Q3: 16,425	M	Dec-22	17,335	⇩	●			High is good
	CYP Eating Disorders - Routine	95%	Q	Q3 2022/23	82.08%	⇩	●	2 / 6	76.05%	High is good
	CYP Eating Disorders - Urgent	95%	Q	Q3 2022/23	75.00%	⇩	●	3 / 6	76.77%	High is good
	Perinatal Mental Health Access	Q4: 1279	M	Jan-23	900	⇧	●			High is good
Community Services	Children's Wheelchairs - % received in 18 weeks	Q3: 75.63%	Q	Q3 2022/23	61.40%	⇩	●			High is good
Quality & Safety	Serious Incidents	0	M	Dec-22	18	⇧				Low is good
	Infection Control - C-Difficile	12	M	Jan-23	12	⇧	●	4 / 6	8.79	Low is good
	Infection Control - MRSA	0	M	Jan-23	2	⇩	●	5 / 6	0.57	Low is good

Key	
Trend Arrows	
⇧	Improving
⇩	Deteriorating
⇔	No change
Achievement RAG	
	On Track
	Off Track
YTD	
●	YTD On Track
●	YTD Off Track
Regional RAG	
	ICS vs Regional Average
	ICS vs Regional Average

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Board of the Integrated Care Board
19, Finance Report January 2023 (Month 10)

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 ☐			

What are the members being asked to do?		
Approve ☐	Note ☒	Discuss ☐

Report Author	Finance Department
Date to which the information this report is based on was accurate	24/02/2022
Senior Responsible Owner	Dean Westcott, Chief Finance Officer

Executive summary
This paper sets out the 2022/23 BLMK ICS financial position at month 10 (January 2023) for revenue and capital spend. NHS organisations hosted within the system are reporting a £0.6m surplus against plan for Income & Expenditure at Month 10; the forecast remains delivery of a breakeven position. System efficiency plans are on plan and forecast to deliver slightly higher than the planned £55.6m by the end of the year. There remains a risk that the level of non-recurrent savings, which is forecast at 27% of all savings, will give rise to a problem going into 2023/24.
What are the available options?
Not applicable
Recommendation/s
The Board is asked to **note** the following: 1) the month 10 and forecast position for revenue and capital 2) the risks to the financial forecast
Key Risks and Issues
The key risks to delivering the 2022/23 financial plan now appear to be mitigated and there is a level of confidence that the breakeven position will be achieved by all intra-ICS partners.

Have you recorded the risk/s on the Risk Management system?	Yes ☒	No ☐

Are there any financial implications or other resourcing implications?
The paper presents the financial position of the BLMK ICB, intra system NHS partners and a summary commentary of the position of local authorities.
How will / does this work help to address the Green Plan Commitments? Click to view Green Plan
How will / does this work help to address inequalities?
The finance plan reflects operational plans that include a focus on addressing inequalities.
The following individuals were consulted and involved in the development of this report:

BLMK Directors of Finance
Next steps:
Appendices
Appendix A – Local Authority Financial Position Update

1.0 Introduction

1.1 The purpose of this paper is to report the Integrated Care System (ICS) financial position at month 10 (January) for those NHS organisations that form part of the Bedfordshire, Luton and Milton Keynes (BLMK) ICS financial control total. These organisations are:

- Bedfordshire Luton and Milton Keynes Integrated Care Board
- Bedfordshire Hospital NHS Foundation Trust
- Milton Keynes University Hospitals NHS Foundation Trust

A commentary on the current financial position of Local Authority partners is included in Appendix A. It reflects the latest available publicly available information of partners.

1.2 The paper sets out income and expenditure performance, capital, efficiency plans, and key financial risks.

2.0 System Income & Expenditure Position

2.1 NHS organisations that form part of the BLMK ICS financial control total have individually and collectively set financial plans that aim to deliver breakeven financial positions for the 2022/23 financial year. The table below shows the position for intra-ICS NHS organisations.

Surplus / (Deficit)	Year-to-date			Forecast Outturn		
	Plan	Actual	Variance	Plan	FOT	Variance
	£m	£m	£m	£m	£m	£m
Bedfordshire Hospital NHS FT	0.0	0.8	0.8	0.0	0.0	0.0
Milton Keynes NHS FT	(2.6)	(2.8)	(0.2)	0.0	0.0	0.0
BLMK CCG/ICB	(0.0)	0.0	0.0	(0.0)	0.0	0.0
Intra ICS Organisations	**(2.6)**	**(2.0)**	**0.6**	**(0.0)**	**0.0**	**0.0**

2.2 The ICS is reporting a deficit of £2.0m year to date, which is £0.6m better than planned at this stage, due to a surplus being reported at BHFT. All organisations continue to forecast breakeven by the end of the year.

2.3 **Intra ICS Performance:**

Financial performance commentary for each intra-ICS organisation is set out below:

Bedfordshire Hospital NHS Foundation Trust

A summary financial position at month 10 for Bedfordshire Hospital NHS Foundation Trust is set out in the table below

Income & Expenditure	Year-to-date			Forecast Outturn	
	Plan	Actual	Variance	Actual	Variance
	£'000	£'000	£'000	£'000	£'000
Income	583,948	605,422	21,474	724,836	24,079
Pay	(376,978)	(387,938)	(10,960)	(466,338)	(14,000)
Non-Pay	(206,995)	(216,707)	(9,712)	(258,498)	(10,079)
SURPLUS / (DEFICIT)	**(25)**	**776**	**801**	**0**	**0**

The key drivers for the variances are:

- Income – Income ahead of plan due to the pay awards. Forecast has been updated to reflect this.
- Pay – Higher levels of bank and agency, particularly on medics driven by high levels of emergency activity, covid staff sickness and elective recovery.
- Operating Expenses (Non-Pay) – High level of drugs spend, and ahead of plan on premises expenses due to RPI increases in contracts.
- Finance Costs – Over performance on finance costs, specifically interest receivable.

Milton Keynes University Hospital NHS Foundation Trust

The summary financial position for Milton Keynes University Hospital NHS Foundation Trust at month 10 is set out in the table below:

Income & Expenditure	Year-to-date			Forecast Outturn	
	Plan	Actual	Variance	Actual	Variance
	£'000	£'000	£'000	£'000	£'000
Income	271,578	284,716	13,138	347,473	20,477
Pay	(174,780)	(187,245)	(12,465)	(226,280)	(18,073)
Non-Pay	(99,444)	(100,266)	(822)	(121,193)	(2,404)
SURPLUS / (DEFICIT)	**(2,646)**	**(2,795)**	**(149)**	**0**	**0**

The key drivers for the variances are:

- Income – wage award, PbR overperformance on Bucks/Northants contracts, and various non-clinical income streams
- Employee Expenses (Pay) – Wage award and bank and agency increase to cover vacancies and winter escalation capacity
- Operating Expenses (Non-Pay) – higher clinical consumables and drugs in month which are activity related
- Finance Costs – higher interest receivable

Integrated Care Board

Clinical Commissioning Groups (CCG) remained as statutory organisations between 1 April 2022 to 30 June 2022. The full year 2022/23 Integrated Care Board allocation has been reduced by the resources consumed by Bedfordshire, Luton and Milton Keynes CCG in the first three months of the year. Therefore, at the point of establishment, the ICB received the remaining funding for the balance of the financial year.

At the end of quarter 1 there was a surplus of £9.3m in BLMK CCG. CCG allocations were adjusted by NHSE to bring all CCGs to breakeven and any surplus or deficit compared to the quarter 1 allocation was rolled forward into the new ICB. The difference of £9.3m has been carried forward into the ICB allocation for the remainder of the year.

The table below shows combined CCG and ICB performance against key financial performance indicators. At month 10 the ICB is delivering and forecasting full achievement of these metrics.

Performance Measure	Year To Date - Month 10			Forecast		
	Target	Actual	Variance	Target	Actual	Variance
Revenue Resource Limit	£1,490.5m	£1,490.5m	£0.0m	£1,810.2m	£1,810.2m	£0.0m
Capital Resource Limit	£0.8m	£0.8m	£0.0m	£2.4m	£2.4m	£0.0m
MHIS Expenditure	£129.6m	£130.7m	£1.1m	£155.5m	£156.3m	£0.8m
Efficiency Savings	£12.7m	£12.9m	£0.2m	£15.4m	£15.6m	£0.2m
BPPC	>95%	95%	0%	>95%	95%	0%

The ICB is reporting a breakeven YTD against a planned breakeven position and is forecasting a breakeven financial position. The position by commissioning programme as at month 10 is set out in the table below:

PROGRAMME AREA	YEAR TO DATE - MONTHS 04 - 10			FORECAST OUTTURN		
	Budget £000	Actual £000	Variance £000	Budget £000	Forecast £000	Variance £000
Acute Services	579,620	576,790	2,829	742,034	739,087	2,947
Mental Health Services	112,918	114,278	(1,360)	145,314	147,019	(1,705)
Better Care Fund	20,182	20,692	(510)	26,168	26,830	(663)
Other Community Services	93,034	92,794	240	119,574	119,545	28
Continuing Care Services	43,546	45,014	(1,467)	55,923	57,840	(1,917)
Primary Care Co-Commissioning	95,466	96,120	(653)	122,875	124,335	(1,460)
Prescribing	81,364	87,667	(6,303)	105,234	112,264	(7,031)
Other Primary Care Services	19,006	18,892	114	24,518	25,101	(583)
Other Programme Services (incl. Reserves)	6,879	10,483	(3,605)	25,749	27,621	(1,872)
Total Commissioning Budget	**1,052,015**	**1,062,730**	**(10,714)**	**1,367,388**	**1,379,643**	**(12,255)**
Running Costs	**11,840**	**10,420**	**1,420**	**14,945**	**13,257**	**1,688**
Surplus / (Deficit)	**9,294**	**0**	**9,294**	**9,294**	**0**	**9,294**
Total ICB Net Expenditure	**1,073,149**	**1,073,149**	**0**	**1,391,627**	**1,392,900**	**(1,273)**
Expected Allocation from NHSE for ARRs roles	0	0	0	1,273	0	1,273
Total Net Expenditure after NHSE Allocation	**1,073,149**	**1,073,149**	**0**	**1,392,900**	**1,392,900**	**0**

The key drivers for the ICB variances are:

Acute - The main driver of this underspend in the YTD and forecast is Elective Service Recovery Funding where £3m expenditure was accounted for by the CCG in Q1 but the funding was received in Q2.

Mental Health – the key contributors towards the YTD overspend are due to NCA spend £0.5m which is expected to carry on at similar levels of spend, £0.2m Learning Difficulties SDF and £0.6m Special Placement patient costs.

Continuing Care Services – majority of the overspend is in Adult CHC and Funded Nursing Care (FNC) reporting a YTD overspend of £1m which is an increase of £0.2m from month 9 and is driven by activity and costs. The overspend is forecast to increase to £1.3m by year end. The balance is due to a forecast overspend now materialising in Children's CHC.

Primary Care Co-Commissioning - The forecast overspend of £1.5m is mainly due to the continuing monthly ARRS run rate being above baseline allocation. ARRS workforce is forecast to be £1.3m above allocation having factored in current ARRS staffing and potential further recruitment planned by PCNs by year end. The £1.3m ARRS overspend is recoverable from the monies that NHSE hold centrally for such purposes.

Prescribing – Drugs information available is to November 2022 and runs two months in arrears. Consequently, current month's position and forecast includes a material judgement as to estimating levels of accruals for the last two months. The forecast overspend is driven by increasing unit costs for drugs due to supply issues and increases in home oxygen prices.

Other Programme Services - The forecast underspend is mainly due to vacancies in the programme management budgets. This is partly offset by the costs associated with the transition team and expenses to establish the ICB. Other budgets associated with Covid vaccinations, and 111 services are also underspending.

Running Costs – The forecast underspend is mainly due to vacancies.

3.0 NHS Financial Performance of Inter ICS NHS Organisations (organisations who provide services in BLMK but are hosted in other systems)

3.1 Intra ICS NHS Providers are reporting year to date deficit of £7.2m and a forecast deficit of £11.1m against a planned deficit of £0.5m for services delivered within BLMK. This is a further deterioration compared to month 9. The table below shows the position by organisation:

Surplus / (Deficit)	Year-to-date			Forecast Outturn		
	Plan	Actual	Variance	Plan	FOT	Variance
	£m	£m	£m	£m	£m	£m
CNWL	0.0	(2.3)	(2.3)	0.0	(4.7)	(4.7)
ELFT	(0.4)	(5.3)	(4.9)	(0.5)	(6.4)	(5.9)
CCS	0.0	0.0	0.0	0.0	0.0	0.0
Inter ICS Providers	**(0.4)**	**(7.6)**	**(7.2)**	**(0.5)**	**(11.1)**	**(10.6)**

CNWL: The forecast deficit of £4.7m splits to £3.7m for MK Mental Health and £1.0m for MK Community Health.

The main drivers are the level of spending on agency staff due to the difficulties in recruiting staff. The Trust has been able to reduce the level of nursing vacancies through locally focused recruitment events. Recruiting doctors to medical posts in the current environment remains exceptionally challenging, and agency cover for these roles is very expensive.

CNWL are working with BLMK ICB on the demand pressures for Complex Placements, which are symptomatic of the wider demand pressures and increased acuity of patient presenting for Mental Health treatments across Milton Keynes, driven by both population growth and changing demographics.

ELFT: The forecast deficit of £6.4m is driven by the following factors:

- For adult mental health services pressures on beds requiring Out of Area placements and in the Recovery and Bedford Triage, Assessment and Brief Intervention services.

- In Primary Care, agency usage of Medical and Nursing resources is driving an overspend which is being reviewed on an ongoing basis.
- In Bedfordshire Community services agency usage is required in the home teams and there are historic price and activity pressures in Wheelchairs and Continence services.

CCS: Costs are forecast to be in line with contract value.

4.0 System Efficiency Plans

4.1 The system financial plan includes delivery of £55.6m efficiencies for in-system NHS partners.

4.2 The ICS is reporting savings of £44.6m year to date, so on plan, and the forecast is to deliver savings of £55.9m by the end of the year, so very slightly above plan.

	Year-to-date				Forecast Outturn			
	Plan	Actual	Variance		Plan	Actual	Variance	
	£'000	£'000	£'000	%	£'000	£'000	£'000	%
ICB - Recurrent	6,665	9,488	2,823	42%	8,214	11,561	3,347	41%
ICB - Non recurrent	5,987	3,365	(2,622)	-44%	7,227	4,094	(3,133)	-43%
Subtotal - ICB	**12,652**	**12,853**	**201**	2%	**15,441**	**15,655**	**214**	1%
BHFT - Recurrent	19,965	19,965	0	0%	23,951	23,951	0	0%
BHFT - Non recurrent	3,500	3,500	0	0%	4,200	4,200	0	0%
Subtotal - BHFT	**23,465**	**23,465**	**0**	0%	**28,151**	**28,151**	**0**	0%
MKHFT - Recurrent	6,748	3,717	(3,031)	-45%	9,049	5,428	(3,621)	-40%
MKFT - Non recurrent	1,500	4,531	3,031	202%	3,000	6,621	3,621	121%
Subtotal - MKFT	**8,248**	**8,248**	**0**	0%	**12,049**	**12,049**	**0**	0%
Total Efficiencies	**44,365**	**44,566**	**201**	**0%**	**55,641**	**55,855**	**214**	0%

4.3 £14.9m of the programme us forecast to be delivered non-recurrently, representing 27% of the total. This is an issue for the system going into next financial year.

5.0 System Financial Risks

5.1 The system financial plan set out several risks to plans which are under constant review. Mitigations to offset these risks and other emerging risks continue to be developed. The current risks are set out below:

Risk Title	Risk Description (Cause & Effect)	Risk Control	Action Required
Delivery of Efficiency Programme	As a result of the efficiency plan not being delivered there is a risk that the ICS will not breakeven at the end of 2022/23	Regular meetings with scheme leads to update on progress and ability to stretch, plus any actions required if deviations from plan identified Presented to Performance & Delivery Group and to Finance & Investment Committee	Ongoing monitoring and early escalation of any scheme deviating from plan Continued scanning for further opportunities to add to plan to mitigate any shortfalls

Risk Title	Risk Description (Cause & Effect)	Risk Control	Action Required
Inflation	As a result of inflation being higher than funded via tariff and allocations, there is a risk that providers will face additional costs that they cannot manage and look to the ICB for financial support, and the ICB will see its own costs increase		Monthly monitoring of spend against budget Review of non-recurrent opportunities within 2022/23 available to mitigate inflation
Management / Running Costs	As a result of the pay award being higher than budgeted, and unfunded, which is a real-terms cut in Running Costs, there is a risk of a reduction in ICB staffing and capacity to support establishing the new organisation and ways of working,	Vacancy control process NHSE business case completed for interim staff and consultancy spend	Pay award to be modelled and impact understood on each budget Agree approach to managing individual budget pressures with Executive budget holder
Covid	As a result of a new variant of covid or an increase in infections and hospitalisations, costs may increase whilst the covid allocation that was issued to cover these additional costs, has reduced	Reporting of spend against covid allocation monthly to identify early any pressures on funding	Monitoring of covid expenditure within ICB and across ICS

5.2 The system plan is underpinned by full receipt of Elective Recovery Fund (ERF) income. Funding for the first six months of the financial year has been confirmed, and full funding is now expected for the second half of the financial year. The in-year risk has therefore been reduced.

6.0 System Capital

6.1 BLMK ICS has a capital expenditure limit (CDEL) which it cannot breach. This limit applies to those organisations which form part of the BLMK ICS financial control total. Currently capital for East London NHS Foundation Trust (ELFT), Central and North West London NHS Foundation Trust (CNWL) and Cambridgeshire Community Services (CCS), who provide community and mental health services in Bedfordshire, Luton and Milton Keynes, is held within their lead systems.

6.2 ICS organisations may also receive other capital funding from ringfenced national sources to support key priorities including the Government's New Hospitals Programme and capital to support elective recovery, digital, community diagnostics etc…

6.3 The table below shows the year-to-date and forecast financial performance of intra system providers against CDEL and other capital funding sources. The system annual CDEL is £43.3m and at month 10 providers are forecasting that they will deliver a break-even position against this limit. The ICB does not have a CDEL limit.

	Year-to-date			Forecast Outturn		
	Plan	Actual	Variance	Plan	Actual	Variance
	£m	£m	£m	£m	£m	£m
Bedfordshire Hospital NHS FT	76.7	56.6	20.1	115.8	120.6	(5.5)
Milton Keynes NHS FT	14.2	14.4	(0.2)	18.3	21.6	(3.3)
BLMK ICB	0.0	0.0	0.0	1.6	1.6	0.0
Intra ICS Organisations	**90.9**	**71.0**	**19.9**	**135.7**	**143.8**	**(8.8)**

6.4 The ICS is expecting an increase to the CDEL limit to offset the impact of the implementation of financial reporting standard IFRS 16. New leases or modifications of existing leases from 1 April 2022 will count against the capital departmental expenditure limit (CDEL) and limits will need to be increased to manage the impact of the implementation of the new standard.

6.5 The table below shows the year-to-date and forecast position for the intra-ICS NHS organisations across all capital funding streams (CDEL and national sources). There is a currently a £8.8m forecast overspend across the intra-ICS organisations - this reflects a timing issue relating to the allocation of funds for non-CDEL national capital programmes and is expected to be amended in future periods, resulting in a breakeven financial forecast.

Capital Plan - Provider Based	Year-to-date			Forecast Outturn		
	Plan	Actual	Variance	Plan	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Charge against capital allocation (	37,252	36,648	604	43,341	44,051	(710)
Other funding streams	53,662	34,397	19,265	90,766	98,194	(8,128)
Total	**90,914**	**71,045**	**19,869**	**134,107**	**142,245**	**(8,838)**

- BHFT is reporting an overall £20.1m underspend year to date, mainly due to outside of envelope schemes. The Trust is forecasting an overspend on capital against the original plan by £5.5m. This is due to approval of the additional theatre on the Bedford site.
- MKUHFT is reporting a forecast overspend against of £3.3m which is the result of the additional national funding for CDC lease asset and frontline digitisation which has not yet been received. The trust expects to spend the full capital allocation this year and remain within its CDEL allocation.
- The ICB has been allocated capital funding of £1.6m to support GPIT, primary care estates and corporate capital. The ICB is reporting no spend to date but forecasts to spend this allocation in full. Spend has been incurred but is netted off against anticipated allocations. Capital expenditure on GPIT is capitalised by NHS England rather than the ICB. All ICB capital is therefore subject to NHS England business case processes and only released when business cases are approved.

7.0 Recommendations

7.1 The Integrated Care Board is asked to:

- Note the year-to-date financial position of the ICS at month 10 and forecast position for revenue and capital
- Note the risks to the financial forecast

Appendix A

Financial Position of ICS Local Authority Partners

A summary of the latest publicly available financial position of Local Authorities is set out below.

Bedford Borough Council: The authority faces a wide number of challenges to the provision of its services in the current year resulting in a forecast overspend position of £7.04m at the end of the financial year (4.9% of the council's net budget). Specific pressures include Adult Services forecast overspend of £0.655m due to a consistent level of clients but increasing unit costs and Children's Services forecast overspend of £6.329m due to an increase in numbers of children's placements, particularly in residential care, and costs. There are other pressures in Environmental and Corporate Services. The Authority is taking steps to manage and reduce the overspend by the end of the financial year.

In addition, the 2022/2023 Budget includes £5.170 million of capital expenditure funded from revenue budgets and it is considered appropriate to now fund this expenditure from borrowing, thereby releasing the revenue funding to help meet the projected revenue budget overspend and this will not impact the work still included in the Capital Programme.

[Source: BEDFORD BOROUGH COUNCIL – FULL COUNCIL, 30 NOVEMBER 2022 REPORT BY THE EXECUTIVE, SUBJECT: 2022/2023 REVENUE AND CAPITAL TRENDS, Agenda Item 12.1]

Central Bedfordshire Council: As at the end of September, forecasting a gross overspend of £10.7m before any release of the contingency and application of grants. Specific pressures include Children's Services forecast overspend of £6.9m due to the costs of placements (fostering, residential care etc), staffing and the cost of education transport There is a forecast underspend on Adult Social Care of £0.2m. There are also pressures in Resources and Place and Community, but these are offset by underspends elsewhere, and after application of budget contingency and Covid and financial hardship related grants, the Council is forecasting achievement of a balanced outturn position.

[Source: Central Bedfordshire Council Executive Meeting 06 December 2022 Subject: Revenue Budget Monitoring Q2 (September) 2022/23, Agenda Item 18.1]

Luton Borough Council: Forecast overspend of £7.817m after the application of contingencies and specific reserves. The adverse position reflects the impact of price inflation, pay award, the enduring impact of covid and delivery risks regarding the budgeted savings programme. Specific pressures include Children's Services forecast overspend of £1.49m due to pressures on adoption services, placements and additional staff to meet Ofsted requirements. Adult services are forecast to underspend by £0.26m. There are other significant pressures within council budgets including SEN transport, neighbourhood services and property offset by a forecast reduction in borrowing costs. There is also a forecast overspend of £0.4m on the Public Health Grant. Recovery actions have been put in place with the aim to reduce the current forecast overspend to a balanced position by the end of the year.

[Source: Luton Borough Council Executive Meeting 05 December 2022 Subject: Revenue & Capital Budget Monitoring – Quarter 2 2022/23 Agenda Item 11]

Milton Keynes: General Fund Services are currently forecasting an overspend of £1.161m at quarter 3. There are specific pressures in Children's services where the forecast is an overspend of £2.137m, due to external placements, but is offset in part due to vacancies. Adult Services are forecast to overspend by £2.639m, which is a deterioration since quarter 2, and due to increased Temporary Accommodation costs, also, offset by vacancies. Combined these account for the main areas of overspends. Management are now planning to take a number of actions to manage the financial position. The forecast outturn position for the 2022/23 capital programme compared to budget (resource allocation). shows an underspend of (£102.028m); however, after slippage of £104.626m, this will result in an overspend of £2.598m in year.

[Source: Milton Keynes City Council Cabinet Meeting 07 February 2023 Subject: QUARTER 3 FORECAST OUTTURN, 2022/23 GENERAL FUND REVENUE, HOUSING REVENUE ACCOUNT, DEDICATED SCHOOLS GRANT AND CAPITAL PROGRAMME Agenda Item 12]

Glossary of commonly used terms in Finance reports

Acronym	Name	Description
BHFT	Bedfordshire Hospitals NHS Foundation Trust	
CCS	Cambridge Community Services NHS Trust	Provides community services in Luton and Bedfordshire
CDEL	Capital Department Expenditure Limit	Each department of Her Majesty's Treasury (HMT) has a departmental expenditure limit (DEL) which can be separated into capital and revenue DEL. The government controls overall expenditure by deciding each department's DEL. The Department of Health and Social Care (DHSC) sets a capital departmental expenditure limit (CDEL), which covers the capital spend of NHS trusts and is used by DHSC and HMT to monitor and manage capital expenditure within the sector.
CNWL	Central and North West London NHS Foundation Trust	Provides Community and Mental Health Services in Milton Keynes.
ELFT	East London NHS Foundation Trust	Provides Community and Mental Health Services in Bedfordshire and Luton.
ERF	Elective Recovery Funds	The ERF is designed to support systems to work collaboratively to restore elective services against the backdrop of unprecedented demands on the service because of Covid. It ensures that the marginal costs of delivering extra activity to tackle a lengthening waiting list can be met.
H1 or H2	Half Year	H1: Covers April-September H2: Covers October-March
HDP	Hospital Discharge Programme	Details the discharge requirements for all NHS trusts, community interest companies, private care providers of acute, community beds and community health services and social care staff in England. The guidance, based on successful discharge to assess principles, aims to ensure that all individuals are discharged from hospital in a safe, appropriate and timely way. Funding was provided by NHS England to support HDP in 2020/21 and 2021/22
ICS	Integrated Care System	ICSs are partnerships between the organisations that meet the health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups.
MHIS	Mental Health Investment Standard	MHIS is the requirement for ICBs to increase investment in Mental Health services in line with their overall increase in allocation each year.

Acronym	Name	Description
MKUHFT	Milton Keynes University Hospital NHS Foundation Trust	
NHSE	NHS England	
SDF	System Development Funds	Resource allocations for specific programme activities deemed a priority by NHSE for 2022/23.
YTD	Year-To-Date	

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Board of The Integrated Care Board (ICB)
20. Board Assurance Framework

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 [click all that apply]	
☒	**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	Ola Hill, Deputy Head of Organisational Resilience
Date to which the information this report is based on was accurate	15th March 2023
Senior Responsible Owner	Maria Wogan, Chief of System Assurance and Corporate Services

The following individuals were consulted and involved in the development of this report:
Maria Wogan, Chief of System Assurance and Corporate Services
This report has been presented to the following board/committee/group:
Audit and Risk Assurance Committee – 3 March 2023

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

The members are asked to **discuss and note** the updated Board Assurance Framework and agree any additional actions required.

1. Brief background / introduction:

BLMK ICB's vision for risk management is for all decision makers to be fully informed of risk and that risks are effectively managed in the achievement of our objectives. Risk management benefits the ICB, our stakeholders and the local population by enabling new ideas to be explored and potential risks to be managed to minimise their impact. The approach is to utilise the ICB Board Assurance Framework (BAF) as the key tool to hold the strategic risks as defined by the ICB: the major risks that could prevent the ICB from fulfilling the objectives in its agreed strategy. These are strategic risks which pertain to the whole system as opposed to the ICB as a statutory organisation. Risks that pertain to the ICB as a statutory organisation are held on the ICB's corporate risk register and directorate sub-risk registers.

The development of the Board Assurance Framework is an iterative process engaging all the parts of the system to ensure that appropriate risks are identified and mitigated to support the ICB in achieving its objectives.

2. Summary of key points:

Progress with Board Assurance Framework (BAF)

When the BAF was reviewed at the Board meeting in January, it was agreed that:

- The Primary Care Commissioning and Assurance Committee (PCCAC) should give consideration to adding a primary care risk or risks to the BAF – on the topics of primary care access and the delegation of Pharmacy, Optometry and Dentistry (POD) – this meeting is on 17 March and an update will be reported verbally at the Board meeting;
- The mitigation plan for the population growth risk would be discussed further at the next Board seminar, and local authority members will be asked to share information on population and housing growth – this information was provided at the Board seminar on 24 February 2023;
- Links should be made with local authorities regarding risk management approaches – this will be taken forward by the ICB Risk Lead and progress reported to the next Audit and Risk Assurance Committee (ARAC) – support from the Local Authority CEOs in making the right connection within their Councils is requested; and
- Consideration should be given to amending the inequalities risk description to refer to capability and cultural change, and how that impacts inequality outcomes – this will be addressed by the Director of Nursing building on the deep dive review of the inequalities risk at the Quality and Performance Committee on 3 March 2023.

The Board Assurance Framework or specific BAF risks have been reviewed at the following meetings since the last Board meeting:

- **System Oversight and Assurance Group** (SOAG) on 3rd February 2023 – Focus on the Population Growth strategic risk (BAF 8) and consideration of an additional potential risk 'failure to collaborate' It was agreed that the BAF would be further developed in respect of the above:
- ***Population Growth risk***
    - Risk is being updated to ensure it captures changing need as well as population growth

- Current risk score being increased based on this being one of the most significant risks being managed by the system
- Target risk rating is being reviewed – system partners do not feel that the current target can be attained
- Mitigation plan being reviewed and strengthened, informed by the Board seminar on 24 February 2023
- A separate but associated reputational risk should be assessed for inclusion on the BAF that should include joined-up communications and stakeholder management between local authority and NHS partners

- ***Potential 'Failure to Collaborate' risk:***
  - SOAG agreed that collaboration in the system was strong and had strengthened over time and did not consider this to be a strategic risk for the BAF
  - Proposed that the following potential risks should be assessed in relation to collaboration:
    - Risk that an over-commitment to collaborative working does not deliver sufficient value; and
    - Risk of poor collaboration between ICSs impacting outcomes for residents (particularly in relation to neighbouring ICSs)
  - An initial risk assessment for these risks will be undertaken by the ICB Executive Team and reported to the next SOAG on 20 June 2023.

- **Quality and Performance Committee – 3 March 2023** – deep dive on inequalities risk (BAF 4)

Julia Robson, ICB Inequalities Lead, facilitated a deep-dive into Inequalities risk with the Quality and Performance Committee.

The session provided an opportunity to look at the inequalities risk in depth and consider how BLMK was tackling inequalities using the Core20 PLUS 5 framework developed by NHSEI and considered how different parts of the system could contribute to this.

In relation to the inequalities risk and the mitigation plan, the Committee agreed that taking a population based approach was the most effective way to tackle inequalities and supported the proposals to invest in equality and inequalities resources at place and in improvements in the system's intelligence and analytical capability to drive the work programme and risk mitigation plan. These actions will be reflected in the risk's mitigation plan.

The Quality and Performance Committee also suggested that the impact of Industrial Action on BAF risks should be reviewed to see if risk scores should be increased and mitigation plans updated. This is currently being actioned following initial meetings with partners, especially on the longer term impact on recovery of elective services.

- **Audit and Risk Assurance Committee – 3 March 2023** – review of BAF with focus on Population Growth Risk

The Audit & Risk Assurance Committee reviewed the Board Assurance Framework in depth on 3rd March. The Committee considered the recommendation from SOAG that the current risk rating of the Population Growth risk is increased as although this is good engagement from system partners regarding this, there is scope for stronger mitigation. The Committee felt that there needed to be stronger links between ICB strategies and local planning strategies to ensure that healthcare can be provided appropriately to the growing population and supporting new housing developments, without putting undue strain on NHS services.

The Committee considered the proposed risk escalation and de-escalation model proposed by the System Risk Community of Practice and noted that there was more work to do to incorporate Local Authority partners and to ensure that there is a common language of risk across the system.

The Committee also agreed with the recommendation from SOAG that there should be a reputational risk in respect of resident expectation for service provision, managing communications with stakeholders and residents. This will be a joint risk working together with Local Authority Partners

Current Board Assurance Framework

The Board Assurance Framework currently hold nine strategic system risks. The current risk rating on **BAF 8 Population Growth** has increased reflecting the need for closer links between Health and Care strategies and local planning. The risk rating of BAF 1 Recovery of Services will likely increase following meetings with partners to ascertain the longer term impact of the Junior Doctors Industrial Action on recovery of elective services.

A summary of the Board Assurance Framework is below and is attached in full at Appendix A.

Ref	Risk Title	Risk Description	Current Risk Rating	Change
BAF 1	Recovery of Services	There is a risk that the NHS is unable to recover services and waiting times to pre-pandemic levels due to Covid related pressures, or demand led pressures. This may lead to poorer patient outcomes and reputational damage.	16	
BAF 2	Developing suitable workforce	If system organisations within BLMK ICS are unable to recruit, retain, train and develop a suitable workforce then staff experience, resident outcomes and the delivery of services within the ICS, ICB People Responsibilities and the System People Plan are threatened.	20	
BAF 3	System Pressure & Resilience	As a result of continued pressure on services from various factors (staff sickness, increased activity etc) there is compromised resilience in the system which threatens delivery of services across BLMK	20	
BAF 4	Widening inequalities	There is a risk that inequalities in the system widen due to a range of factors leading to compromise to population health and increases in system pressure in the most deprived areas.	16	
BAF 5	System Transformation	There is a risk that as a result of significant operational pressures, there will be decreased capacity to focus on strategic transformational change to deliver improved outcomes for our population.	16	
BAF 6	Financial Sustainability and Underlying Financial Health	As a result of increased inflation, significant operational pressures, elective recovery and the enduring financial implications of the covid pandemic - there is a risk to the underlying financial sustainability of BLMK that could result in failure to deliver statutory financial duties.	15	
BAF 7	Climate Change	Due to climate change and wider impacts on the environment and biodiversity, there is a significant risk of increased pressure on health and care services.	16	
BAF 8	Population Growth	As a result of fast rate of population growth in BLMK, there is a risk that our infrastructure will not keep pace with the needs of our population, resulting in poor health and wellbeing for residents.	20	
BAF 9	Rising Cost of Living	As a result of rising cost of living there is a risk that residents will not be able meet their basic needs resulting in deteriorating physical and mental health resulting in pressure on all public services	16	

Next Steps in Work Programme

The System Risk Community of Practice will meet in Q1 23/24 to further develop the first phase of the proposed escalation and de-escalation process for risks, working with Trusts and Local Authorities

In advance of the next Board and SOAG meetings in June, the ICB Executive Team will:

- further consider the new risk around 'Resident Expectation For Service Provision' and agreeing the initial risk score and identifying a Risk Owner in discussion with partners;
- Review the mitigation plans for BAF 4 (population growth);
- Scope and assess the two proposed risks on collaboration as requested by SOAG; and
- Review the impact of industrial action on the BAF risks.

3. Are there any options?

Not applicable

4. Key Risks and Issues

This report is wholly focused on risk

Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☒	No ☐

The ICB Board Assurance Framework is wholly hosted on 4Risk.

5. Are there any financial implications or other resourcing implications, including workforce?

- There are no direct financial or resourcing implications arising from this report.
- The ICB's Deputy Head of Organisational Resilience lead on strategic risk management as part of her wider Emergency Planning Resilience and Response portfolio equivalent to 0.5 WTE.

6. How will / does this work help to address the Green Plan Commitments?

Click to view Green Plan

Climate change is a key strategic system risk on the Board Assurance Framework.

7. How will / does this work help to address inequalities?

Reducing inequalities is a key strategic system risk on the Board Assurance Framework

8. Next steps:

- System Risk Community of Practice
- ICB Executive April 2023
- SOAG 20 June 2023

9. Appendices

Appendix A - ICB Board Assurance Framework

10. Background reading

BLMK ICB Board Assurance Framework

NHS
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Report Date	15 Mar 2023
Risk Status	Open
Risk Area	0. ICB Board Assurance Framework
Comparison Date	In the past 3 Month(s)
Control Status	Existing
Action Status	Outstanding

Growth

Risk Ref	ICB Priorities	Risk Title	Risk Description	Initial Score	Risk Control	Current Score	Action Required	Target Score
BAF 5	Growth	System Transformation **Risk Owner:** Anne Brierley **Risk Lead:** **Last Updated:** 06 Jan 2023 **Latest Review Date:** 15 Mar 2023 **Latest Review By:** Abimbola Hill **Last Review Comments:** Reviewed with Anne Brierley 15th March 2023	There is a risk that sustained operational pressures and complexity of change, there will be reduced delivery and benefit from strategic transformational change to deliver improved outcomes for our population.	I = 4 L = 4 16 To I = 4 L = 4 16 =	Agreed strategic priorities across the system in place Chief Exec/SOAG - regular reviews of operational performance issues to agree mitigations EPRR Framework and System monitors and responds to incidents resulting from operational pressures to wider system Operational performance management process in place taking account of responses to operational pressures Performance & Delivery Group - manages immediate operational issues Same Day Urgent Primary Care Offer	I = 4 L = 4 16 To I = 4 L = 4 16 =	Set clear timescales and expectations for place plans to deliver transformation for the population **Person Responsible:** Anne Brierley **To be implemented by:** 31 Mar 2023 Agree joint forward plan **Person Responsible:** Anne Brierley **To be implemented by:** 30 Jun 2023	I = 3 L = 2 6 To I = 3 L = 2 6 =

Risk Ref	ICB Priorities	Risk Title	Risk Description	Initial Score	Risk Control	Current Score	Action Required	Target Score
BAF 2	Growth	Developing suitable workforce **Risk Owner:** Martha Roberts **Risk Lead:** John Syson **Last Updated:** 03 Jan 2023 **Latest Review Date:** 03 Jan 2023 **Latest Review By:** John Syson **Last Review Comments:** National and regional workforce picture continues to be exceptionally challenging with industrial action affecting health providers as well as winter pressures. Turnover and sickness absences have seen increases in autumn and are expected to continue throughout winter. Cost of living pressures are also continuing to affect all organisations, particularly social care with competition from other sectors and employers	If system organisations within BLMK ICS are unable to recruit, retain, train and develop a suitable workforce then staff experience, resident outcomes and the delivery of services within the ICS, ICB People Responsibilities and the System People Plan are threatened.	I = 4 L = 5 20 To I = 4 L = 5 20	EDI & Wellbeing: People Board Sub Group focussing on supporting the wellbeing of staff across the ICS. Also responsible for improving workforce inequalities relating to protected characteristics and development and implementation of initiatives e.g. 'no more tick boxes' to address recruitment inequalities. Education Partnership: People Board Sub Group responsible for development and co-ordination of CPD fund use & demand scoping for system as well as use of apprenticeship levy, school and university engagement and development of innovate courses and training courses across health and care workforce Leadership & OD: People Board Sub Group focussing on building the OD capacity and skills within the system to support workforce transformation across health and care. Development of leadership and development programmes for the ICB and system partner organisations in conjunction with regional and national bodies. People Board: ICS Executive Group with responsibility for People Plan delivery to meet ICS workforce priorities linked to BAF and People Board workforce risks. This enables delivery of ICS Strategic Objectives, ICB People Responsibilities and development of Workforce strategy Primary Care Training Hub supporting in recruitment, retention and training of primary care workforce	I = 4 L = 5 20 To I = 4 L = 5 20	Launch, asses and embed the Health and Wellbeing pilot: (Primary Care) Pilot a range of wellbeing support and interventions for primary care staff, assess their impact and embed those which represent value to the system. **Person Responsible:** Susi Clarke **To be implemented by:** 31 Mar 2023 Rotational Apprenticeship: (Education Partnership) Pilot of level 3 HCA rotational apprenticeship between health and care providers in Bedfordshire to launch in 22/23 as proof of concept **Person Responsible:** Catherine Jackson **To be implemented by:** 31 Mar 2023 50k Nursing Target: (linked to Workforce Modelling and Supply) System has a target to increase NHS system nurses WTE to in excess of 3113WTE by March 2023. Sources range from international recruitment, apprenticeships to graduates and those recruited from other systems. **Person Responsible:** Marie Lambeth -Williams **To be implemented by:** 31 Mar 2023	I = 4 L = 3 12 To I = 4 L = 3 12

Risk Ref	ICB Priorities	Risk Title	Risk Description	Initial Score	Risk Control	Current Score	Action Required	Target Score
					Primary Care: People Board Sub Group focussing on workforce programmes as they relate to Primary Care Workforce. Wellbeing, career development, new roles (e.g. ARRS), international recruitment and workforce planning and OD Workforce Modelling & Supply: People Board Sub group focussing on the development of workforce strategy, recruitment, retention programmes and innovative role pilots		Embed use of 'No more tick boxes' recruitment approach: (EDI & Wellbeing) To ensure that system organisations have implemented the key principals of the 'no more tick boxes' approach to recruitment in at least some recruitment episodes in 22/23 **Person Responsible:** Martha Roberts **To be implemented by:** 31 Mar 2023	

Live Well

Risk Ref	ICB Priorities	Risk Title	Risk Description	Initial Score	Risk Control	Current Score	Action Required	Target Score
BAF 9	Live Well	Rising Cost of Living **Risk Owner:** Maria Wogan **Risk Lead:** Martha Roberts **Last Updated:** 15 Mar 2023 **Latest Review Date:** 15 Mar 2023 **Latest Review By:** Tammy Harding-Edwards **Last Review Comments:** Risk reviewed with Maria Wogan 15/03/2023	As a result of rising cost of living there is a risk that our staff and residents will not be able meet their basic needs resulting in deteriorating physical and mental health resulting in pressure on all public services	I = 4 L = 4 16 To I = 4 L = 4 16	Delivery of ongoing communications to support population access to support services in partnership with Trusts and Local Authorities. Partner and national NHS financial plans for managing increased costs due to inflation Partner support schemes for residents Partner Support Schemes for staff	I = 4 L = 4 16 To I = 4 L = 4 16	Agree medium-term financial plan with NHS partners. As part of joint forward plan. **Person Responsible:** Dean Westcott **To be implemented by:** 30 Jun 2023 Implementation of inequalities work programme to support the most vulnerable people and communities (review quarterly). **Person Responsible:** Maria Laffan **To be implemented by:** 30 Jun 2023 [EDI & Wellbeing People Sub-Group established]: Ongoing work plan for maximising support for staff across BLMK. **Person Responsible:** Martha Roberts **To be implemented by:** 30 Jun 2023 Develop and implement Population Health Intelligence Unit with Local Authorities to enable identification of groups most vulnerable to the rising cost of living. **Person Responsible:** Sarah Stanley **To be implemented by:** 30 Jun 2023	I = 3 L = 4 12 To I = 3 L = 4 12

Risk Ref	ICB Priorities	Risk Title	Risk Description	Initial Score	Risk Control	Current Score	Action Required	Target Score
BAF 7	Live Well	Climate Change **Risk Owner:** Maria Wogan **Risk Lead:** Tim Simmance **Last Updated:** 15 Mar 2023 **Latest Review Date:** 15 Mar 2023 **Latest Review By:** Tammy Harding-Edwards **Last Review Comments:** Risk reviewed with Maria Wogan 15/03/2023	Due to climate change and wider impacts on the environment and biodiversity, there is a significant risk of increased pressure on health and care services, due to: i) exacerbation of existing health conditions (e.g. CVD, COPD, Asthma, mental health); ii) new health challenges (e.g. tropical disease prevalence, population migrations); iii) extreme weather events resulting in harm (e.g. storms, floods, wildfires); iv) disruption to day-to-day healthcare provision (e.g. supply chain, workforce availability, power outages, infrastructure damage); and v) a deterioration in population health outcomes. This risk is materialising now, in some contexts, and will increase in both likelihood and severity as climate change progresses.	I = 4 L = 4 16 To I = 4 L = 4 16	BLMK ICS Green Plan 2022-25 Local Resilience Forum Adverse Weather Plans Partner Green Plans and Sustainability Plans. NHS organisations, local authorities and other public sector bodies have plans to reduce their contribution to climate change, and put in place both business continuity and adaptation plans to address the impacts of climate change. The ICB will support NHS providers to implement their green plans and ensure adaptation plans are in place, and work in partnership with other public sector bodies and anchor institutions to mitigate the risks of climate change. Severe Weather Plan	I = 4 L = 4 16 To I = 4 L = 4 16	Identify a BLMK ICS lead, who will then oversee creation, approval and delivery of a BLMK system-wide, healthcare Adaptation Plan, outlining how the system and services will work to increase resilience to the effects of climate change. **Person Responsible:** Tim Simmance **To be implemented by:** 30 Apr 2023 Support review of business continuity arrangements of ICS partners to ensure forward planning to manage climate change-related incidents. **Person Responsible:** Abimbola Hill **To be implemented by:** 30 Apr 2023 Develop and begin implementation of the delivery plan high impact elements of the BLMK ICS Green Plan (including supply chains, estates, medicines, care model transformation), linking with sustainability plans in partner organisations (including local authorities, NHS Trusts, other anchor organisations), to reduce the impact of healthcare on the climate and other environmental concerns. **Person Responsible:** Tim Simmance **To be implemented by:** 30 Jun 2023 Implement recommendations from Green Plan Health Impact assessment. **Person Responsible:** Tim Simmance **To be implemented by:** 30 Sep 2023	I = 2 L = 4 8 To I = 2 L = 4 8

Risk Ref	ICB Priorities	Risk Title	Risk Description	Initial Score	Risk Control	Current Score	Action Required	Target Score
BAF 1	Live Well	Recovery of Elective & Cancer Services **Risk Owner:** Anne Brierley **Risk Lead:** Michael Ramsden **Last Updated:** 03 Feb 2023 **Latest Review Date:** 03 Feb 2023 **Latest Review By:** Michael Ramsden **Last Review Comments:** Further control added about independent sector use. Otherwise remains accurate	There is a risk that the NHS is unable to recover elective and cancer services and waiting times to pre-pandemic levels due to Covid and Urgent and Emergency Care pathway related pressures, workforce constraints or demand led pressures. This may lead to poorer patient outcomes and reputation damage.	I = 4 L = 4 16 To I = 4 L = 4 16	1. All Trusts have recovery action plans. 2. Changes made to L&D Endoscopy service so referrals through one route (Referral Assessment Service) where clinical triage occurs. 3. Change in national guidance for aerosol generation procedures leading to improvement in capacity 4. Significant increase in Endoscopy capacity. However still a high number of patients waiting and cancer demand increasing. 5. Clinical Prioritisation of wait list across BLMK. Reduction in Long waits with elimination of 104ww and 78ww in 22/23 6. Cancer 62 day backlog recovery action plans and revised trajectory of improvement 7. Waiting list validation and mutual aid programme An Elective Recovery Board has been convened to track recovery and instigate actions. The Board involves CEO/executive/senior stakeholders across commissioning, providers & NHSEI and is accountable for delivery of the Elective Transformation Programme and Elective Accelerator Programme in Bedfordshire, Luton and Milton Keynes. It sets the vision and change needs to deliver the programme objectives whilst assuring quality, safety and value for the BLMK system and our population.	I = 4 L = 4 16 To I = 4 L = 4 16	Maintain oversight of the 22/23 Operational Plan delivery. All actions will support recovery of Elective performance and will be monitored through the Elective Collaboration Board **Person Responsible:** Michael Ramsden **To be implemented by:** 31 Mar 2023 System wide transformation plan to increase productivity using GIRFT data); transform outpatients through advice and guidance, PIFU and virtual clinics; demand management actions such as clinical triage. All outlined in the 22/23 Operational Plan and delivery overseen by the Elective Collaboration Board **Person Responsible:** Michael Ramsden **To be implemented by:** 31 Mar 2023	I = 4 L = 3 12 To I = 4 L = 3 12

Risk Ref	ICB Priorities	Risk Title	Risk Description	Initial Score	Risk Control	Current Score	Action Required	Target Score
					Independent Sector and community services use to support Trusts in their wait reduction and where choice is indicated, transfer care to providers with short waits. In addition, Trusts are now using a Digital Mutual Aid System (DMAS) to request support from providers across the country (where choice has indicated they are willing to have care transferred) Monthly RTT report indicating size of waiting list and length of wait. Ongoing work with hospitals to optimise utilisation of ISP's Clinical Prioritisation (P1-6) review and shared decision making in place Monthly RTT report indicating size of waiting list and length of wait. Ongoing work with hospitals to optimise utilisation of ISP's Processes in place to ensure those with most urgent clinical needs are treated first. Quality - Supporting review of performance across service provision in particular Cancer services and associated Pathways & diagnostics. Triangulating information and soft intelligence such as serious incidents , complaints , HW engagement , Safeguarding partnership information. Involvement in ICS board discussion for MH , Stroke , Cancer, safeguarding		06/09/2022 - AGEM unable to forecast demand and capacity due to issues with the national tool. Signficant delays therefore expected in 22/23. Work continues to develop a useful forecast for 23/24 planning round Demand and Capacity modeling. Working with AGEM CSU to develop a model. 04/02/2022 - now to include the Strategic Planning Tool 05/04/2022 - Deloittes have undertaken D+C analysis for BLMK. The draft report is being reviewed at the Elective Collaboration Board in April where further actions will be agreed. To remain open until report is signed off as accurate. D+C data will need periodic refreshes which will be undertaken by AGEM 17.7.21 - Due to national issues with the Strategic Planning Tool, the Elective Board agreed to revert to a manual process for Demand and Capacity Modelling in 22/23. Further updates to be presented to the Elective Board throughout the year **Person Responsible:** Michael Ramsden **To be implemented by:** 31 Mar 2023	

Risk Ref	ICB Priorities	Risk Title	Risk Description	Initial Score	Risk Control	Current Score	Action Required	Target Score
					The actions and controls to support the Pandemic and System Pressures risk will support Elective Recovery, as, if there is strong demand management and flow, then the likelihood of emergency medical patients outlying to surgical ward (and concomitant elective cancellation) will be mitigated.			
BAF 8	Live Well	Population Growth **Risk Owner:** Anne Brierley **Risk Lead:** **Last Updated:** 15 Mar 2023 **Latest Review Date:** 15 Mar 2023 **Latest Review By:** Abimbola Hill **Last Review Comments:** Reviewed with Anne Brierley 15th March 2023	As a result of fast rate of population growth in BLMK, there is a risk that our infrastructure will not keep pace with the needs of our population, which will exacerbate widening inequalities and outcomes.	I = 4 L = 4 16 To I = 4 L = 5 20	Joint forward plan population trajectories Local Authority Place Plans Oxford-Cambridge Arc	I = 4 L = 4 16 To I = 4 L = 5 20	Infrastructure plans (capital, estates, health services, workforce) will be addressed in the 5 year Joint Forward Plan, in line with Local Authority plans. **Person Responsible:** Anne Brierley **To be implemented by:** 30 Jun 2023 Primary Care estates strategy aligned with One public estates plan **Person Responsible:** Nicky Poulain **To be implemented by:** 04 Dec 2023 One public estates plan mapped against population growth for each borough **Person Responsible:** Dean Westcott **To be implemented by:** 04 Dec 2023	I = 2 L = 4 8 To I = 3 L = 4 12

Risk Ref	ICB Priorities	Risk Title	Risk Description	Initial Score	Risk Control	Current Score	Action Required	Target Score
BAF 3	Live Well	System Pressure & Resilience **Risk Owner:** Anne Brierley **Risk Lead:** **Last Updated:** 15 Mar 2023 **Latest Review Date:** 15 Mar 2023 **Latest Review By:** Abimbola Hill **Last Review Comments:** Reviewed with Anne Brierley 15th March	As a result of continued pressure on services from various factors (staff sickness, increased activity etc) there is compromised resilience in the health and social care system which threatens delivery of services across BLMK. This may lead to poorer patient outcomes and reputational damage.	I = 4 L = 5 20 To I = 4 L = 5 20	BLMK engaged with regional critical care groups BLMK Performance & Delivery Group reviews performance on a bi-monthly basis and agrees system mitigations and actions BLMK Primary Care Access Program CCG officers review performance weekly via reset & restoration meetings Discharge To Assess process is being implemented in Bedfordshire (already in place in Milton Keynes and Luton) In line with escalation process, daily system calls in place for Bedfordshire Increased Patient Transport Services to facilitate swifter discharge Monthly reports are reviewed at the TILT, Q&P and F&P meetings and the GB Reports are provided to the ICS CEO meeting regarding the performance issues and Covid position Revised escalation process in place to prompt system response across BLMK SHREWD being implemented across BLMK to enable real time resilience/flow data. Specific ICB focus on community bed management across Bedfordshire. The Exec Team reviews performance on a monthly basis	I = 4 L = 5 20 To I = 4 L = 5 20	Milton Keynes and Bedfordshire Care Alliance will confirm their winter plans for 23/24 **Person Responsible:** Anne Brierley **To be implemented by:** 31 Mar 2023 Continued development and implementation of support/access improvement projects via BLMK Access Group and sub-groups **Person Responsible:** Nicky Poulain **To be implemented by:** 28 Apr 2023	I = 3 L = 4 12 To I = 3 L = 4 12

Risk Ref	ICB Priorities	Risk Title	Risk Description	Initial Score	Risk Control	Current Score	Action Required	Target Score
					Winter Planning to include commissioning of further capacity (beds and care) across BLMK Work with Councils to review and redesign care pathways to release more therapy resource to focus on flow.			

Reduce Inequalities

Risk Ref	ICB Priorities	Risk Title	Risk Description	Initial Score	Risk Control	Current Score	Action Required	Target Score

Risk Ref	ICB Priorities	Risk Title	Risk Description	Initial Score	Risk Control	Current Score	Action Required	Target Score
BAF 4	Reduce Inequalities	Widening inequalities **Risk Owner:** Sarah Stanley **Risk Lead:** **Last Updated:** 15 Mar 2023 **Latest Review Date:** 06 Jan 2023 **Latest Review By:** Abimbola Hill **Last Review Comments:** Risk reviewed. Controls updated and action progress updated by Anne Brierley.	There is a risk that inequalities and outcomes for specific demographic groups within BLMK population will widen (e.g. cost of living, health and care demand pressures) compromising our ICS purpose to improve outcomes and tackle inequalities.	I = 4 L = 4 16 To I = 4 L = 4 16	Cross-ICS inequalities steering group and working group to coordinate inequalities activity across the ICS framed around the core20plus5 approach Developing Business Intelligence reporting to report key health outcomes/NHS constitutional standards by place and PCN. For example: uptake of cancer screening and early diagnosis of cancer and 62-day treatment standards to highlight populations with late cancer diagnoses and enable proactive case finding and community engagement. Health inequalities defined at place and PCN level ICS system inequalities lead appointed giving more capacity for this workstream Learning from incidents , safeguarding case review, Community partnership safety work Resource allocation for 22/23 to help to reduce inequalities and draw out learning for future investment Review to understand the impact of Covid on inequalities (Lloyd Denny) Literature review completed. Safeguarding partnership board priorities (Neglect , transition etc..) Working with providers and partners on access for seldom heard communities Supporting the workforce to deal with the impact of the pandemic being overseen by the BLMK Peoples Board.	I = 4 L = 4 16 To I = 4 L = 4 16	Assurance and outcome metrics to be developed by Director of Contracting **Person Responsible:** Kathryn Moody **To be implemented by:** 31 Mar 2023	I = 4 L = 3 12 To I = 4 L = 3 12

Risk Ref	ICB Priorities	Risk Title	Risk Description	Initial Score	Risk Control	Current Score	Action Required	Target Score
					The new PCN Impact Investment Fund (criteria released 24.08.21) states that by 31 March 2022, PCNswill make use of GP Patient Survey results for practices in the PCN to identify patient groups experiencing inequalities in their experience of access to general practice, and develop and implement a plan to improve access for these patient groups.			
					Work with voluntary agencies e.g maternity Voices , parent carer forums SEND in coproduction of outcomes			

To recover from the impact of Covid-19, optimise people's health and wellbeing, advance health equality and make the best use of NHS resources

Risk Ref	ICB Priorities	Risk Title	Risk Description	Initial Score	Risk Control	Current Score	Action Required	Target Score
BAF 6	To recover from the impact of Covid-19, optimise people's health and wellbeing, advance health equality and make the best use of NHS resources	Financial Sustainability & Underlying Financial Health **Risk Owner:** Dean Westcott **Risk Lead:** Stephen Makin **Last Updated:** 10 Jan 2023 **Latest Review Date:** 10 Jan 2023 **Latest Review By:** Stephen Makin **Last Review Comments:** reviewed	As a result of increased inflation, significant operational pressures, patient backlogs and the enduring financial implications of the Covid pandemic - there is a risk to the underlying financial sustainability of BLMK that could result in failure to deliver statutory financial duties.	I = 5 L = 3 15 To I = 5 L = 3 15	Monthly financial reporting to Finance & Investment Committee and Integrated Care Board - includes analysis of financial performance: revenue, capital, underlying financial performance plus risks & mitigations. System led financial oversight through SOAG, Performance & Delivery Group and System DoFs Group. Update and development of system Medium Term Financial Plan for 2023/24 to 26/27. Includes scenario modelling of key variables and downsides.	I = 5 L = 3 15 To I = 5 L = 3 15	Development and implementation of system transformation, improvement and efficiency programme covering for 2023/24 + across and between ICS partners **Person Responsible:** Anne Brierley **To be implemented by:** 31 Mar 2023	I = 4 L = 3 12 To I = 4 L = 3 12

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Board of the Integrated Care Board
21. Corporate Governance 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	Gaynor Flynn, Governance & Compliance Manager
Date to which the information this report is based on was accurate	9 March 2023
Senior Responsible Owner	Maria Wogan, Chief of System Assurance & Corporate Services

The following individuals were consulted and involved in the development of this report:
Maria Wogan, Chief of System Assurance and Corporate Services. Committee Chairs.
This report has been presented to the following board/committee/group:
None. The reports from Committees summarise the outcomes of the meetings of the Committees of the Board of the ICB.

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

The purpose of this paper is to outline the following and ask Members to:

A) **Approve** the proposed amendments to the ICB's Governance Handbook in relation to:
- The Terms of Reference of the Primary Care Commissioning and Assurance Committee – see 2.1 below and Appendix A; and
- Cover arrangements following the resignation of a non-executive member – see 2.3 below.

B) **Note** the following:
- Resignation of non-executive member – see 2.2 below;
- Recruitment of a Non-Executive Member and Chair of Audit Committee – see 2.4 below;
- Update on recruitment for a Primary Medical Services partner member on the Board of the ICB – see 2.5 below;
- Plan for the development of the Annual Report & Accounts 2022/23 – 2.6 below;
- Proposed date for Annual General Meeting 2023 – see 2.7 below; and
- Committee Chairs' updates, provided in appendix B – see 2.8 below.

Executive Summary Report

1. Brief background / introduction:

This report provides a list of key Corporate Governance points to approve or note as indicted below.

Approval of amendments to the ICB's Governance Handbook is a power reserved to the Board of the Integrated Care Board. A link to the ICB's Governance Handbook can be found in section 9 below.

2. Summary of key points:

2.1 Terms of Reference of the Primary Care Commissioning and Assurance Committee (PCCAC)

Attached as Appendix A are revised terms of reference for the Primary Care Commissioning and Assurance Committee which have been changed to reflect the requirements needed to accommodate the delegation of podiatry, optometry and dentistry services from NHS England which is taking effect from 1 April 2023. There will be a need for additional sub-committees of PCCAC to be established to cover these new services which have been outlined in the earlier item on the Board agenda.

2.2 Resignation of non-executive member

Due to an ongoing health issue, Andrew Blakeman, Non-Executive Member and Chair of the Audit and Risk Assurance Committee and the Quality and Performance Committee has resigned. As Chair of Audit and Risk Assurance Committee, Andrew was also the Integrated Care Board's (ICB's) Conflicts of Interest Guardian.

The ICB acknowledges Andrew's hard work since its formation, particularly with the development of part 2 of the Audit and Risk Assurance Committee meeting which deals with system risks.

2.3 Cover Arrangements Following the Resignation of Non-Executive Member

Non-Executive Member, Manjeet Gill has been appointed as an interim member of the Audit and Risk Assurance Committee until a replacement for Andrew Blakeman (see 2.2 above) is recruited.

This appointment will help to strengthen the membership of the committee at this pivotal time of the financial and auditing year and will provide support to Alison Borrett who, as Deputy Chair, will chair the Committee until a permanent replacement is appointed.

Shirley Pointer has been nominated to take over as Chair of Quality and Performance Committee.

2.4 Recruitment of a Non-Executive Member and Chair of Audit and Risk Assurance Committee

The People Directorate have initiated a recruitment process for a replacement Chair of Audit and Risk Assurance Committee. An external search agency will be engaged to help source high quality candidates to enable as diverse a candidate pool as possible.

The timetable aims for the new Chair to be in place by the next Board meeting on 30 June 2023.

2.5 Update on Recruitment for a Primary Medical Services partner member of the Board of the ICB

A further recruitment process is underway to appoint to the vacancy for a primary services partner member of the Board. An unsuccessful recruitment process was undertaken in late 2022 and it is hoped that this new recruitment process will be successful. Again, the intention is that the successful candidate will be in place for the next Board meeting in June.

2.6 Plan for the development of the Annual Report & Accounts 2022/23

The ICB is required to produce Annual Report and Accounts for:

- NHS Bedfordshire, Luton & Milton Keynes Clinical Commissioning Group (CCG) for Q1 2022/23 and,
- NHS Bedfordshire, Luton & Milton Keynes Integrated Care Board (ICB) Q2 to Q4 2022/23

Work to develop the CCG's Q1 2022/23 report was undertaken in 2022.

Work has commenced to develop the ICB's Annual Report for Q2 to Q4 2022/23 and is being led by the Chief of System Assurance and Corporate Services (COSAC) as project executive. The ICB's Annual Report will be used by NHS England as part of their review of the functioning of the ICB.

The Audit and Risk Assurance Committee will oversee production of the Annual Report and Accounts on behalf of the Board, with involvement of the Finance and Investment Committee for aspects of the Annual Accounts.

The plan for the development of these reports was approved at the Audit and Risk Assurance Committee meeting held on 3 March 2023 and includes extraordinary meetings of the Audit and Risk Assurance Committee and Board on 23 June 2023 to receive the report from the External Auditors and approve the Annual Report and Accounts.

2.7 **Proposed date for Annual General Meeting 2023**

It is proposed that the Annual Report and Accounts for 2022/23 be presented at an Annual General Meeting (AGM) to be held on Friday 29 September 2023 following the meetings of the Board of the ICB in public and private.

The calendar invitation already sent to board members for the 29 September Board meetings will be extended to accommodate the AGM. Exact timings for each meeting will be finalised and communicated nearer the time.

2.8 Committee Chairs Updates

With three exceptions, updates from the following Committees of the Board can be found at appendix B. Unfortunately, it has not been possible to provide written updates for the committees that met on 16 and 17 March 2023 so verbal updates will be given at the Board meeting, where necessary.

Name of Committee	Meeting Held On
Audit & Risk Assurance Committee	3 March 2023
Bedfordshire Care Alliance – *no written report*	16 March 2023
Finance & Investment Committee	10 March 2023
Health and Care Partnership	7 March 2023
Primary Care Commissioning and Assurance Committee – *no written report*	17 March 2023
Quality & Performance Committee – *no written report*	3 March 2023
Working With People & Communities Committee	17 March 2023

3. Are there any options?

Approval of amendments to the ICB's Governance Handbook is a power reserved to the Board of the Integrated Care Board.

Given the timescale and statutory requirements for the CCG and ICB Annual Report and Accounts there are limited suitable options for delivery and sign-off.

4. Key Risks and Issues

None identified.

Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☐	No ☒

Not applicable as no risks identified.

5. Are there any financial implications or other resourcing implications, including workforce?

As with previous years, the services of a copywriter are being engaged to support development and delivery of the report at various stages.

6. How will / does this work help to address the Green Plan Commitments?

Click to view Green Plan

Not applicable.

7. How will / does this work help to address inequalities?

Not applicable.

8. Next steps:

The Governance Handbook will be updated and re-published on the Integrated Care Board website.

9. Appendices

Appendix A – Amended Primary Care Commissioning and Assurance Committee terms of reference Appendix B – Committee Chairs' Updates
10. Background reading
The ICBs Governance Handbook – Governance - BLMK Integrated Care Board (icb.nhs.uk)

Governance Handbook Appendix F Primary Care Commissioning and Assurance Committee Terms of Reference v2.0 approved by the Board of the Integrated Care Board 29-07-2022 with proposed amendments v3.0 approved by Primary Care Delivery Group and Primary Care Commissioning & Assurance Committee 27.09.22 subject to approval by the Board of the Integrated Care Board. Proposed amendments to the terms of reference for the Primary Care Commissioning and Assurance Committee will be presented to the Board for approval 23.03.2023 to incorporate the ICBs delegated responsibility from April 2023 primary care pharmacy, optometry and dental (includes acute and community) service from April 2023 subject to Board approval in March 2023. Changes to the Primary Care Delivery Group terms of reference will be made to incorporate primary care pharmacy, optometry and dental services.

1.0 Constitution

1.1 The Primary Care Commissioning and Assurance Committee (the Committee) is established by the Integrated Care Board (ICB) as a Committee of the Board of the ICB (the Board) in accordance with its Constitution.

1.2 These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

1.3 The Committee is a non-executive chaired Committee of the Board, and its members are bound by the Standing Orders and other policies of the ICB.

2.0 Authority

2.1 The Primary Care Commissioning and Assurance Committee is accountable to the ICB and shall report to the Board on how it discharges its delegated primary care commissioning functions for primary medical services from July 2022 and primary community pharmacy, optometry and dental services from April 2023.

2.2 The ICB holds only those powers as delegated in these Terms of Reference as determined by the NHS England Commissioning Board.

3.0 Purpose

3.1 The Committee exists to scrutinise and provide assurance to the ICB that there is an effective system of primary care services including medical, pharmacy, optometry and dental services commissioning that supports it to effectively deliver its statutory and strategic objectives and provide sustainable, high quality primary care.

3.1.1 The Committee acknowledges in exercising the ICB's functions (including those delegated to it), it must comply with the statutory duties including:

a) Management of conflicts of interest (section 14O).
b) Duty to promote the NHS Constitution (section 14P).
c) Duty to exercise its functions effectively, efficiently and economically (Section 14Q).
d) Duty as to improvement in quality of services (section 14R);

e) Duty in relation to quality of primary medical services (section 14S);
f) Duties as to reducing inequalities (section 14T).
g) Duty to promote the involvement of each patient (section 14U).
h) Duty as to patient choice (section 14V).
i) Duty as to promoting integration (section 14Z1).
j) Public involvement and consultation (section 14Z2).
k) Delivery of the ICB & Health & Care Partnership strategic objectives for primary care commissioning.

3.1.2 The Committee acknowledges that it is subject to any directions made by NHS England or the Secretary of State to the ICB.

3.2 Role of the Committee

3.2.1 The Committee has been established in accordance with the above statutory provisions to enable the members to, for example, make collective decisions on the review, planning and procurement of primary medical services, dental services and review pharmacy market entry requests through the regional Pharmaceutical Services Regulatory Committee (PSRC) in Bedfordshire, Luton and Milton Keynes under delegated authority from NHS England.

3.2.2 The role of the Committee shall be to carry out the functions relating to the commissioning of primary care services including primary medical, pharmacy, optometry and dental services under section 83 of the current NHS Act.

3.2.3 In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and Bedfordshire, Luton and Milton Keynes ICB which will sit alongside the delegation and Terms of Reference.

3.2.4 The functions of the Committee are undertaken in the context of a desire to promote increased quality, efficiency, productivity and value for money and to remove administrative barriers.

3.2.5 NHS Bedfordshire, Luton and Milton Keynes to receive assurance from the regional Pharmaceutical Services Regulatory Committee (PSRC) in relation to community pharmacy services including market entry requests

4.0 Membership and attendance

4.1 The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

4.2 The Board will appoint no fewer than eight members of the Committee including two who are Non-Executive Members of the Board (from the ICB). Other attendees of the Committee need not be members of the Board, but they may be.

4.3 When determining the membership of the Committee, active consideration will be made to equality, diversity and inclusion.

4.4 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of matters.

Chair and Deputy Chair

4.5 The Committee shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.

4.6 If the Chair has a conflict of interest, then the co-chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.

4.7 Members with Voting rights:

a) Non-Executive Member (Chair)
b) Non-Executive Member
c) ICB Chief Primary Care Officer
d) ICB Chief Finance Officer
e) ICB Chief Nursing Director
f) ICB Chief Medical Director
g) At least three Clinical Representatives who have primary care leadership experience delivering either primary medical, primary dental and primary ophthalmic services or services that may be provided as pharmaceutical services, following appointment of the ICB Partner Members or clinical lead roles. One of these members will be the Deputy Chair of the Committee.

4.8 Other attendees – non voting

4.8.1 The following non-voting attendees will be invited to attend the meetings of the Primary Care Commissioning and Assurance Committee, as subject area specialists and as pertinent to Agenda items:

a) Associate Directors of Primary Care and Transformation (2)
b) Associate Director of Primary Care Development
c) Associate Director of Medicines Optimisation
d) One representative from each Health Watch (4)
e) One representative from each Local Medical Committee (2)
f) One representative from the Local Pharmaceutical Committees
g) One representative from the Local Optometry Committees
h) One representative from the Local Dentistry Committees
i) One representative from each Health and Wellbeing Boards
j) One or more Public Health Representatives.

5.0 Meeting Quoracy and Decisions

5.1 The Primary Care Commissioning and Assurance Committee shall meet in private and public on a quarterly (four times per year) basis (to be determined by the ICB). Additional meetings may be convened on an exceptional basis at the discretion of the Committee Chair.

5.1.1 Meetings of the Committee shall be held in public, subject to the application of a)

a) The Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for the other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

Quorum

5.2 There will be a minimum of one Non-Executive Member - Chair or nominated deputy for the meeting, ICB Chief Primary Care Officer or ICB Chief Medical Director, ICB Chief Finance Officer plus one other ICB Executive Board Member.

5.3 Where members are required for quoracy but unable to attend, they should ensure that a named and briefed deputy is in attendance who is able to participate and vote on their behalf. No other deputies are permissible.

Decision making and voting

5.4 Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

5.5 Only voting members of the Committee, or deputies for members required for quoracy, may vote. Each voting member is allowed one vote and a majority will be conclusive on any matter.

5.6 Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be recorded in the minutes.

6.0 Responsibilities of the Committee

6.1 The responsibilities of the Primary Care Commissioning and Assurance Committee will be authorised by the ICB Board. It is expected that the Committee will:

a) Review and approve recommendations made by the Primary Care Delivery Group to include:

i. GMS and APMS contracts (including the design of APMS contracts, performance of contracts, appropriate contractual action such as issuing branch/remedial notices and removing a contract) has been applied.
ii. the commissioning of newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services").
iii. Decision making on whether to establish new GP practices in an area.
iv. Approving practice mergers.
v. Approving primary medical services incorporation applications
vi. Making decisions on discretionary payments.
vii. Making decisions relating to Primary Care Estates issues.
viii. Making decisions relating to Primary Care Digital issues.
ix. Making decisions relating to Primary Care Workforce.

b) Utilise local clinical knowledge to influence the development of and investment in general practice to improve access to services and taking a population health management approach.
c) Develop and commission end to end care and increased autonomy to shape future primary care services including medical, pharmacy, optometry and dental services.
d) Take an active role in driving forward the NHS Long Term Plan.
e) Provide assurance on and manage the budget for commissioning of primary medical services including pharmacy, optometry and dental services (from 2023) in Bedfordshire, Luton and Milton Keynes.
f) Plan, primary medical care, pharmacy, optometry and dental services in the BLMK area in response to population health assessments.
g) Undertake reviews of primary care services in the BLMK area, including primary medical services, community pharmacy, optometry and dental services.
h) Co-ordinate a common approach to the commissioning of primary care services generally.
i) Ensure collaborative working on monitoring and addressing issues of quality in primary care based on the principle of continuous improvement.
j) Agree and put forward the key primary care priorities that are included within the ICB strategy/annual plan, including priorities to address variation/inequalities in care.
k) Oversee and monitor delivery of primary care related ICB key statutory requirements.
l) Review and monitor those risks on the Board Assurance Framework and Corporate Risk Register which relate to primary care, and high-risk

operational risks which could impact on care. Ensure the ICB is kept informed of significant risks and mitigation plans, in a timely manner.

m) Oversee and scrutinise the ICB's response to all relevant (as applicable to primary care) Directives, Regulations, national standards, policies, reports, reviews and best practice as issued by the Department of Health and Social Care, NHS England and other regulatory bodies / external agencies (e.g. Care Quality Commission, National Institute of Clinical Excellence), to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained;

n) Maintain an overview of changes in the methodology employed by regulators and changes in legislation/regulation and assure the ICB that these are disseminated and implemented across all sites.

o) Ensure that mechanisms are in place to review and monitor the effectiveness of the quality of care delivered by providers and place.

p) Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for equality and diversity as it applies to people drawing on services.

q) Oversee the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for medicines optimisation and safety.

r) Have oversight of and approve the Terms of Reference and work programmes for the group reporting into the Primary Care Commissioning and Assurance Committee (Primary Care Delivery Group).

s) The Committee will provide regular assurance updates to the ICB in relation to activities and items within its remit.

t) Provide assurance on delivery of the Primary Care Strategy through the BLMK Fuller Neighbourhood Programme.

7.0 Behaviours and Conduct

ICB Values

7.1 Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and Diversity

7.2 Members must consider the equality and diversity implications of decisions they make.

Declarations of Interest

7.3 All members, ex-officio members and those in attendance must declare any actual or potential conflicts of interest which will be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration will be excluded from the discussion at the discretion of the Committee Chair.

8.0 Accountability and reporting

8.1 The Primary Care Commissioning and Assurance Committee is directly accountable to the ICB. The minutes of meetings shall be formally recorded. The Chair of the Committee shall report to the Board after each meeting and provide a report on assurances received, escalating any concerns where necessary.

8.2 The Committee will advise the Audit and Risk Assurance Committee on the adequacy of assurances available and contribute to the Annual Governance Statement.

8.3 The Committee will receive scheduled assurance report from its delegated group the Executive led Primary Care Delivery Group which will include quarterly assurance reports from the Primary Care Workforce & Education Network Training Hub Steering Group, the Estates Working Group and the Primary Care Contracting Panel. Any delegated groups would need to be agreed by the ICB Board.

9.0 Secretariat and Administration

9.1 The Committee shall be supported with a secretariat function which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary.
- Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.
- The Chair is supported to prepare and deliver reports to the Board.
- The Committee is updated on pertinent issues/ areas of interest/ policy developments.
- Action points are taken forward between meetings and progress against

those actions is monitored.

10.0 Review

10.1 The Committee will review its effectiveness at least annually.

10.2 These Terms of Reference will be reviewed at least every two years and more frequently if required. Any proposed amendments to the Terms of Reference will be submitted to the Board for approval.

10.3 The Committee will utilise a continuous improvement approach in its delegation and all members will be encouraged to review the effectiveness of the meeting at each sitting.

11.0 Responsibilities of the Committee to provide assurance of Delegated Functions

11.1 The Primary Care Commissioning and Assurance Committee is responsible for providing the ICB with assurance in relation to its decisions for the commissioning, procurement and management of Primary Medical Services Contracts, including but not limited to the following activities:

i) Decisions made in relation to Directed and Local Enhanced Services and Local Incentive Schemes (including the design of such schemes).

ii) decisions in relation to the establishment of new GP practices (including branch surgeries) and closure of GP practices.

iii) decisions made about 'discretionary' payments.

iv) decisions about commissioning urgent same day access ~~(including home visits as required) for out of area registered patients.~~

a) Ensuring robust planning for primary medical care services in the area, including carrying out needs assessments.

b) undertaking reviews of primary medical care services in the area.

c) providing assurance on contractual compliance and decision making in relation to the management of poorly performing GP practices and including, without limitation, decisions and liaison with the Care Quality Commission where the Care Quality Commission has reported non-compliance with standards (but excluding any decisions in relation to the performers list).

d) providing assurance and oversight of the management of the delegated primary medical services funds in the area.

e) Ensuring compliance with the Premises Costs Directions (PCD) functions.

f) co-ordination of a common approach to the commissioning of primary care services with other commissioners in the area where appropriate; and

g) such other ancillary activities as are necessary to exercise the Delegated Functions.

h) Providing assurance on contractual compliance and decision making in relation to the management of poorly performing dental, pharmacy and optometry services including, without limitation, decisions and liaison with the Care Quality Commission where the Care Quality Commission has reported non-compliance with standards (but excluding any decisions in relation to the performers list).

i) Ensuring robust planning and integration of primary, community and acute dental care services in the area including the utilisation of the Public Health Dental Needs Assessment (DNA)

j) Ensuring robust planning and integration of community pharmacy services including the utilisation of the Public Health Pharmacy Needs Assessment (PNA)

k) Assurance of the integration of pharmacy, optometry and dental services including utilising public health prevention flexibilities within the contractual/framework to support

Appendix B – Committee Chairs Updates:

Audit & Risk Assurance Committee – Part 1 – 3 March 2023
Update to Board on key points
▪ Due to the resignation of Andrew Blakeman, Non-Executive Member and Chair of Audit and Risk Assurance Committee, Non-Executive Member, Manjeet Gill has been appointed as an Interim Member of the Committee until a replacement for Andrew is recruited. This appointment will help to strengthen the non-executive membership of the committee at this pivotal time of the financial and auditing year. ▪ External Auditors Grant Thornton presented the Audit Plan for the Annual Report for the period April 2022 to 30 June 2022 for Bedfordshire, Luton and Milton Keynes Clinical Commissioning Group (CCG) (2021/22) and provided a verbal update on progress made to date. ▪ Internal Auditors BDO presented several reports including, Progress Report, EDI briefing paper, Key Financial Systems Audit Report, HFMA Financial Sustainability ICB Benchmarking Report, Internal Audit Follow up report and the Draft Internal Audit Plan 2023/24, which will be represented in May 2023 for approval following requested amendments. ▪ The BDO Counter Fraud Specialist presented a progress update and a draft Counter Fraud Annual Work Plan 2023/24 which the Committee approved. A robust discussion took place regarding the link between fraud and cyber risks. ▪ The Deputy Chief Finance Officer presented a report which proposed that the ICB prepares its accounts on a going concern basis with several management judgements and estimates. ▪ The Chief of System Assurance and Corporate Services (COSAC) presented a report which outlined the requirement for the ICB to produce an Annual Report for Q2 to Q4 2022/23 and a Q1 2022/23 CCG Annual Report and the process in place for the preparation, development and approval. The committee approved the process. ▪ The Podiatry, Ophthalmology and Dentistry (POD) Delegation and Transformation Lead updated the Committee on the due diligence work undertaken in preparation for the transfer of POD contracts to the ICB on 1 April 2023. There are several risks which the Committee felt it needs to remain aware of and has requested an update at the next meeting. ▪ The Director of Contracting presented a report on Specialised Commissioning Delegation and Hosting due diligence. The Committee approved for the assessment of bidder submissions and the award of contract to the preferred bidder to be delegated to the Chief Executive and Chief Financial Officer, in order to not delay the contract award. ▪ The COSAC presented the Risk Management Report noting that, as we get nearer to the end of the financial year, there is expectation that the risk scores on some of the financial risks will start reducing or closing as we get greater certainty of the year-end financial position. Discussion took place regarding two particular risks which require clarification regarding the scope and mitigating actions. ▪ The Head of Digital presented a Cyber and IT Security Assurance Report which highlights the measures the ICB's IT service provider, Hertfordshire, Bedfordshire and Luton Information Technology (HBLICT) have in place to identify and prevent threats and attacks. ▪ The Chief People Officer provided a verbal update on Freedom to Speak Up (FTSU) noting that the ICB's FTSU Guardian (Non-Executive Member, Alison Borrett) will be attending an All Staff Briefing in March to make herself known to staff and to highlight that from 1 April 2023, FTSU will be a mandated training module for ICB staff.
Decisions for approval by the Board

There are none.

Audit & Risk Assurance Committee – Part 2 – 3 March 2023
Update to Board on key points
▪ The Chief of System Assurance and Corporate Services (COSAC) presented a Strategic System Risk Management presentation. ▪ Discussions took place with regards the content of the presentation which included the following subject areas: o Primary Care Podiatry, Ophthalmology and Dentistry (POD) Delegation Risk; o Population Growth Risk; o Failure to Collaborate; o Population Expectations; and o Risk Movement (Escalation/De-escalation).
Decisions for approval by the Board
There are none.

Bedfordshire Care Alliance Board Committee - next meeting 16 March 2023
Update to Board on key points
• There is no further written update since the last meeting.
Decisions for approval by the Board
There are none.

Finance & Investment Committee - 10 March 2023
Update to Board on key points
• There is no further written update since the last meeting.
Decisions for approval by the Board
There are none.

Health and Care Partnership - 7 March 2023
Update to Board on key points
▪ **Joint forward plan** - An update on the development of the joint forward plan has Place plans as its foundation was presented. ▪ **Place plans, Health and Wellbeing Board updates and Health and Wellbeing Board guidance** – Place plans and the local priorities were presented and key areas of discussion from the Health and Wellbeing Board meetings in Central Bedfordshire,

Luton, Milton Keynes and Buckinghamshire Council was provided. Bedford Borough Health and Wellbeing Board is meeting on 15 March.

Health and Wellbeing Board guidance that was published in November 2022 and the requirements it on the Health and Wellbeing Boards, ICBs and ICPs was noted. Health and wellbeing boards – guidance - GOV.UK (www.gov.uk)

- **Delegation of Dentistry, Optometry & Community Pharmacy** – an update on the delegation of responsibility from 1 April 2023 to the ICB of dentistry, optometry and community pharmacy was provided. It was noted that 2023/24 would be a transitional year and provides an opportunity to build relationships with contractors. It was reported that there are significant challenges with the national contracts and partners supported the lobbying for change in contracts to enable more local flexibility. Access to NHS dentists was a real concern for residents and coupled with community pharmacy closures, increases the workload for GPs.

- **Mental Health, Learning Disability and Autism collaboration –** information was shared on the progress that had been made in provision of mental health services since the Mental Health Five Year Forward view was published in 2016 and the investment through the Mental Health Investment Standard. There was an opportunity to have greater collaboration for people with mental illness, learning disabilities and autism and the Board had agreed the development of this collaborative. The report contained an update on feedback from engagement that has taken place and what areas of focus service users are identifying.

- **Community Engagement** – a presentation was given on the new approach of pooling partner resources to avoid engagement duplication, agreeing co-production principles and highlighted areas of work e.g. the Denny review.

- **Membership of the Health and Care Partnership –** the membership of the Partnership will be changing as a result of the appointment of new Chairs of NHS Trusts, Councillors not standing for re-election and the outcome of the local elections in May 2023.

Decisions for approval by the Board

There are none.

Health & Care Senate – 8 December 2022

Update to Board on key points

The Committee noted and discussed the following:

1. Research and Development Hub – BLMK Projects including the links to the Fire Service and Falls prevention work
2. Polypharmacy
3. Re-conditioning the Nation
4. BLMK Network Meetings

Decisions for approval by the Board

There are none.

Primary Care & Commissioning Assurance Committee (PCC&AC) in Public – Next meeting 17 March 2023
Update to Board on key points
▪ There is no further written update for the Board
Decisions for approval by the Board
There are none.

Quality & Performance Committee – 3 March 2023
Update to Board on key points
▪ There is no further written update for the Board
Decisions for approval by the Board
There are none.

Working With People & Communities Committee (WWPAC) – workshop 17 February 2023
Update to Board on key points
Engaging with Local People (The Big Conversation) We held a workshop on 17 February 2023 for members of the Working with People and Communities Committee, with additional representation from the VCSE and the health inequalities workstream, to inform the next steps of involving local people in our work. We had a comprehensive discussion around the main issues which affected engagement and attendees were able to provide experiences and knowledge from their respective organisations. The feedback and insights will be used to inform the engagement approach for the ICB, helping us to deliver a process of continuous conversations with residents and undertake detailed NHS planning in line with the Working with People and Communities Strategy.
Decisions for approval by the Board
There are none.

ICB in PUBLIC - Annual Cycle of Business - 2023 - 2 For the preparation of Board meeting agendas

Subject	Accountable Person (name on agenda)	Author/s	30/06/2023	29/09/2023	08/12/2023	22/03/2024
Opening Actions						
Welcome, Introductions and Apologies			✓	✓	✓	✓
Core Purposes of ICSs			✓	✓	✓	✓
Relevant Persons Disclosure of Interests			✓	✓	✓	✓
Approval of Minutes and Matters Arising			✓	✓	✓	✓
Review of Action Tracker			✓	✓	✓	✓
Chair's Report (Verbal)			✓	✓	✓	✓
Chief Executive Officer's Report			✓	✓	✓	✓
Questions from the Public			✓	✓	✓	✓
Strategy						
Reports from Place Based Boards: • Bedford Borough • Central Bedfordshire • Luton • Milton Keynes	Local Authority CEOs		✓	✓	✓	✓
Fuller Stocktake - quarterly	Chief Primary Care Officer (CPCO)	CPCO	✓	✓	✓	✓
Delegation of Pharmacy, Optometry and Dentistry	Chief Primary Care Officer		✓	✓	✓	✓
Operational						

Subject	Accountable Person (name on agenda)	Author/s	30/06/2023	29/09/2023	08/12/2023	22/03/2024
Quality & Performance Statement/Report	Chief Nursing Director (CND)	Performance Team Team/CND	✓	✓	✓	✓
Finance Report	Chief Finance Officer	Stephen Makin	✓	✓	✓	✓
Planning for Winter 2023 - 2024	Chief Transformation Officer			✓		
Workforce Race Equality Standard (WRES)	Chief People Officer			✓		
ELFT, CNWL, BLMK ICB - MHLDA Collaborative business case	Chief Transformation Officer	Loraine Rossati				✓
BLMK ICB - Implementing the target operating model (TOM)	Chief People Officer	Emma Richards		✓		
Delegation of Specialised Commissioning	Chief Transformation Officer	Richard Alsop	✓			
Joint Forward Plan	Chief Transformation Officer	Hilary Tovey	✓			
Resident's Story	Chief of System Assurance & Corporate Services	tbc	✓	✓	✓	✓
Governance						
Board Assurance Framework	Chief of System Assurance & Corporate Services	Ola Hill	✓	✓	✓	✓
Corporate Governance Update	Chief of System Assurance & Corporate Services	Sarah Feal	✓	✓	✓	✓
Updates from Committee Chairs	Chief of System Assurance & Corporate Services	Kim Atkin	✓	✓	✓	✓
Annual Cycle of Business and/or Forward Planner	Chief of System Assurance & Corporate Services	Kim Atkin	✓	✓	✓	✓
Communications from the meeting to all ICS partner organisations	Chief of System Assurance & Corporate Services	-	✓	✓	✓	✓
Annual Evaluation of Performance of Board, its Committees, the Chair and individual directors			✓			
Review of Meeting Effectiveness (for each meeting)	Chief of System Assurance & Corporate Services	-	✓	✓	✓	✓

Subject	Accountable Person (name on agenda)	Author/s	30/06/2023	29/09/2023	08/12/2023	22/03/2024
Closing Actions						
Any Other Business	Chair	-	✓	✓	✓	✓
Date and Time of Next Meeting	Chair	-	✓	✓	✓	✓