NHS England

Primary Care Commissioning Newsletter

5 July 2013

Issue 6

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WELCOME

Dear Colleagues

We are already on our sixth issue of the newsletter! We will keep publishing on a regular basis, as your feedback is encouraging and your input welcomed. Please contact the team to request features on areas you would like more details about, share best practice, or simply a good news story to encourage us all.

Best Wishes

Dr David Geddes
Head of Primary Care Commissioning

Guidance imminent on PMS reviews baseline disaggregation exercise

You will have now seen the letter from Ann Sutton and Ben Dyson circulated to area teams on 5 June which advised on progressing a national approach to reviewing PMS contracts during 13/14 and beyond. This is to commence with systematic work by each area team to gather and understand fully at individual PMS contract level the basis of existing PMS funding and its component parts.

On the 4 July a further letter was published from the National Support Centre asking area teams to proceed with this data collection exercise and provides the materials and details of the support arrangements available to area teams to carry out this work. These are also available on the NHS Employers website at www.nhsemployers.org/pms. We have tasked NHS Employers to project manage the delivery of this exercise on behalf of the National Support Centre and to work with you to ensure its completion by the 16 August 2013.

This exercise will provide the necessary information to underpin the decisions about how we apply the principles of equitable 'core' funding to PMS practices and how we ensure the best possible value from PMS resources from 2014/15 .

Area teams heads of primary care are reminded the meeting on 8 July 2013 hosted by PC Operations will provide an opportunity to discuss the national PMS review.

If you have any comments or questions on this data collection exercise, please send these to pms@nhsemployers.org in the first instance www.nhsemployers.org/pms

Commissioning of Secondary Care Dental Services

From 1 April 2013 NHS England became responsible for the commissioning of secondary care dentistry. This responsibility has been delegated to each Area Team to enable commissioners, supported by emerging Local Professional Networks, to influence the entire dental pathway for their patients.

Work conducted, following the release of Securing Excellence in Commissioning NHS Dentistry, concluded that to enable the safe transfer of this responsibility, area teams should take individual associate status on contracts led and negotiated by CCGs. Providers should therefore, unless notified otherwise by an area team or group of area teams, treat each individual area team as a separate commissioner for the purpose of contracts. Where patients registered with a GP or resident in area team receive a service from a provider with which that area team has no NHS contract, the provider should issue an invoice to that area team in the same way that providers would invoice non contracted activity (NCAs) to PCTs prior to 1 April.

The recommendations for 2013-14 were partly driven by a pragmatic perspective. Following a review of options it was concluded that NHS England would be a more effective commissioner of secondary care dentistry by co-ordinating their own contracts. It was also concluded that secondary care dental

commissioning and contracting would be best achieved through area teams grouping together and establishing lead arrangements.

It was therefore recommended that following the start of the new financial year regions should establish plans for NHS England to coordinate its own contracts with providers of secondary care dental services and those plans should recognise the benefit of grouping area teams together. For example contracts currently managed by specialised commissioning are suitable hosts for these services. However, plans should reflect the need for primary care dental commissioners to ultimately become commissioners of secondary care dentistry.

It is also anticipated, as per Securing Excellence in Commissioning NHS Dentistry that non dental related activity within maxillofacial specialty will be analysed during 2013-14 with a view to a transfer of responsibility to CCGs in 2014-15.

Dental Specialty	PBR Specialty Code (Where Applicable)
Oral Surgery	140
Restorative Dentistry	141
Paediatric Dentistry	142
Orthodontics	143
Oral and maxillofacial Surgery	144, 145
Endodontics	146
Periodontics	147
Prosthodontics	148
Oral Medicine	450
Oral and maxillofacial pathology	
Dental and maxillofacial radiology	

Additional Services Commissioning

Commissioners should be aware that the payments online codes for additional items, with the exception of the dental SFE items maternity, long term sickness, paternity, adoptive and seniority, were changed to non superannuable with effect from 1/4/2013. This was to comply with the changes to the Pension regulations which made it quite clear that the pensionable earnings for a practice cannot exceed 43.9% of the total contract value and therefore any service elements not included in the total contract value would not have the opportunity to attract superannuation contributions. Some additional services may be:

Endodontic treatment
Domiciliary service
Minor oral surgery
Complex dental surgery
Local enhance service
Access slots

We would advise that in order for practitioners to be eligible for superannuation on these additional services they should be added to the total contract value. For further information please contact christine.elliotts@nhs.net

Useful information about General Ophthalmic Services

We reported in issue 4 about the release of the new GOS mandatory / additional contracts. On the back of this there have been several queries which we hope to address in this issue.

There appears to be some debate over large chains of practices from national companies (such as Boots Chemist) having one contract for all of their practices rather than individual contracts for each practice. The operating model and staffing structure for NHS England is based on the area teams being responsible for the ex PCTs contracts in their area. If one area team became responsible for all of the boots contracts, we would be into major transfer of resources, funding and structures. Area teams are advised that the number of practices on a contract should be related to the practices within the geography of the area team.

Whilst the new national contract does not define a geographical area in which a contractor is able to provide sight test, it is suggested that it would be helpful to describe this within a contract to give contract assurance at an area team level.

With regards to domiciliary sight testing (i.e. additional services contracts) and scope to say that a contractor is able to provide sight test within a defined area and send notifications to the area team in that area. Legally this appears to be able to be achieved through issuing an annex to the national contract to specify the boundaries of a domiciliary contract. NOAA is supporting NHS England to draw up a template for such an annex. This would allow contracts to use postcodes to define boundaries within which domiciliary providers are able to operate rather than a single contract entitling them to work anywhere in the country.

And finally, some clarity on processes for managing the performers lists. If, for example, a performer moved from Sunderland to Cornwall what should the individual and area teams do? Although there is a national performers list, performers in certain geography will be managed by the area team that has responsibility for that locality and the NPL in that region. When a performer moves between area teams there will be no need for them to reapply and to submit references / CRB check etc. as has been the case previously in PCTs. There will be a requirement for the area team to which the performer moves, to pick up the administrative function of that performer and to take responsibility for any concerns regarding the performers performance.

There is a policy in development for managing performers transfers between area teams, and for managing the transition for management of poor performers. These are being developed as part of the transformation of FHS services and will be available by July 13.

Continuing Education and Training Payment for 2013

Guidance and a claim form for the continuing education and training payment for ophthalmic practitioners relating to 2013 are available on the NHS England website at http://www.england.nhs.uk/. Claims should be made between 1 July and 31 October 2013 in line with the payment directions issued by the Secretary of State to the NHS Commissioning Board (NHS England) which are on the NHS England website at http://www.england.nhs.uk/

Focus on Pharmacy

As we have received a number of queries relating to the pharmacy contractual framework, we thought it would be helpful to share our responses. There are some areas which are still being worked through, which we aim to share as soon as possible. NHS England and the Department of Health are liaising over identified risks and issues, which we have also detailed in this section for your awareness.

Enhanced Services
Area teams were notified in the 10 April 2013 Primary Care Commissioning Newsletter that there were issues relating to the mapping of pharmacy enhanced services through the contract transfer process. In response to this article we received a number of queries regarding what the actions and implications are for area teams, which we have outlined our responses below.

It is important for area teams to establish if any pharmacy enhanced services were transferred erroneously to Clinical Commissioning Groups (CCGs), as this has a financial implication. Where this has occurred, the national support team is working closely with primary care finance colleagues to establish a mechanism by which this anomaly can be addressed. In the intervening period, area teams are recommended to communicate effectively with CCGs on this matter as it is important to prevent any inappropriate decommissioning of these services.

It has become apparent that there is some confusion about what constitutes a pharmacy enhanced service. We did make reference to this in the 10 April newsletter, however for clarity have detailed further. As the powers to commission pharmacy enhanced services lie solely with the NHS Commissioning Board (NHS England is the brand name not the 'body' that can enter into contracts for services), the only services commissioned by that legal entity can be called pharmacy enhanced services. It is worth noting that NHS England has a responsibility to publish the remuneration payable for enhanced services, which will require area teams to establish how best we do this.

This situation does not prevent CCGs or local authorities from commissioning services from community pharmacies, however if they do, those services cannot be called enhanced services. NHS England would recommend that in this situation these services should be referred to as locally commissioned services.

Local authorities are commissioning relevant public health services from community pharmacies (e.g. smoking cessation and sexual health services). These services should not be termed enhanced services unless the relevant local authority asks (and agrees funding with) the NHS Commissioning Board (NHS England) to commission these services on its behalf as enhanced services.

Unwanted drugs contracts
NHS England has a statutory responsibility to provide incineration bins to community pharmacies to enable them to satisfy the essential service element of the community pharmacy contractual framework for safe disposal of unwanted drugs. These arrangements are devolved to area teams and as such it is important that area teams have in place provision for unwanted drugs to be collected from the community pharmacies that they are responsible for. In line with the Waste (England and Wales) Regulations 2011 organisations which arrange to remove waste from other businesses are required to register as a waste broker with the Environment Agency. It is therefore important that relevant steps are taken by area teams to ensure that this registration has occurred. David Geddes issued letters to Waste Contractors (cc'd to Heads of Primary Care) on 26 June regarding the issue of charging pharmacies for use of on-line or paper templates to undertake the required pre acceptance audit. Following on from this a number of meetings have also been arranged to scope out potential procurement of waste contractors on a large footprint.

Access to prescription bundles
The Pharmaceutical and Local Pharmaceutical Services (Prescriptions, Payments and Listings) Directions 2013 requires NHS England to have a system in place for pharmacy contractors to view their prescriptions after they have been processed by the NHS Business Services Authority (NHS BSA). To cover this issue there is currently work underway to develop a policy, however in the meantime if a pharmacy contractor requests to view their prescriptions after they have been processed, this needs to occur in area team premises.

Provision of Domiciliary Medicines Use Reviews (MURs)
NHS England's policy on the 'provision of advanced services by pharmacy and dispensing appliance contractors' can be found on NHS England intranet and includes details on MURs that are provided outside of the pharmacy premises and how applications should be dealt with.

Certificates of Conformity (CoCs), Certificates of Analysis (CoAs) and CCG access to dispensed prescriptions
We have been made aware of issues relating to CCG access to CoCs/CoAs and processed prescriptions. Both these situations pose potential information governance issues with regards to access to patient data and commercially sensitive data. NHS England is working through what access in what circumstances might be appropriate and will develop a policy to ensure equity and consistency in access. In the meantime, NHS BSA will refer all requests from practices and CCGs to area teams. When considering requests, area teams are advised to keep the following principles in sight:

- Information governance issues
- The drug tariff (a statutory document) determines that CoCs and CoAs are sent from community pharmacies to area teams.
- CCGs have no contractual relationship with either primary care medical contractors or community pharmacists operating under the community pharmacy contractual framework

Top-up , discretionary, electronic prescription service (EPS) and pre-registration payments
These are statutory payments as outlined in the Drug Tariff, however they are only paid to dispensing contractors where they have been authorised by area teams and notified to NHS BSA via the local payment system. The national support centre is currently developing a policy to determine how all of these types of payments should be handled. In the meantime area teams are advised to consider all claims and authorise payments as appropriate via the local payment system

Drug Tariff distribution
The Drug Tariff is a statutory document and as such it is vital that all community pharmacy contractors receive a copy on a monthly basis. NHS England has a responsibility to ensure this happens. Prior to 1 April 2013 this function was provided by FHS services and the expectation is that this will remain the same.

Declaration of conflict of interest- Pharmaceutical Services Regulations Committee
With regards to the terms of reference for this group, we have been asked if NHS England will be issuing a declaration template for group members to sign. Whilst we are aiming to produce a template, it would be helpful if colleagues have already a version drafted, to send it to us for consultation. Please send to: england.primarycareops@nhs.net

Monitoring arrangements for pharmacies with more than 40 core opening hours
There is work underway to consider flexibility in the monitoring of pharmacies with more than 40 core opening hours, in order to reduce any unnecessary burden on providers and commissioners, whilst still meeting the necessary requirements for contract monitoring. If you are interested in sharing in this discussion please contact: england.primarycareops@nhs.net

Publication and maintenance of pharmaceutical and dispensing doctor lists
Consideration is being given to where the pharmaceutical and dispensing doctor lists should be published and how these can be updated most effectively. Previously this function was mainly performed by FHS agencies/departments on behalf of PCTs.

Dispensing Services Quality Scheme (DSQS)
Work is underway to consider an NHS England policy plus templates in support of the dispensing services quality scheme. If you would be interested in being part of a virtual reference group considering the outputs of this work please contact; england.primarycareops@nhs.net

Assurance Management of CPCF
We are considering the availability of web based data tools to assist area teams in monitoring the CPCF and the value of a national solution. Some potential solutions are being tested and from this we hope to build a business case for more general roll-out next year. For further information please contact: england.primarycareops@nhs.net

Pharmacy Reference Group
We hope to be establishing a pharmacy reference group to consider the area teams' need for additional products, from guidance through to templates, including many of those mentioned above. Further information will be provided in future newsletters.

Update on pharmaceutical services policies and procedures
All pharmaceutical services policies and procedures have now been reformatted and we have taken this opportunity to amend some of them following feedback from area teams. It is important that area teams use these revised versions as opposed to those which were published on our intranet. Below is a summary of the main changes that have been made.

Pharmaceutical lists
Persons wishing to provide pharmaceutical services in England must be included in a pharmaceutical list held by NHS England. The NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (the 2013 regulations) require NHS England to hold pharmaceutical and dispensing doctor lists at health and well-being board (HWB) level rather than at a national level. This was not clear in the previous versions of all documents and so this has been clarified.

Application forms
When applications for inclusion in a pharmaceutical list are made the applicant is required to state which pharmaceutical list they are applying for inclusion in. This information was missed from the original forms so the revised forms ask the applicant to confirm which list they are applying to be included in i.e. they are asked to name the health and well-being board in whose area they wish to open premises.

Market entry procedures – Pharm01 to Pharm21
For most types of applications to open pharmacy or dispensing appliance contractor premises there is a fee. The only exceptions are:

- Applications for a temporary listing arising out of a suspension
- Applications from persons exercising a right of return to a pharmaceutical list
- Applications relating to temporary arrangements during emergencies or because of circumstances beyond the control of an NHS chemist.

The applicant is required to submit the fee with their application (by BACS or cheque) and where applicants indicate on their application form that they have paid the required fee, the application is to be processed in good faith. Applications should not be held until confirmation is received that the payment has cleared; however area teams must ensure that payment has cleared.

Where payment does not clear the applicant is to be written to and given 5 working days to make a payment; if the second payment does not clear then the application is to be treated as withdrawn (paragraph 12, Schedule 2 of the 2013 regulations). This is a change to the 2012 regulations and was made after the consultation on the draft 2013 regulations. The market entry procedures have been amended to reflect this and a new template letter has been produced to be used by area teams should a second payment not clear. Applications must not be determined if no payment is made and area teams must therefore ensure they have systems in place to identify both non-payment of the relevant fee in the first instance and also payments which do not clear.

Notice of commencement
Where an application is approved the 2013 regulations require area teams to send the notice of commencement with the approval

letter (paragraph 29, Schedule 2). This has led to some applicants submitting the completed notice of commencement within the 30 day appeal period. The 2013 regulations state that a notice of commencement shall cease to have effect if the NHS Litigation Authority's Family Health Services Appeal Unit receive a valid notice of appeal (paragraph 34(5), Schedule 2) so a situation could arise whereby an applicant submits their notice of commencement and opens within 30 days of the area team's decision letter, only for a valid appeal to be lodged.

The applicant approval letters have been amended to include a statement to the effect that notices of commencement cannot be submitted within the 30 day appeal period.

A reminder for Area Teams to register for case investigator training

All area teams are being given the opportunity to nominate 4 delegates for case investigator training plus additional reserves if required. The majority of these places have now all been offered and remaining places are available on a first-come first-served basis. To register for training, please visit https://www.surveymonkey.com/s/caseinvestigatorsPRIMARY

Dates available for NHS England specific courses are:
17/18 July - York (Royal York Hotel)
4/5 September - London (Prospero House)

In addition, there are generic dates where all sectors are invited to attend. The programme for these course is identical to that of the above dates, however discussions will cover MHPS rather than being purely focussed on NHS England processes. Last year all sectors attended the generic dates so delegates would not be disadvantaged if they attended these dates. For more details on registering for generic courses, please email events@rst.nhs.uk For information, these courses are all in London - 18/19 June, 8/9 July, 6/7 August.

National Performers Lists

We are in the process of developing a single operating policy and procedures for managing the national performers lists. PCC has been commissioned to undertake this work and they facilitated a focus group meeting this month to review and develop the draft policy/ procedure and application form to ensure a consistent and robust approach. Daryl Peter from the Preston PCS office has also been leading elements of this work. My thanks to all who have been involved in this work with PCC.

Copies of draft documentations and key consultation questions are being forwarded to all ROs as part of our consultation process. All feedback will be via the RO, so please link with them if you are interested in being involved. The deadline for feedback is 15 July 2013.

We will be sharing the draft documentation with the national representative bodies after 15 July and the aim is to get a final version of the policy, procedure and supporting documentation live on the PCC intranet in early August 2013.

Payment for General Practice local GPSoC IT Support Services

For local General Practices that use GP clinical IT systems provided under the GP Systems of Choice (GPSoC) contract, an element of the cost of the systems falls to local organisations for IT support services. GPSoC Suppliers have invoiced CCGs for these costs but a number of CCGs have not responded or paid their invoices. This places a risk that suppliers will withdraw IT support services if no payment is received.

The funding distributed to area teams for GP IT Services includes the cost for local IT GPSoC Services. If you have distributed this funding to CCGs, please can you contact the CCGs and ask them to confirm that they have paid or are planning to pay supplier invoices in respect of GPSoC Services.

However, if the funding is with the area team, then please can you contact the suppliers and provide details of who they should invoice and the list of practices in your area so that they can re-direct invoices to NHS England area team.

Supplier Contact details:
EMIS: EMISHSCICProgrammeoffice@e-mis.com
INPS: Adam.Mathieson@inps.co.uk
CSC: athompson26@csc.com
Microtest: bridget.munday@microtest.co.uk
Advanced Health and Care:
Adam.Sayer@advancedcomputersoftware.com

Serious Incident Framework 2013

A revised serious incident framework was published by NHS England (previously NHS Commissioning Board) in March 2013. This was developed in partnership with commissioners, regulators and experts. This framework explains the responsibilities and actions for dealing with serious incidents and the tools available to help commissioners. It is relevant to all NHS-funded care in primary, secondary and tertiary sectors. The framework does not fundamentally alter existing principles set out in the National Patient Safety Agency (NPSA) 2010 *National Framework for Reporting and Learning from Serious Incidents Requiring Investigation* and elsewhere, but updates the framework to reflect responsibilities within the new commissioning landscape. The framework can be accessed via the NHS England website at http://www.england.nhs.uk/wp-content/uploads/2013/03/sif-guide.pdf

Details relating to the management of serious incidents within services directly commissioned by NHS England will be published within a Single Operating Model for Serious Incident. Management, currently being developed by NHS England's Patient Safety Team.

For further information relating to the management of serious incidents, please contact the NHS England patient safety

CCG ENGAGEMENT NOTE

NHS England is currently addressing some of the transitional issues relating to its responsibilities around the safer management and use of controlled drugs.

A short life working group has been convened and is working through a number of issues. However it has come to light that there is a pressing need to ensure that CCGs and Area Teams work

in collaboration to minimise risks around controlled drugs in this transitional period.

Clinical Commissioning Groups (CCGs) are not required to appoint a Controlled Drugs Accountable Officer (CDAO). However, Regulation 13(4) of the Controlled Drugs (Safe Management and Use) Regulations 2013 (SI 2013/373) states that "A CCG..... must assist the relevant CDAO of the NHSCB (now NHS England) in the carrying out of the CDAO's functions under paragraph (1)" of that Regulation.

Paragraph (1) requires NHS England CDAOs to establish and operate appropriate arrangements for those activities listed in paragraph (2). These are:

- Monitoring and assessing a relevant individual's performance (e.g. a health professional in a GP practice) in connection with the management and use of controlled drugs
- Determining whether incidents or concerns that relate to that individual's performance in respect of controlled drugs require further investigation;
- Investigating such incidents or concerns; and
- Taking appropriate action with regard to such incidents or well-founded concerns.

In addition, all CCGs in England are designated as responsible bodies under Regulation 6. It is open to NHS England CDAOs to invite some or all of their CCGs to be members of the relevant local intelligence networks (LINs). LINs have certain duties and functions set out in Regulations 14 – 16. These include a duty to co-operate with other LIN members in identifying cases where action may be appropriate, what the best course of action is and then putting it into effect. The regulations expressly provide that LIN members can share information and intelligence, including personal confidential information where justified, without breaching the Data Protection Act. All responsible bodies are under a duty (Regulation 15(3) and (4)) to notify their local lead CDAO at NHS England and any other responsible bodies they consider relevant, where they are investigating an incident, complaint or other concern about CD management or use, or where action is being taken. Responsible bodies are also required to assist each other in sharing relevant information about a serious concern.

Since CCGs are not required to appoint CDAOs, CCGs may wish to consider nominating a relevant senior individual within the CCG who will act as a focal point for liaison with NHS England CDAOs on controlled drugs matters locally, bringing in others as appropriate. NHS England considers it good practice for CCGs to assist its CDAOs in the following ways:

- Provide full support to the NHS England CDAO in any investigation;
- Report all complaints involving controlled drugs;
- Report all incidents or other concerns involving the safe use and management of CDs to the CDAO;
- Share all standard operating procedures (SOPs) in relation to the management of CDs, or ensure organisations from whom they commission services, do so;
- Analyse the CD prescribing data available; and
- Supply, or ensure the organisations that CCGs commission services from which involve the regular use of CDs, supply, periodic self-declaration and/or self-assessments to the NHS England CDAO as requested by NHS England Lead CDAO.

The CQC has responsibility for making sure that health and social care providers and other regulators maintain a safe environment for the management of controlled drugs. As part of this responsibility for oversight of the arrangements for controlled drugs in England the CQC is of the view that both CDAOs and CD leads must be mindful of their continuing responsibilities for good governance and safe use of CDs and that this will be critical to ensure progress during this period of transition. It is therefore important that there is on-going, constructive dialogue between CCGs and NHS England Area teams to ensure the system is safe.

This dialogue should include ensuring that there are sufficient authorised witnesses across primary care to ensure that there is not a build-up of obsolete controlled drugs that could represent a threat to patient and public safety.

Practice number changes / mergers within CCGs

We would like to clarify NHS England's position relating to the change in practice numbers / mergers within CCGs.

It has been agreed that all variations to the CCG constitution will require an application, and this includes where practices have merged and this has no effect on the CCG population, as well as typographical amendments.

We remain committed to making this as easy as possible for CCGs. We are pulling together a formal communication on this out to all area teams, and in order to cover all the requirements of the application, we're asking for:

A signed letter from either the CCG chair or accountable officer providing:

- The reason why the variation is being sought;
- Assurance that member practices have agreed to the proposed changes;
- Assurance that stakeholders have been consulted if required;
- Assurance that the revised constitution continues to meet the requirements of the Act (the self-certification); and
- Assurance that the CCG has considered the need for legal advice on the implications of the proposed changes, including whether advice has been sought.
- The proposed constitution in Microsoft Word format with tracked changes on so that we can see which changes are being proposed;
- Impact assessment – though this could be part of the letter.

Risk stratification DES and Information Governance issues

The aim of the risk stratification DES is to reduce readmissions and targeting clinical interventions to high risk patients; as well as providing decision support for care pathways.
Guidance has been published http://www.networks.nhs.uk/networks/news/advice-for-ccgs-and-gps-on-information-governance-and-risk-stratification describing a range of options that CCGs can choose in order to conduct risk stratification, and setting out a number of steps that GP practices, CCGs, and other organisations must undertake in order to remain compliant with the law.

However, there will still be a requirement to change how the current systems work, resulting in a potential delay in use whilst the changes are enacted.

The most popular options available to GPs and CCGs are
Use of closed system technology to control risk modelling of person confidential data (this option will be suitable for CCGs and CSUs that have already secured the services of a third party software and / or service such as MedeAnalytics and United Health Commission the services of their CSU/ and or HSCIC to provide risk stratification (we expect all CSUs to meet the minimum level to operate jointly with HSCIC to provide risk stratification services)

- Prepare to become an accredited safehaven and then change the risk stratification modelling to use de-identified data to feed the risk modelling part of the process – this will take a bit of time for them to meet the required standard and agree the development plans with HSCIC.
- Change the risk stratification tool to one that only uses pseudonymised data

In terms of high level timelines, we should continue to encourage practices to sign up to the DES by end of June, still with the expectation that practices will be able to do their first risk stratification process by end September.
NHS England hopes that all CSUs will have met accredited safehaven (ASH) standards by end October 2013. If HSCIC is initially unable to collect GP data for the purpose of risk stratification, this can be worked around where GPs are using a closed system technology, the data being sent directly to the third party in a secure transfer for processing without going through the HSCIC. In the longer term we would envisage this flow to transfer from GP to HSCIC.

Premises Directions 2013

Area teams should be aware of business cases that have been considered previously by PCTs and be clear on the legal position in relation to NHS England's responsibilities to progress developments, which have previously been approved. In most cases, NHS England will be bound to reimburse current market rent for the new premises when a new application for rent reimbursement is received, following the prior approval of the development by the PCT. This is subject, of course, to the application and the development itself (including specifically the rent payable) according with the business case and approval.

Paragraph 55(a) provides that "any act" by the PCT before 1 April 2013 in respect of the exercise of the functions of the PCT under the 2004 Directions is deemed to be an act of NHS England. In addition, paragraph 55 (b) reinforces the position that the actions of the PCT (whether completed or on-going) will be adopted by NHS England.

The strength of NHS England's position, in any particular case, will depend on precisely what was agreed by the PCT and how it was agreed. Where an AT is considering not progressing with a development previously approved by a PCT, substantive legal advice on the issue should be sought. NHS England will need to assess whether it is in a position to renege on the decision of the PCT should it be so minded (which it has now, by virtue of the new Directions, adopted as its own), and to do this will need to know how that decision was documented and the background to it.

Whether it is now open to NHS England to withdraw an approval that it has already given, is complex and turns on a number of public law principles regarding the exercise of statutory powers by public bodies, including the principle of legitimate expectation. The principle of legitimate (or reasonable) expectation applies to the way that public bodies exercise statutory powers and may arise either from an express promise given on behalf of a public authority or the existence of a regular practice which the other party can reasonably expect to continue.

In summary, the presumption should be that the PCT's approval of developments should be adhered to unless there is an operational justification for not doing so, together with a sound legal basis for the change of approach. There would also, clearly, be adverse PR implications of a withdrawal of approval and, likely significant dispute with the GPs.

Local Professional Networks - Single Operating Framework

The single operating framework for LPNs has now been released. Please use the following link to obtain a copy http://www.england.nhs.uk/wp-content/uploads/2013/07/lpn-sing-op-fram.pdf

The LPN steering group had its first meeting on 31 May, with the response to be involved in this agenda has been overwhelming. As a result the group has decided to have a steering group for each of the three areas and come together regularly to ensure the network stays connected. The LPN newsletter is currently under development along with its own webpage and we hope to release further information in the next edition of this newsletter.

Primary Care Policies and Procedures

Many of you are already aware of the exercise we have been undertaking to reformat all policies and procedures into NHS England branding. This exercise has now been completed and policies and procedures can now be found on NHS England website using the following link:
http://www.england.nhs.uk/ourwork/d-com/primary-care-comm/

The website does advise if you have any comments please send them to the primary care generic email address. We will ensure

that all comments are considered and that we advise which policies are being reviewed at any given time. We will begin reviewing shortly, prioritising according to nature of feedback and volume.

NHS England and use of our full legal name

Guidance has recently been published on the intranet on the use of our full legal name and can be found at the following: http://commissioningboardintranet.ning.com/page/style-guide

For ease we have put a short summary together:

From 1 April 2013, we adopted the name NHS England. A name that gives people a greater sense of our role, scope and ambitions - as the organisation responsible for allocating the NHS budget, working to improve outcomes for people in England and ensuring high quality care for all, now and for future generations.

Our legal name remains NHS Commissioning Board as set out in our establishment orders. Whilst we will be known as NHS England in everything that we do, there are times when our statutory name is required for legal and contractual transactions.

The following provides an example of legal documentation which requires the use of our full legal name:

- HR contract of employment
- Any documentation involving a court of law, i.e. Litigation claims; and contracts for directly commissioned services.

In these documents the full legal name only needs to be referred to once at the start of any document. You may wish to use the following line:

'The NHS Commissioning Board operates under the name of NHS England and will be referred to as such throughout the remainder of this document/contract.'

Whilst we need to refer to our full legal name in these documents, we should still use the NHS England logo or the normal corporate templates to produce them. There is no need to refer to the NHS Commissioning Board in any guidance we produce, or corporate policies, as these are not legal documents in themselves.

Primary Care Contractors and the need to update NHS Choices

Primary care contractors need to ensure they check and where required update their contact details on the NHS Choices website http://www.nhs.uk/Pages/HomePage.aspx

This is as a result of a potential serious issue brought to our attention. As you are aware new pharmacies are obliged to complete a market entry application. This application needs to be determined by the relevant Area Teams within a specific timeframe of 30 days and therefore contractors are being directed to the NHS Choices website for the Area Team contact details. However having looked at the site some of the area team's addresses still have Quarry House as their contact address. If the local contractor sends the application to us at Quarry House then this potentially delays the process thus not being completed in the timescales and is has been indicated that NHS England may have action taken against them for maladministration

Where to find a local healthcare provider

NHS England is frequently asked for information about local healthcare providers; therefore we have put together a list of where to find your local healthcare provider. A variety of websites hold a huge raft of information but if a patient does not have access to online information then local libraries and council offices will be able to help.

Order or view repeat prescriptions online

NHS Choices - www.nhs.uk

Identify the 'Services Near You' tab, and then insert relevant information for your query. The site includes information on Hospitals, Dentists, Pharmacies, Opticians Consultants and more NHS listing.

- Registering patients
- Patient survey
- Electronic prescription service
- Accepting patients
- Online appointments booking

Local Authority web sites

Identify the 'Health & Social Care' tab, this will provide you with a link directly to NHS Choices webpage.

Search engines (examples below)

www.google.co.uk
www.yahoo.co.uk

UK Local Area - http://www.uklocalarea.com/index.php

Enter your postcode and the services are located on the left hand side of the website under the map - this includes where to find your local GP surgery, dentist, pharmacy etc

118 500 - www.118500.com

Type in 'GP Practice' or emergency dentist and then your postcode
You can also search for other services.

This service provides Practice names, addresses and telephone numbers for both dentists and GP surgeries.

Forthcoming events and key dates

Dental Stakeholder workshops

9 July – London
31 July - Manchester

Area team case investigator training

17/18 July - York
(Royal York Hotel)
4/5 September - London (Prospero House)

Updates and queries
For all enquiries or comments please email:-
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