NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

BNSSG ICB Primary Care Committee Meeting

Minutes of the meeting held on 25th October 2022 at 9.00am, held in the Conference Room, 4th Floor, 360 Bristol, Marlborough Street, Bristol, BS1 3NX

Minutes

Present		
Alison Moon	Chair of Committee, Non-Executive Member – Primary Care	AM
Richard Brown	Chief Officer, Avon Local Pharmaceutical Committee	RB
Debbie Campbell	Deputy Director (Medicines Optimisation), BNSSG ICB	DC
Amanda Cheesley	Partner Non-Executive Member, Sirona care & health	AC
Jamie Denton	Head of Finance, Primary, Community & Non-Acute Services, BNSSG ICB	JD
Nikki Holmes	Head of Primary Care, South West, NHS England and Improvement	NH
John Hopcroft	Avon Local Optical Committee	JH
David Jarrett	Director of Primary and Integrated Care, BNSSG ICB	DJ
Philip Kirby	Chief Executive, Avon Local Medical Committee	PK
Joanne Medhurst	Chief Medical Officer, BNSSG ICB	JM
George Schofield	Avon Local Dental Committee Secretary	GS
Apologies		
Georgie Bigg	Healthwatch Bristol, North Somerset and South Gloucestershire	GB
Katrina Boutin	GP Collaborative Board Representative	KB
Jenny Bowker	Head of Primary Care Development, BNSSG ICB	JB
Katie Handford	Models of Care Development Lead, BNSSG ICB	KH
Geeta Iyer	Primary Care Provider Development Clinical Lead, BNSSG ICB	GI
Matt Lenny	Director of Public Health, North Somerset Council	ML
Jon Lund	Deputy Chief Financial Officer, BNSSG ICB	JL
Lisa Manson	Director of Performance and Delivery, BNSSG ICB	LM
David Moss	Delivery Director – Woodspring Locality Partnership, BNSSG ICB	DM
Sarah Purdy	Partner Non-Executive Member, North Bristol NHS Trust	SP
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS
Sarah Truelove	Chief Financial Officer and Deputy Chief Executive, BNSSG ICB	ST
In attendance		
Louisa Darlison	Senior Contract Manager Primary Care, BNSSG ICB	LD

Bev Haworth	Senior Programme Lead PCN & Workforce Development, BNSSG ICB	BH
Sukeina Kassam	Interim Head of Primary Care Contracts, BNSSG ICB	SK
Kat Showler	Senior Contract Manager Primary Care, BNSSG ICB	KS
Steve Sylvester	Primary Care, South West, NHS England and Improvement	SS
Sarah Carr	Corporate Secretary, BNSSG ICB	SC

	Item	Action
1	**Welcome and Apologies** AM welcomed all to the meeting and the apologies were noted. The meeting was quorate but the schedule would be revisited to ensure that meetings were not scheduled for the half term holidays if possible.	**AM/DJ**
2	**Declarations of Interest** There were no new declarations of interest and no existing declarations of interest relating to agenda items.	
3	**Minutes of the previous meeting held on 27th September 2022** The initials for Amanda Cheesley would be corrected to read AC. With this amendment the minutes were agreed as a correct record.	
4	**Review of Action Log** The Committee reviewed the action log: **Action 218**. SK confirmed the paper would come to the November Committee meeting. The action remained open **Action 8:** LD confirmed that legacy clinical waste agreements had been passed to the managing agent. Further reporting would be made to the Primary Care Operational Group. The action was closed. **Action 9:** It was confirmed that heat maps showing variation would be included in future reporting where appropriate. The action was closed. AM observed it was important that locality inequalities, including 'below and above average' positions, were included in future papers as standard. **Action 11:** DJ commented that the NHSE monthly activity reports for Pharmaceutical, Ophthalmic and Dental services followed a standard format; feedback would inform their ongoing development. The action was closed. **Action 12:** SK confirmed the Homeless Health service contract was on track and would be reported to the Finance, Estates and Digital Committee. The action was closed. **Action 13:** It was noted the request was to ensure the Primary Care Strategy reflected the user voice. The action remained open. All other due actions were closed	
5	**Review of Risk Register** AM drew attention to the risks relating to the Committee's remit. It was explained that the risks discussed previously relating to the delegation of primary care services would be added to the register. AM asked that these were added for the November review. There was a discussion about the workforce risk. DJ explained workforce issues and mitigating actions would be included in the Primary Care Strategy update at the next meeting. AM observed	**DJ/JB**

	Item	Action
	that workforce was a risk across the system and asked about the capacity to develop the strategic system workforce plan. DJ explained that there was capacity to develop the plan and this was being refocused and realigned to ensure it met the system requirement. Work on capacity planning had been completed as part of the planning submission process and this was being taken forward. There was a discussion about system workforce, available capacity, activity and productivity. It was noted that there were significant gaps in key workforce areas and issues relating to recruitment and retention. JM commented that further detailed analysis was being completed and that a range of factors impacted on workforce and productivity. AM asked about system partnership working. JM confirmed that this was progressing and observed the national mandate for system control centres supported the shift in focus. **The Primary Care Committee:** • **Reviewed the Corporate Risk Register ensuring that appropriate and effective mitigations were in place for risks reported and specifically those areas relating to the Committee's remit** • **Reviewed risks recommended for closure to ensure it was assured that the risk score had been sufficiently reduced** • **Considered whether the Corporate Risk Register (CRR) was an accurate reflection of the risks brought to the Committee's attention** • **Agreed that the Primary Care Delegation Risks would be added to the Register**	
6	**Primary Care Committee (PCC) Terms of Reference** AM drew attention to the amendments to the Terms of Reference. DJ sought confirmation of the quoracy. This was confirmed. RB asked about the addition of the three Local Committees. It was confirmed that these would be added to the list of attendees once the delegation of primary care services was completed. The Terms of Reference would be reviewed and amended in full in April 2023. DC noted that representation from the Medicines Optimisation team was included twice. It was agreed to remove one reference. **The Primary Care Committee reviewed the Terms of Reference and recommended them to the ICB Board, subject to the amendment agreed**	**SC**
7	**Primary Care Operational Group (PCOG) Terms of Reference** AM commented that it was important that the Committee was focused on the four aims of the ICB and an effective executive function that managed operational detail was needed to support the Committee to deliver its remit. DJ set out the background to the proposed revised Terms of Reference. The revisions were intended to enable the PCC to undertake its assurance function and have oversight of strategy. The PCOG would have a role in decision making within delegated limits set out in the ICB Scheme of Reservation and Delegation and Standing Financial Instructions. The terms of reference would be reviewed in April. DJ noted that the four core aims of the ICB were omitted	

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	from the Terms of Reference and these would be added. The delegated responsibilities included in the Terms of Reference were highlighted. The Terms of Reference would support the preparation for further delegations from NHSE. PCC would remain accountable for the decisions made by PCOG and decisions made by PCOG would be reported to the PCC. JM commented on the development of the Terms of Reference of the Health and Care Professional Executive (HCPE). The intention was for this group to have a 'right to pause' proposed developments that were considered to have a significant clinical/social care impact across the system. JM asked that the PCOG Terms of Reference reflected this and referenced the HCPE. There followed a discussion about the HCPE and links to the PCOG and other committees. It was noted that the HCPE had an important role in the wider decision-making process, however it was not a decision-making body. AM observed that it was important that decision making for the system was agile. It was explained that the HPCE met fortnightly. There was a question about the inclusion of representatives of dental, ophthalmic and pharmacy services and JM agreed to raise this. DJ and JM agreed to discuss this further outside of the meeting. There was a discussion about the remit of the HCPE; it was noted that this would have implications for all decision making. AM commented that it would be helpful to have an additional question in business case and decision-making templates that included impacts across the system. AM asked for the service user voice to be strengthened in the Terms of Reference; this was agreed. AM asked about the quoracy. DJ explained that the quoracy reflected the arrangements for the PCC. It was noted that the PCC retained accountability and there was a discussion about how the PCOG would provide assurance regarding decision making. It was agreed that initial decisions made by PCOG would be reported to the PCC and a decision-making audit trail would be provided for assurance. There was a discussion about the range of decisions within the remit of the PCOG and it was noted that there would be exceptions where the decision was within the financial limits of delegations however other aspects of the decision would mean it would be reserved to the PCC and potentially the ICB Board. It was agreed this would be clarified in the Terms of Reference. **The Primary Care Committee approved the revised PCOG Terms of Reference, subject to the amendments agreed and noted that they would be reviewed for April 2023**	**DJ** **DJ** **JM** **DJ/JM** **DJ** **DJ**
8	**Winter Planning Approach** BH drew attention to the evaluation of the 2021/22 Winter Access Fund and the schemes set out in the appendices. Those schemes with the highest uptake and most positive feedback supported the provision of same day appointments. As a result of the schemes a higher number of same day appointments had been offered. The schemes were delivered through a significant collaboration	

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	between general practices, the GP Collaborative Board (GPCB), the LMC and CCG colleagues. Feedback received was that some of the schemes for 2021/22 were overly complex and ambitious and simpler schemes with short implementation timescales were preferred. BH drew attention to the guidance issued for 2022/23. This increased the focus on capacity outside of acute care and included the upscaling of primary care access. The NHSE Board Assurance Framework six key performance metrics were highlighted. Further guidance for general practice outlining steps to support the expansion of primary care capacity had been released. This included a framework for supporting general practice, and help to assess the resilience needs of practices and PCNs. There were changes to the Network Contract DES with a number of indicators deferred. The funding released would be redirected as a PCN Support Payment to increase workforce and clinical capacity to provide additional appointments and improve access. Other measures included introducing two new Additional Roles; General Practice Assistants, providing clinical and administrative support to GPs to release clinical time for patient care, and Digital and Transformation Leads to support increased access to care for patients through new technologies and initiatives. A system wide winter planning meeting had been held, focusing on the 6 metrics. The GPCB Urgent Care Network had agreed to take forward the general practice contribution to the system plan as detailed in the paper. ICB colleagues had met with GPCB representatives to review the ICB framework. An initial desktop review to identify gaps was agreed with PCN level engagement as required. It was explained that priorities for bids for potential capital investment were discussed and that further guidance on the bidding process was anticipated. The response to the framework would feed into the submissions against the Board Assurance Framework. BH drew attention to the Primary Care Plans for winter 2022/23 in the paper. These included a focus on increasing the number of appointments available from the 1st of October through the Enhanced Access specification and the PCN support payment. The intention was to provide approximately 14,000 additional appointments. The success of the Community Pharmacy Consultation service would be built on and new Patient Group Directions were in development. The Access, Resilience and Quality Programme had expand and the team was working with nine practices. The Community Clinic programme would continue. Other plans included a winter communications campaign, general practice recovery funding and actions in response to the Fuller Stocktake. AM welcomed the papers. JM commented that further nationally mandated guidance had been received which would affect primary and community care. This included the management of high frequency users of services, the creation	

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	of respiratory hubs and a focus on community falls, which was based on the Weston model. JM noted that it was important to roll out existing projects across the wider footprint. The main challenge was the flow of patients through acute hospital services and all parts of the system had a role in address the key issues. GS commented on the 2021/22 winter schemes noting that lead in times, the non-recurrent nature of funding, and workforce issues were barriers to their effective uptake. AM commented it was important to have assurance that schemes were able to be implemented quickly. It was noted that a lack of general practice same day appointments and delays in seeing GPs continued to be raised in the GP survey. JH commented that optometrist services could support acute and urgent presentations. JM agreed it was important to have a multi-disciplinary approach, with teams working at the top of their license. AC commented on a recent meeting of community provider chairs with the NHSE Director of Primary and Community Care. It had been noted that it was important to consider the role of GPs as gatekeepers for services and how this could be changed to free up primary care availability. It was noted that challenges were no longer confined to winter periods and the system needed to consider whether to recruit on a more permeant basis to address issues. BH commented on the process used to develop schemes in 2021/22 and encouraged colleagues to provide further feedback. DC asked whether the evaluation had looked at the impact of the schemes on A&E attendances, admissions and length of stay. It was agreed that DC and BH would discuss this outside the meeting. **The Primary Care Committee noted:** • **the learning from the Winter Access Fund evaluation** • **the guidance received for winter 2022/23 and the responses to the actions and** • **approved the approach to increase Primary Care capacity and General Practice resilience over winter 2022/23**	**BH/DC**
9	**Delegation of POD Services** SS joined the meeting via MS Teams for this item. DJ explained there would be a longer session for the Committee in November that would focus on dental services. The paper presented at this point focused on the South West Dental Reform Programme Roadmap. SS explained the roadmap set out the direction of travel for dental services reform. The paper included the programme action plan and metrics. The roadmap had been discussed with ICBs in the context of joint commissioning. The ICB was being asked to provide its views on the direction. DJ noted the paper was for comment and input. SS confirmed this was an iterative document and that it would be localised for each ICB footprint. AM asked that the November seminar presentation contained BNSSG specifics. SS confirmed that localised data would be available including access rates and performance. AM asked that information for the seminar included	

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	variations within BNSSG and good practice from elsewhere. SS confirmed he would be meeting with DJ and the LDC to discuss the new working arrangements. GS asked about the national position regarding the Dental Contract. SS committed to raising this with colleagues in the centre. SS left the meeting. DJ provided an update on progress towards the delegation of pharmaceutical, ophthalmic and dental services. The ICB Board had supported the recommendation of the Committee and the Finance, Estates and Digital Committee to proceed with the delegation and had delegated authority to the PCC to seek assurances in relation to the risks discussed and presented to the ICB Board. The pre-delegation assessment framework had been reviewed by the national moderation panel and had been approved for delegation from the 1st of April 2023. This would go forward for final approval by the NHSE Board in December. The ICB team was working through the Safe Delegation Checklist and the key risks identified would be managed through the checklist process. NHSE SW was working collaboratively with ICB teams across the region to complete the checklist. JD commented that the financial allocation methodology for dental services would be considered by the Chief Financial Officers in November. It was explained that specialist groups had been established to take forward each workstream. The Safe Delegation Checklist would be taken through the ICB governance structures for sign off and final sign off in February 2023. AM asked about the evaluation of the Commissioning Hub arrangements. It was explained that the proposed evaluation would be delayed to enable the Hub to embed. GS commented on the financial risk and asked about the implications for providers. JD explained the financial risks related to the overall ICB allocations and financial balance and individual service areas. There was a discussion about the risks and the focus of the Committee on risks to the ICB and the wider system. It was noted that there were issues with the dental contract. The proposed delegation of services provided an opportunity to work with dental service providers and engage provides with schemes across BNSSG. There was a discussion about the issues facing dental services and it was observed it was important that the issues facing each service were understood. NH commented that the details of work undertaken by the NHSE dental team with the Local Dental Committee focused on resilience would be shared at the November meeting. GS highlighted the pressures facing dental services relating to the cost-of-living crisis and the impact of changes in the Dental Contract. AM observed it was important to receive an update on the position at the November meeting. An update on the Safe Delegation Checklist would come to the next meeting. DJ noted the Committee had not received the NHSE activity	**DJ**

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	reports and asked NH if there were issues to draw to the Committee's attention. NH commented there were some minor changes in activity relating to some waiting lists, and for pharmacy changes in supplementary hours. NK explained the team worked with each provider to understand the overall impact of these. **The Primary Care Committee received the paper and noted the update**	
10	**Fuller Stocktake Draft** DJ explained the Fuller recommendations were not mandatory however they were constructive and aligned with the primary care strategy. The recommendations related to the integration of wider primary care services. The paper to the Committee was an initial self-assessment against the recommendations. The GPCB, the Primary Care Collaborative, Sirona, Severnside and the Avon LMC would be invited to provide their assessment against the recommendations and identify key priorities for action. This approach had been discussed and agreed at the Primary Care Locality Development Group with key partners. AM welcomed the paper and observed there was only one example of best practice example from the South West in the Fuller Report. There was a discussion about encouraging primary care colleagues to come forward to help promote good practice examples. AM asked about the development of the out of hospital strategy. DJ explained this was embedded within the ICS Strategy. JM commented that having a good practice/good news section in the meeting would be one approach to highlighting good practice to the ICB Board and sharing in the wider public domain. It was agreed this would be considered as part of the agenda setting process. DJ explained the final stock take assessment and recommended priorities would come back to the Committee. **The Primary Care Committee received the report**	**AM/DJ**
11	**Primary Care Finance Report** JD explained there was no material change in the reported forecast position. The variances reported were planning differences and these would continue to be reported. Attention was drawn to the primary care prescribing underspend reported which was attributed to an overestimate of costs in quarter 4 2021/22 and lower than planned year to date costs. It was anticipated that Category M drug costs would rise and the position would change. Expenditure against the allocation for additional roles was highlighted. AM asked for further information to come to a future Committee about restricted and unrestricted funds. RB asked about the overspend against the PCN DES. JD explained that NHSE would reimburse this expenditure. **The Primary Care Committee:** • **Noted the summary financial plan** • **Noted the key risks and mitigations to delivering the financial plan** • **Noted that at Month 6 (September), combined Primary Care budgets reported a £2,986k underspend, and a forecast of £3,333k (including the Additional Roles Reimbursement)**	**JD**

	Item	Action
12	**Key Messages for the ICB Board** The Committee agreed the key messages for the ICB Board which included: • The discussions relating to winter planning • The progress made on delegation • The Fuller Stocktake • The changes to the Terms of Reference of the PCOG and adaptations to the primary care governance	
13	**Helios Medical Centre Closure- Lessons Learnt** The item was for information. There were no questions. **The Primary Care Committee received the report**	
14	**Redacted**	
	Part B minutes to be taken in closed ICB Board	
15	**Redacted**	
16	**Primary Care Operational Group (PCOG) Minutes** **The Primary Care Committee received the minutes**	
17	**Any Other Business** It was noted and commended that the BNSSG ICB 'Insight driven approach to maximising Covid 19 vaccine uptake amongst Minority Ethnic and non-English speaking communities' had won the HSJ Patient Safety Award for improving health outcomes for Minority Ethic communities.	
	Date of Next Meeting 22nd November 2022, MS Teams	

Sarah Carr, Corporate Secretary, October 2022

Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Meeting of BNSSG ICB Board

Date: 1st December 2022
Time: 12:15pm
Location: MS teams

Agenda Number:	7.4.2
Title:	Review of Primary Care Committee Terms of Reference
Purpose: For decision	
Key Points for Discussion:	
The Committee Terms of Reference were approved by the ICB Board at the July 1st meeting. As part of the governance process the terms of reference of all ICB committees have been reviewed. Following this review the Primary Care Committee Terms of Reference have been amended as highlighted in the paper..	
Recommendations:	To approve the revised Primary Care Committee Terms of Reference
Previously considered by and feedback:	The Terms of Reference have been reviewed by the Primary Care Committee
Management of Declared Interest:	There are no potential or actual Conflicts of Interest.
Risk and Assurance:	There is a risk that without a change to increase the membership of the committee achieving a quorum may be challenging. This will affect the committee's ability to progress ICB governance business and provide the ICB with adequate assurance. The proposed amendment is intended to mitigate this risk. Unmitigated this risk is rated as 4 (probable) x 4 (major) = 16. The proposed mitigation reduces the risk score to 2 (unlikely) x 4 (major) = 8
Financial / Resource Implications:	The is a resource implication in relation to Non-executive Director time.
Legal, Policy and Regulatory Requirements:	The Committee is established by the ICB as a Committee of the Board in line with its Constitution and with Delegations made under section 65Z5 of the 2006 NHS Act as amended by the Health and Care Act 2022.
How does this reduce Health Inequalities:	The Committee will receive reports that relate to the reduction of health inequalities as part of its work programme

How does this impact on Equality & diversity	The Committee will receive reports that relate to the reduction of inequalities as part of its work programme
Patient and Public Involvement:	The Committee will receive reports that relate to the patient and public involvement as part of its work programme
Communications and Engagement:	The revised Terms of Reference will be added to the ICB website as part of the Governance Handbook
Author(s):	Sarah Carr, Corporate Secretary
Sponsoring Director:	Sarah Truelove, Chief Financial Officer

Primary Care ~~Commissioning~~ Committee Terms of Reference

1. Introduction

Constitution:

In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHS England has delegated the exercise of the functions specified in Schedule 1 to these Terms of Reference to the ICB.

The Primary Care ~~Commissioning~~ Committee, PCC (the Committee) is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution and in accordance with Delegations made under section 65Z5 of the 2006 NHS Act (see Appendix 1) as amended by the Health and Care Act 2022.

These terms of reference, 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.

The Committee is a non-executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB

Purpose:

The aims of the ICB are to:

- 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 and economic development.

The purpose of the Committee is to contribute to the overall delivery of the ICB objectives and population outcomes by managing the delivery of those elements of the primary care healthcare services delegated by NHS England to the ICB.

The aim will be to deliver to the people of BNSSG, on behalf of the ICB, services that are of high quality, clinically effective and safe, within available resources

The committee will embed the ICB principles of engaging with and embedding the voice of our local population in co-production and understanding of local need.

In addition, the committee will have responsibility for the oversight and delivery of the BNSSG Primary Care Strategy and its core deliverables of:

i. Workforce development
ii. Reducing Unwarranted Variation
iii. Developing Integrated models of care
iv. Supporting Infrastructure

The Committee will also have oversight of Primary Care Operational Planning and the impact of service and workforce change across the system on primary care services.

The Committee is responsible for the commissioning of primary care and has delegated responsibility from the ICB to fulfil this function. NHS England may at some point delegate authority to the ICB for the commissioning of primary dental services, primary pharmacy and ophthalmic services. The Primary Care ~~Commissioning~~ Committee will at the point of delegation of these services to the ICB, review its terms of reference and include these services within its committee remit.

2. Delegated Authority

The Primary Care ~~Commissioning~~ Committee is authorised by the Board to:

- Investigate any activity within its terms of reference;
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the committee) within its remit as outlined in these terms of reference;
- Commission any reports it deems necessary to help fulfil its obligations;
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the committee must follow any procedures put in place by the ICB for obtaining legal or professional advice;
- Create sub-groups in order to take forward specific programmes of work as considered necessary by the Committee members. The Committee shall determine the membership and terms of reference of any such sub-groups in accordance with the ICB's constitution, standing orders and SoRD. The committee may not delegate any of its accountabilities to such sub-groups.

For the avoidance of doubt, in the event of any conflict, the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference other than the Committee being permitted to meet in private.

3. Membership

The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

Chair and Vice Chair:

In accordance with the constitution, the Committee will be chaired by a Non-Executive Member of the ICB appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee. Committee members may appoint a Vice Chair from amongst the non-executive or elected members. In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number to chair the meeting.

The Chair will be responsible for agreeing the agenda with the support of the lead Director for Primary Care and ensuring matters discussed meet the objectives as set out in these ToR.

4. The members of the Primary Care ~~Commissioning~~ Committee are:

- Non-Executive Member of the ICB (chair)
- At least two Non-Executive and or Elected Members (drawn from Partner members)
- ICB Chief Medical Officer
- ICB Chief Nursing Office
- ICB Chief Financial Officer
- ICB Director/s with responsibility for Primary Care

5. In attendance

The following members may be in attendance at meetings:

- NHS England representative
- A BNSSG Healthwatch representative
- A representative of the General Practice Collaborative Board (GPCB)
- A representative of Locality Partnerships
- A Public Health representative of the BNSSG Health and Wellbeing Boards (to be nominated by the three local authorities)
- LMC Chair or Chief Executive
- ICB Head of Medicines Optimisation
- ICB Clinical Lead for Primary Care Development
- A Patient and Public Involvement (PPI) representative
- ~~A representative of the ICB medicines optimisation team~~

Other persons may be invited to attend, as appropriate, to enable the Committee to discharge its functions effectively. The Committee may also invite guests to attend to present information and/or provide the expertise necessary for the Committee to fulfil its responsibilities. The Corporate Secretary or their deputy will be in attendance at all meetings to advise the Committee on governance matters. Where an attendee of the Committee (who is not a member of the Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair. Suitable alternatives can also attend for members in agreement with the Chair

6. Administration

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;
- 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; and
- Action points are taken forward between meetings.

7. Quoracy

A quorum shall be 4 voting members, to include at least one Non-Executive and or Elected member and an executive member.

Decision making and voting:

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. Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

8. Frequency of meetings

The Committee will meet in private and will meet monthly. ~~Additional meetings may take place as required.~~ In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

9. Remit and Responsibilities

The Committee will make collective decisions on the review, planning and procurement of primary care services in BNSSG, under delegated authority from NHS England. This includes the following activities:

a) The award of GMS, PMS and APMS contracts. This includes: the design of PMS and APMS contracts; and monitoring of contracts;
b) Locally defined and designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");
c) Making decision regarding local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
d) Procurement of new practice provision;
e) Discretionary payment (e.g., returner/retainer schemes); Approving practice mergers;
f) Primary Care Estates Strategy;
g) Premises improvement grants and capital developments;
h) Contractual action such as issuing breach/remedial notices and removing a contract;
i) Delivery of the BNSSG Primary Care Strategy
j) Planning and delivery of the primary care aspects of the ICS Integrating Pharmacy and Medicine optimisation plan (IPMO) and Medicine optimisation strategy

In securing the provision of comprehensive and high quality primary medical services in BNSSG, the committee will carry out the following activities:

- Planning, including needs assessment, primary medical care services in BNSSG
- Undertaking reviews of primary medical care services in BNSSG
- Review the ICB plans for the management of ~~the~~ Primary Care Network Contract Directed Enhanced Services and receive assurances that the planning of Primary Care Networks in BNSSG complies with published specifications and guidance ~~including~~
- Providing oversight of the financial planning and budget management for the commissioning of primary medical care services in BNSSG
- Promote continuous quality improvement through learning, improvement methodologies, research, innovation, citizen insights and data driven improvement initiatives

The Committee shall report on and make recommendations to the ICB on the following:

i. Progress towards delivery of the BNSGG Primary Care Strategy
ii. Planning primary medical care services in BNSSG (including needs assessment)

10. Reporting Requirements

The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities. The minutes of the meetings shall be formally recorded by the secretary and submitted to the Board.

The Chair will provide assurance reports to the Board after each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

The Committee will provide an annual report to the Board to describe how it has fulfilled its terms of reference, details on progress and a summary of key achievements in delivering its responsibilities.

The ICB Primary Care Operational Group (PCOG) shall undertake the operational management, implementation and oversight of the nationally defined primary care contracts and the primary care workstreams. In addition, the PCOG will also monitor complaints and quality

The Primary Care Operational Group shall report and escalate via exception report to the Committee and submit the minutes of their meetings to the Committee for review

11. Behaviours and Conduct

ICB values:

Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB. Members of the Committee and those people in attendance shall behave in accordance with the ICB's constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality diversity and inclusion:

Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

Conflicts of interest:

In discharging duties transparently, conflicts of interest must be considered, recorded and managed. Members should have regard to both the ICB's policies and national guidance on managing conflicts of interest.

All potential conflicts of interest must be declared and recorded at the start of each meeting. A register of interests must be maintained by the Chair and submitted to the Board. If the Chair considers a conflict of interest exists then the relevant person must not take part in that item, and the Chair may require the affected member to withdraw at the relevant point.

12. Review of Terms of Reference

The Committee will review its effectiveness at least annually.

These terms of reference will be reviewed at least annually and earlier if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Review date: 13/10/22

Appendix 1

Schedule 1 –Delegated Functions

a) decisions in relation to the commissioning, procurement and management of Primary Medical Services Contracts, including but not limited to the following activities:

i) decisions in relation to Enhanced Services;

ii) decisions in relation to Local Incentive Schemes (including the design of such schemes);

iii) decisions in relation to the establishment of new GP practices (including branch surgeries) and closure of GP practices;

iv) decisions about 'discretionary' payments;

v) decisions about commissioning urgent care (including home visits as required) for out of area registered patients;

b) the approval of practice mergers;
c) planning primary medical care services in the Area, including carrying out needs assessments;
d) undertaking reviews of primary medical care services in the Area;
e) decisions in relation to the management of poorly performing GP practices and 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);
f) management of the Delegated Funds in the Area;
g) Premises Costs Directions functions;
h) co-ordinating a common approach to the commissioning of primary care services with other commissioners in the Area where appropriate; and
i) such other ancillary activities as are necessary in order to exercise the Delegated Functions.

Schedule 2- Reserved Functions

a) management of the national performers list;
b) management of the revalidation and appraisal process;
c) administration of payments in circumstances where a performer is suspended and related performers list management activities;
d) Capital Expenditure functions;
e) section 7A functions under the NHS Act;
f) functions in relation to complaints management;
g) decisions in relation to the Prime Minister's Challenge Fund; and
h) such other ancillary activities that are necessary in order to exercise the Reserved Functions;