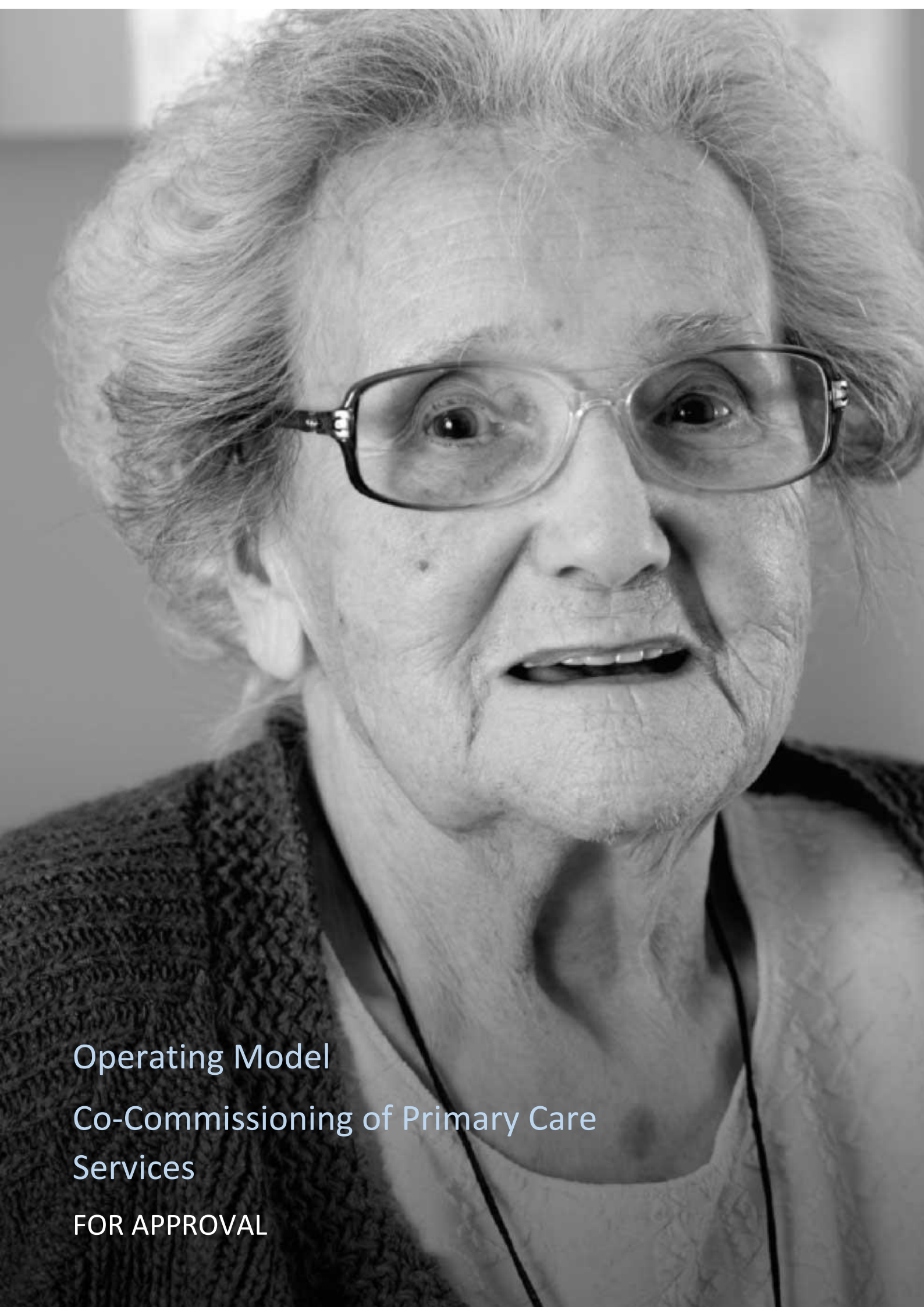


Operating Model

Co-Commissioning of Primary Care Services

FOR APPROVAL

Document filename: Operating Model			
Directorate / programme	Primary Care Commissioning	**Project**	Primary Care Commissioning
Document reference			
Project manager	David Sturgeon	**Status**	For Approval
Owner	Primary Care Management Board/ Primary Care Committees	**Version**	11.1
Author	Patrick Newton	**Version issue date**	02/10/2015

Operating model: Co commissioning of primary care

Document management

Revision history

Version	Date	Summary of changes
1.0	22.04.15	First draft
2.0	23.04.15	Revision following Christina Windle review
3.0	30.04.15	Revision following Heads of Primary Care review
4.0	30.04.15	Draft for review by David Sturgeon
5.0	05.05.15	Review by Primary Care Commissioning and Primary Care Management Board
6.0	03.06.15	Draft updated following comments
7.0	09.06.15	Updated to reference initial comments from CCGs (to be approved in PCMB)
8.0	20.07.15	Draft updated to reflect agreed comments
9.0	14.08.15	Updated following discussion at co-commissioning meeting
10.0	09.09.15	Updated following discussion at co-commissioning meeting
11.0	22.09.15	Final draft for approval
11.1	02.10.15	Factual amendments post approval by SE London (Joint Status of SE London Committees. Some minor editorial changes

Reviewers

This document must be reviewed by the following people before being shared externally:

Reviewer name	Title/responsibility	Date	Version
David Sturgeon	Director of Primary Care Commissioning		
Jill Webb	Head of Primary Care		
Julie Sands	Head of Primary Care		
William Cunningham-Davis	Head of Primary Care		

Approved by

This document must be approved by the following groups:

NHS England:

Name	Signature	Title	Expected Date	Version
Simon Weldon (in recognition of approval at the Primary Care Management Board)		Regional Director for Operations and Delivery (London)		

Following sign off by NHS England (London), this document must be accepted by each of the co-commissioning committees. These groups are therefore shown below:

Co-Commissioning Committees:

Area	Signature	Title	Expected Date	Version
North Central London		Joint Committee		
*City and Hackney**		*CCG*		
South West London		Joint Committee		
Bexley CCG		Joint Committee		
Bromley CCG		Joint Committee		
Greenwich CCG		Joint Committee		
Lambeth CCG		Joint Committee		
Lewisham CCG		Joint Committee		
Southwark CCG		Joint Committee		
North West London		Joint Committee		
Tower Hamlets		Delegated Committee		
Waltham Forest		Delegated Committee		
Newham		Delegated Committee		
Barking & Dagenham, Havering & Redbridge		Delegated Committee		

* This CCG does not have a co-commissioning committee and therefore the forum for this signature is un-confirmed.

Related documents

Title	Owner	Location
NWL Terms of Reference	Primary Care Committee	North West London
NCL Terms of Reference for Joint Committee v0.2	Primary Care Committee	North Central London
SWL Terms of Reference	Primary Care Committee	South West London
Annex F – Delegated TOR Tower Hamlets v0.1	Primary Care Committee	Tower Hamlets
Annex F – Delegated TOR Waltham Forest v1.0	Primary Care Committee	Waltham Forest
Annex F – Delegated TOR Newham vfinal	Primary Care Committee	Newham
BD – Updated Annex F (ToR)	Primary Care Committee	Barking and Dagenham
Havering – Updated Annex F (ToR)	Primary Care Committee	Havering

Document control

The controlled copy of this document is maintained by NHS England. Any copies of this document held outside of that area, in whatever format (e.g. paper, email attachment), are considered to have passed out of control and should be checked for currency and validity.

Contents

1. Introduction

1.1 Purpose of this document

This document aims to provide a blueprint for the way that NHS England (London) primary care commissioning and contracting teams will support CCGs which have moved to joint or delegated co-commissioning arrangements (as of April 2015). CCGs which will be participating at the 'greater involvement' level of co-commissioning should discuss with their local team how they would like to be involved.

As this document provides the standard offer of NHS England in terms of supporting Primary Care Co-Commissioning activities, this document will need to be signed off by NHS England (through the Primary Care Management Board) and then co-commissioning committees, before it is considered final.

It is important to note that some specific details (i.e. the contact points for different committees/ areas) will differ per committee and these added details should be cross referenced with committee terms of reference or other supporting documents. **Governance of this document and Processes**

Once this document has been signed off by both parties, any variance from the processes described here will need to be agreed between the Committee and NHS England as:

- Having no impact on support (for example changes to the contact to be involved in urgent decision making) and can therefore be adopted for a specific Committee
- Is an adjustment or improvement to the process which would be beneficial for all Committees and therefore should be made as a change to standard processes (for example reporting format or processes which makes the reporting cycle more efficient or information more easily understood)
- Is a required change for a specific Committee(s) and therefore a change request will need to be logged (i.e. additional reporting).

In all instances, agreement of these changes will require sign off at the Primary Care Management Board and then with Primary Care Co-Commissioning Committees before it can be considered confirmed. This may require resource and/ or cost implication assessments, and the ownership for any impact of these would need to be discussed as part of the agreement discussions.

1.2 Operating model processes for individual committees

As mentioned above, this document aims to provide a standardised version of the operating model. However the below details will need to be discussed in each individual committee, and therefore decisions relating to the below are seen as acceptable levels of customisation within this standard model:

- Standard policies to assist decision making should be reviewed and agreed by the committee; the committee may wish to add others

- The sub-committee structure is likely to be different per committee. This should follow the principles defined here and be discussed and agreed with NHS England if involved.
- The CCG representative(s) to be contacted in the event of urgent decisions being required.

These elements should be discussed and agreed as part of committee discussions, and should be included as appendices or linked documents.

1.3 Defining co-commissioning

Co-commissioning for primary care refers to the increased role of CCGs in the commissioning, procurement, management and monitoring of primary medical services contracts, alongside a continued role for NHS England. In 2015/16, the scope for primary care is general practice services only. CCGs have the opportunity to discuss dental, eye health and community pharmacy commissioning with their regional team and local professional networks, but have no decision making role.

There are three co-commissioning models, and as of April 2015 there are London CCGs at all three of these levels:

- Level 1: where CCGs have involvement in primary care decision making,
- Level 2: which is where the CCG (or CCGs) participate in decision making with NHS England in a Joint Committee
- Level 3: delegates decision making regarding certain functions (see below) entirely to the CCG (or CCGs)

A high level overview of responsibilities is shown below:

Figure 1: High level breakdown of co-commissioning responsibilities

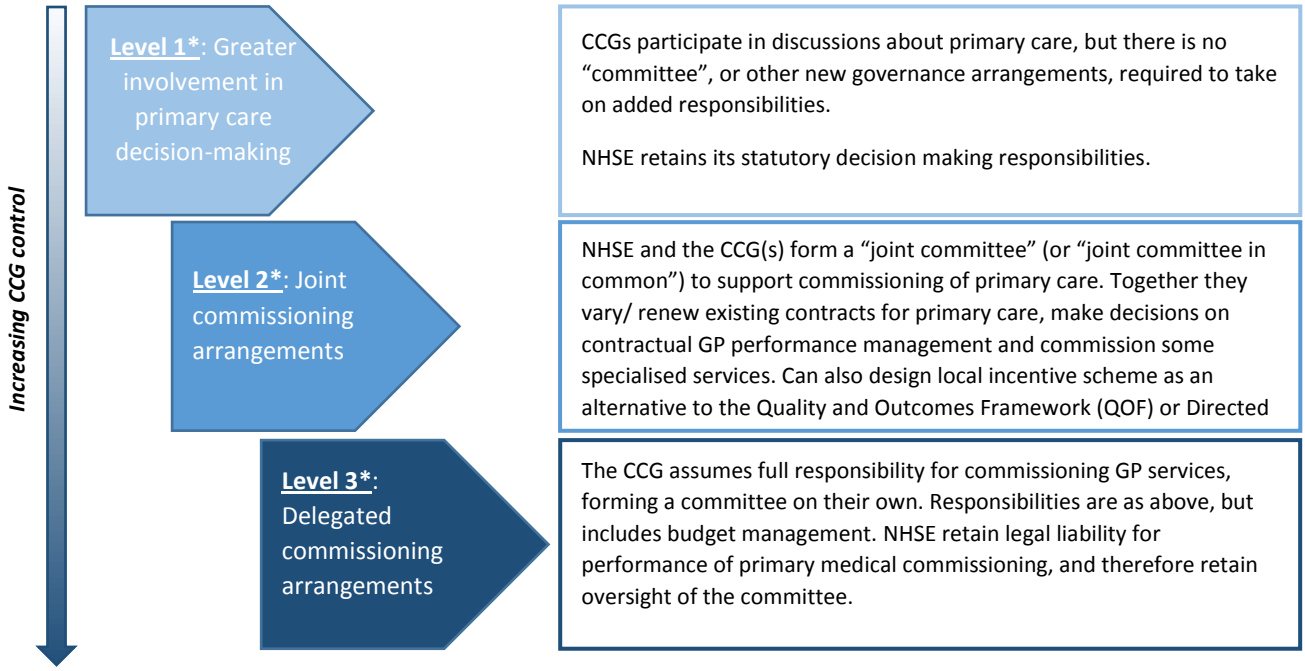


Figure 1: Co-Commissioning Levels

1.4 Terminology:

At levels 2 and 3, co-commissioning decision making is conducted through a, or several, 'committee(s)', which is joint with NHS England, or delegated. The committee could either consist of:

- Committees of single CCGs (with or without NHS England)
- Committees of more than one CCG (with or without NHS England)

The Committees may either be:

- A joint committee is a single committee to which multiple bodies (e.g. NHS England and one or more CCGs) delegate decision-making on particular matters. The joint committee then considers the issues in question and makes a single decision[1].
- In contrast, under a committees-in-common or joint committees-in-common approach, each committee (with our without NHS England dependant on level) must still make its own decision on the issues in question

For simplicity, throughout this document, the body which conducts decision making for co-commissioning is referred to simply as "the committee", and it may refer to any of the parameters above. Where different processes are required for joint or delegated committees, these are called out.

1.5 Differences between Joint and Delegated Committees

The move to co-commissioning, means that certain decisions (see Figure 2) which were previously conducted directly by NHS England, will now be made by the body constituted to support the level of co-commissioning each CCG has applied for – i.e. committees with NHS England (for joint commissioning) or without NHS England (for delegated commissioning).

Regardless of whether the CCGs are conducting Joint or Delegated commissioning, the functions enacted will be for the most part the same; the main difference is whether NHS England is part of the decision making process or not. It should be noted that there will be a joint responsibility for ensuring quality, through the reporting of performance data, and NHS England is likely to support the preparation of papers and other inputs into the committees.

It should be noted that the CCG may ask NHS England to attend and/ or present papers at delegated committees, but this should be done on request and NHS England will not be a voting member.

1.6 Responsibilities remaining with NHS England

At all levels of co-commissioning, NHS England will retain a role in supporting delivery of commissioning and contracting functions. Also the following responsibilities will remain with NHS England and will not be included in joint or delegated committees:

[1] Please note this is only an option for Joint Commissioning arrangements

- Continuing to set nationally standing rules to ensure consistency and delivery goals outlined in the Mandate set by government.
- The terms of GMS contracts and any nationally determined elements of PMS and APMS contracts will continue to be set out in the respective regulations/ directions.
- Functions relating to individual GP performance management (medical performers' lists for GPs, appraisal and revalidation).
- Administration of payments to GPs.
- Patient list management will remain with NHS England.
- Capital expenditure functions.

2. Decision Making

2.1 Decision making principles

One of the exceptions to this as a standard document across all committees, is that there may be some variation as to what and how decisions are made in the committees. Decisions will be taken in line with the criteria set out in each committee's Terms Of Reference. In addition to principles of good practice which are set out in the *Next Steps in Co-Commissioning* document, conflicts of interest policy, terms of reference etc, the following principles should be considered:

- Any **urgent decisions made outside of the committee should be based on what is necessary to maintain patient care**; wherever possible decisions will be taken within the committee.
- **In the event that an urgent decision is required and action must be taken to maintain patient care outside of a committee, NHS England will communicate with the contact nominated in the committee's terms of reference (via phone and email) to aim to involve them in the decision.**
    - CCG contacts are asked to make themselves available to respond to these urgent discussions

2.2 Decision making process

Co-commissioning of Primary Care will enable committees to take responsibility for many decisions which currently sit with NHS England. Any CCG functions which are to be delegated into this committee are not included here.

Decisions have been classified into three types in order to help capacity in the committee. These types are:

1. **Decision making through policies** which therefore require minimal/ do not require discussion because there is a clear approved policy which provides clarity on the action required
2. **Urgent decisions which cannot wait until the committee**. These decisions require emergency processes (see below)
3. **Decisions to be discussed in the committee**. Other General Practice commissioning decisions should be made within the committee. It is expected in

many cases recommendations will be made into the committee from pre-work or sub-committees as appropriate.

These decision types and the related processes can be seen in the below processes:

2.2.1 Decision Making through policies

The below diagram shows how decisions where policies which are already defined might be used to support the co-commissioning committee. ***Please note, this process would be the same for both Joint and Delegated commissioning decisions***:

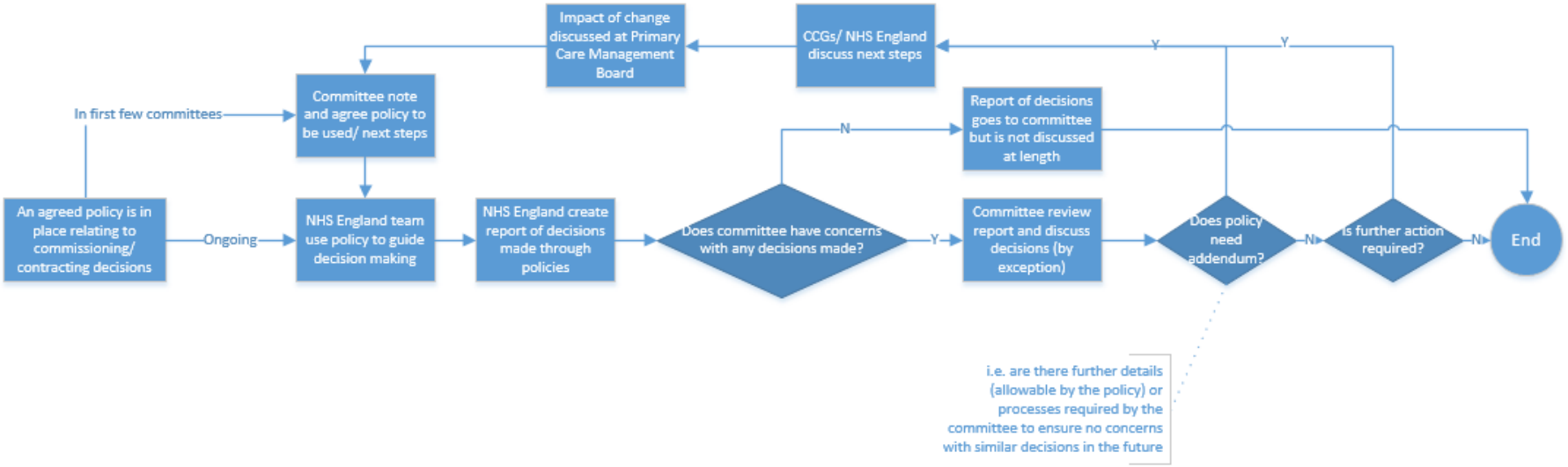


Figure 2: Decisions made through policies

This policy shows that although the policies referred to here would be Nationally or Regionally agreed policies, and therefore with limited scope for change, it is proposed that these are discussed and agreed at one of the early committee meetings in order to confirm that the members are comfortable with the scope and approach. The process also includes provision for addendums to the policy. If for example there are concerns regarding the way a decision has been reached then the committee should talk about the way that this can be improved in the future. It is important to note that the content of an agreed policy may not be able to be changed, and the impact of any material change would need to be signed off at the Primary Care Management Board as well as the committee, but this is to illustrate the opportunity for continual improvement.

The purpose of this process is to relieve agenda pressure in the committee. If there are any decisions or elements of the report which the committee would like to discuss, this can be done and should be offered by the chair at the start of the meeting.

2.2.1.1 Decisions with defined policies

The decisions which can be made through defined policies will be discussed and agreed by each co-commissioning committee, however the expected decisions where policies are expected to be used to make decisions:

- List closure
- Boundary changes
- Discretionary payments
- Contractual changes

There are several other areas where standard operating processes or policies exist, but it is expected that decisions will still need to be made within the committee and therefore are not included here. The full list of potential decisions with policies can be found in Figure 5.

2.2.2 Urgent decision making:

'Urgent' is defined in this document as a decision which cannot be made within a committee because of timing and nature of the decision. The main co-commissioning committee is accountable for all decisions, and should agree to the decision process for this and expected circumstances where this would arise and these agreed arrangements should be reflected in the relevant terms of reference. It is important to note that there are two types of urgent decisions. These are described below, with suggested processes.

It should be noted however that the process and individuals involved should be decided and agreed by the Primary Care Committee, and this should be reflected in their terms of reference (either referring to this operating model and providing details of the individuals to be involved or outlining any changes within the agreed principles).

2.2.2.1 **Urgent unplanned decisions**

An urgent unplanned decision arises when something unexpected occurs that requires immediate action. For example if a practice goes bankrupt a decision will need to be made immediately in order to support the patients on the registered list.

The below principles apply to urgent unplanned decisions:

- Wherever possible, only decisions necessary to maintain patient care should be taken outside of the committee
- The committee must ensure that an appropriate CCG contact is identified to be contacted in the event of an urgent decision being required
- NHS England will communicate with this contact (by phone/ email) in order to make a decision, this will be:
    - A joint decision between the NHS England and CCG representatives if operating in joint commissioning, or
    - The CCG is asked to make a decision in delegated commissioning
    - ***Please note, if the contact cannot be reached, NHS England will make a decision in order to ensure appropriate patient care***
- Depending on timescales for the decision, it may be possible to involve multiple people in the decision making process

- In the event that the CCG is made aware of the need to make an urgent decision, they are:
    - Required to communicate with NHS England to make the decision together if operating in joint commissioning
    - Able to communicate with NHS England if they require support/ advice to make the decision in delegated commissioning

The below diagram shows how urgent unplanned decisions might be made. ***Please note, these process would be the same for both Joint and Delegated commissioning decisions***:

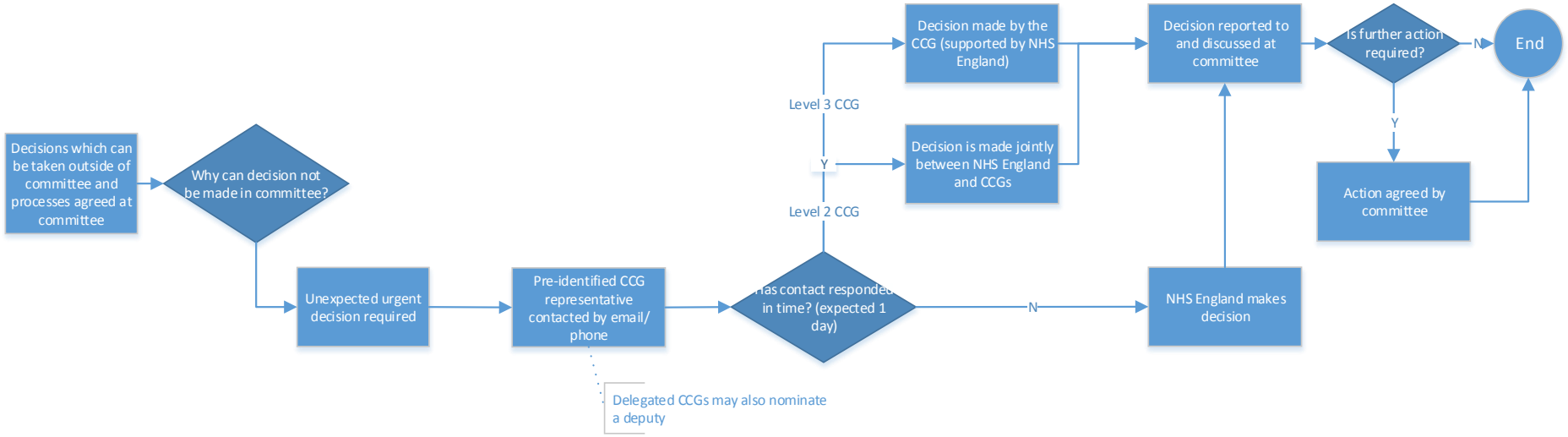


Figure 3: Urgent unplanned decisions

This process is also described below:

- In the event that a situation occurs unexpectedly in which an urgent decision is made, NHS England will communicate with the relevant CCG contact (by phone/ email) in order to support the decision making process
    - For joint commissioning CCGs, the decision will be made by NHS England and the CCG together
    - Delegated commissioning CCGs will make the decision, supported by NHS England as required
- As the definition of urgent decision is that decisions need to be made to maintain patient care, if the CCG contact is not available within the required time (e,g. 1 day), NHS England will need to make the decision on behalf of the CCG. CCGs may nominate a deputy for these circumstances.
- These decisions will be reported back to the committee and discussed. Any further action will be agreed by the committee.

It should be noted that both NHS England and CCGs should aim to learn from and if able create processes for making decisions in these circumstances. Also in the event that the CCG becomes aware of the decision that needs to be made, they will need to:

- In joint commissioning – communicate with NHS England (the relevant Head of Primary Care or Director of Primary Care) in order to jointly make the decision

- In delegated commissioning, the CCG may wish to seek advice or support from NHS England but is not obligated too. They should however inform them of the decision as there may be impacts or other communications which should reflect the decision made.

Some CCGs have outlined a process if the decision making window is longer (for example two weeks), allowing them to bring together a slightly bigger group of people (e.g. Chief officers, the chair of the committee and NHS England representatives). This enables decisions to be more widely considered and tested however it is noted that it may be challenging to gather a wider group at short notice, and it is suggested that virtual or telephone discussions may be easier.

2.2.2.2 **Urgent planned decisions**

There may be some decisions which are expected, but:

- Cannot be made at an earlier committee as, for example there is insufficient information
- Must be made before the next committee

This means that decisions do need to be made through an urgent process, but that some planning can be undertaken ahead of the decision. Specific arrangements and decision rights, for each CCG, should be referenced in their Terms of Reference. The principle of how this should operate is shown below:

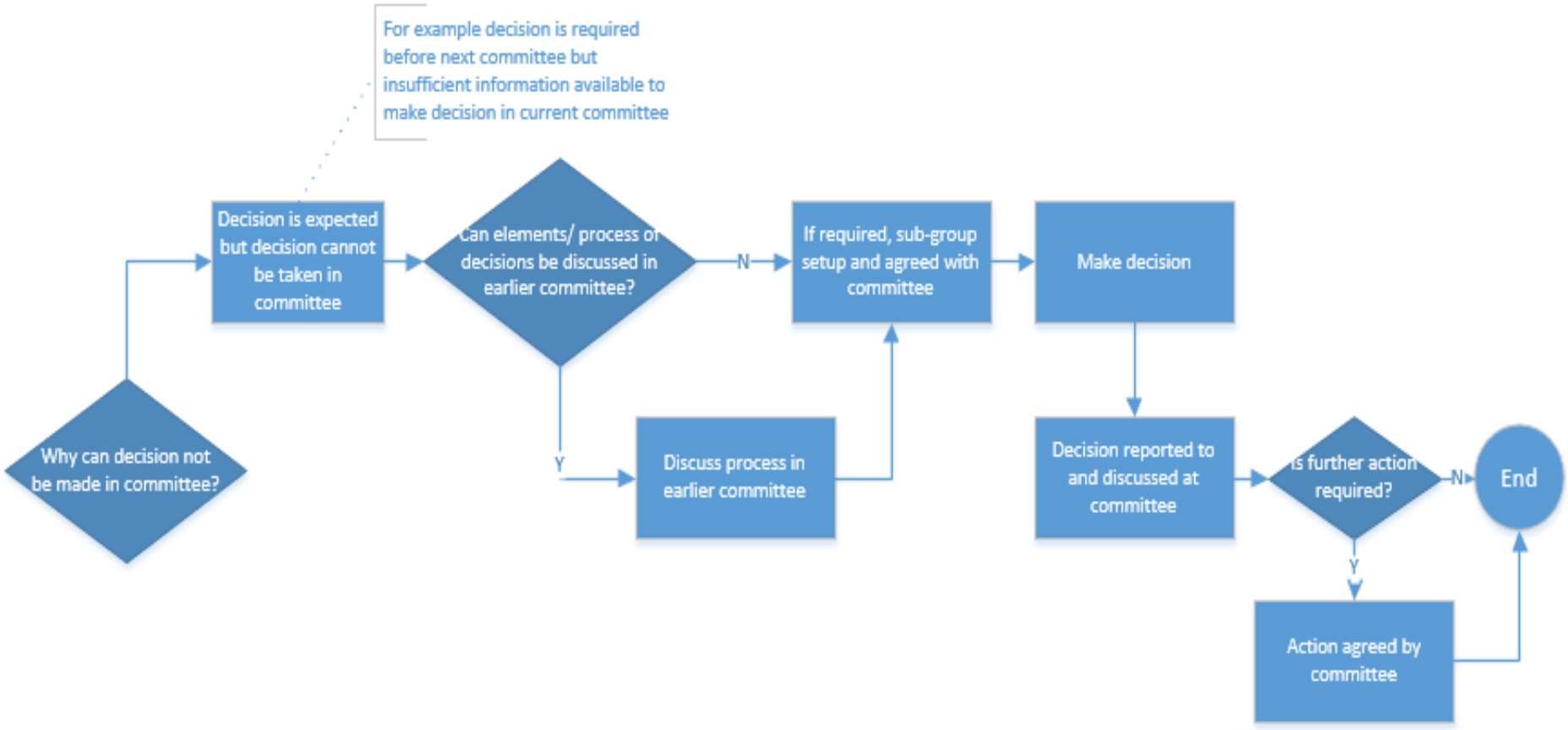


Figure 4: Urgent planned decisions

This process is also described below:

- In the event that a decision cannot be taken in the committee because sufficient information is not known, or there are some other inhibiting circumstances, planning should be undertaken as much as possible to ensure the committee is able to input into the decision making process
- Therefore any elements of the decision or process relating to the decision should be discussed, and if necessary a sub or working group may be set up to continue work towards this decision
    - Please note, there may be an existing group or sub-committee which would undertake this work.
- These decisions will be reported back to the committee and discussed. Any further action will be agreed by the committee.
  It should be noted that both NHS England and CCGs should aim to learn from and if able create processes for making decisions in these circumstances

2.2.3 Main decision types required

2.2.3.1 Business as usual decisions

The table below sets out of the main formerly NHS England functions which will now be decided in the committee. This includes a recommendation as to the type of decision the committee will be asked to make (this is not confirmed until this document has been approved by each committee), as well as estimates of the frequency of each activity.

Please note: these are high level estimates based on the last 12 months and are for all of London rather than the volume any one committee will likely need to decide on.

	Name	Function	Estimated volume of activity across London (12 months)	Committee decisions needed (section 2.2)	Decision possible with approved policy (s 2.2.1)	Need for urgent decisions (s 2.2.2)	Does a national/London SOP/policy/report exist? (If "yes", attached in annex)
Process 1	Determin - ation of key decisions or requests	List Closure	20				Yes
		Practice mergers/ moves	100				Yes
		Boundary Changes	20				SOP practice to apply and general DMG paper derived from this
		Securing services through APMS contracts	40				Yes – options appraisal doc
		PMS (reviews etc)	Ongoing				In process
		Discretionary Payments	600				Process as per SOP. Appeal/ complaint paper below.
		Remedial and breach notices	(Actual)				Yes (Contractual issues of concern)
		Contract termination-e.g Death/ Bankruptcy/ CQC	(Actual)				Yes, for bankruptcy, and options paper
		Contractual changes (contentious/ important)	100				
		Contractual changes (transactional)	650				Yes (Contract signatory changes)
Process 2	Financial Processes	Ensuring budget sustainability	Ongoing				
		Management Accounting	Ongoing				
Process 3	Strategy & Policy	Securing quality improvement	Ongoing				Request to issue breach over quality attached
		Developing and agreeing outcome framework e.g. LIS	70				Yes (for LIS schemes)
		Securing consistent population based provision of advanced and enhanced services	50				As above
		Premises plans, including discretionary funding requests	200				Yes, example PID attached

Figure 5: Table showing former NHS England functions which will now be decided in the committee

2.2.3.2 Strategic Discussion and decision making

The committee should also be used to support discussion on Primary Care strategies, such as delivery of the *Strategic Commissioning Framework* and other strategic aims.

2.3 Reporting Requirements

The current standard reporting offer is shown below. NHS England will prepare these reports, and will provide these to CCGs 4 working days ahead of the deadline for circulation of papers to committees, to allow the CCG the opportunity to review and add any comments. Potential developments indicate where advancement of the reports may be possible but discussion would be required on impact and requirement:

Report	Source	Freq.	Usage now	Available immediately	Potential development
Patient satisfaction with access	NHS England Business Analytics (BA) Team	Every 6 months	Not currently used as part of decision making	Data can be shared directly from BA team. This will not be fully analysed	Interpretation/ summary or recommendations based on data as input into the committee
Performance reporting (incl. breaches)	NHS England case management team*	Quarterly	Used to identify under performers (i.e. bottom 5%) for discussion	Reports (not anonymised) will be provided direct to CCGs. They can then decide if/ how to discuss in committees**	• Development of systematic approach to usage and response • CCGs may want to add information to report (such as complaints)
Primary Care Web Tool	Online	Quarterly	This can be used to extract information on practices, such as smoking cessation target achievement, and flus vacs as well as demographics etc	CCG members with nhs.net and nhs.uk emails will have access as required	

Finance & QIPP	NHS England Finance team	Monthly	High level exceptions analysis	Data is available by: • Regional team level (i.e. South, NCEL, NWL) • Contractor type (GMS, PMS etc) Provided to committees: • A summary file would be available to Level 3 committees • No data would be available to Level 2 committees as cannot be broken down to sub regional team level	• Development of information at a CCG level. • Information to provide to joint committees

In addition to making decisions and reviewing other decisions made related to the above, there will also be general reports which the committee will need to review and potential

Report	Source	Freq.	Usage now	Available immediately	Potential development
PMS Contract	NHS England Contracts Management Team		Not systematically available or reviewed	Only available for areas which have developed KPIs	Post PMS review, further information expected
APMS a) KPI Monitoring	NHS England Contracts Management Team	Annually	Not systematic	Annual summary of achievement against targets	
b) NHS England Commissioned APMS contracts	NHS England Contracts Management Team	Annually	Systematic review of achievement against targets	Annual summary of achievement against targets	
List maintenance	Primary Care Services	Annual	For analysing QIPP	*To be determined based on new provider*	*To be determined based on new provider*
Direct Enhanced Services Sign Up report	Primary Care Commissioning team	Annual	Payment analysis & budget setting	List of practices/ practioners signed up to DES schemes	Assurance of compliance and strategic achievement
E-declarations sign off report	Primary Care Web tool	Annual	For due diligence: - Non compliance	List by practice by level of compliance	• Could be added to performance report

			is investigated - Compliance declarations considered as part of performance management		• Further analysis of reports in consideration with other reports/ information

* Subject to continued programme budget
** Need to define who this is sent to – suggest "safe haven" approach

Figure 6: NHS England reporting

2.3.5 Conflicts of interest

All committees must adhere to the conflicts of interest guidance[2] and this must also be adhered to for any sub groups set up to support the committee.

2.3.5 Other decision-making processes – finance and strategy

Finance

Joint Co-Commissioning Committees

For Joint Committees, NHS England will continue to do all financial and management accounting. However, it will produce monthly financial reports (for instance, covering spending against forecast and narrative on variance) which will be provided to each CCG. The CCG may then chose to add information to these reports before they are submitted to the committee(s).

Delegated Co-Commissioning Committees

[2] i.e. *Managing conflicts of interest, Conflicts of Interest guidance* and *Code of Conduct* guides

For Delegated Committees, a monthly journal will transfer costs of delegated functions to the CCG's ledger from NHSE, and the CCG will be responsible for their own reporting, and their own management accounting of their primary care costs. The CCG may also make further queries of NHSE, to support this process. Management accounting activities will likely include, but not be restricted to:

- Month end procedures
- Accruals, prepayments, and any payments additional to those in the financial plan
- The production of monthly & quarterly CCG management reports at GP practice or locality level to ensure robust financial forecasts and analyse variances to ensure they are explained
- Practice list size analysis by CCG locality for GM/system report downloads
- Quarterly forecasting on CQRS
- Additional year end tasks including working papers and support to AOB process
- Liaise with internal and external audit as required.

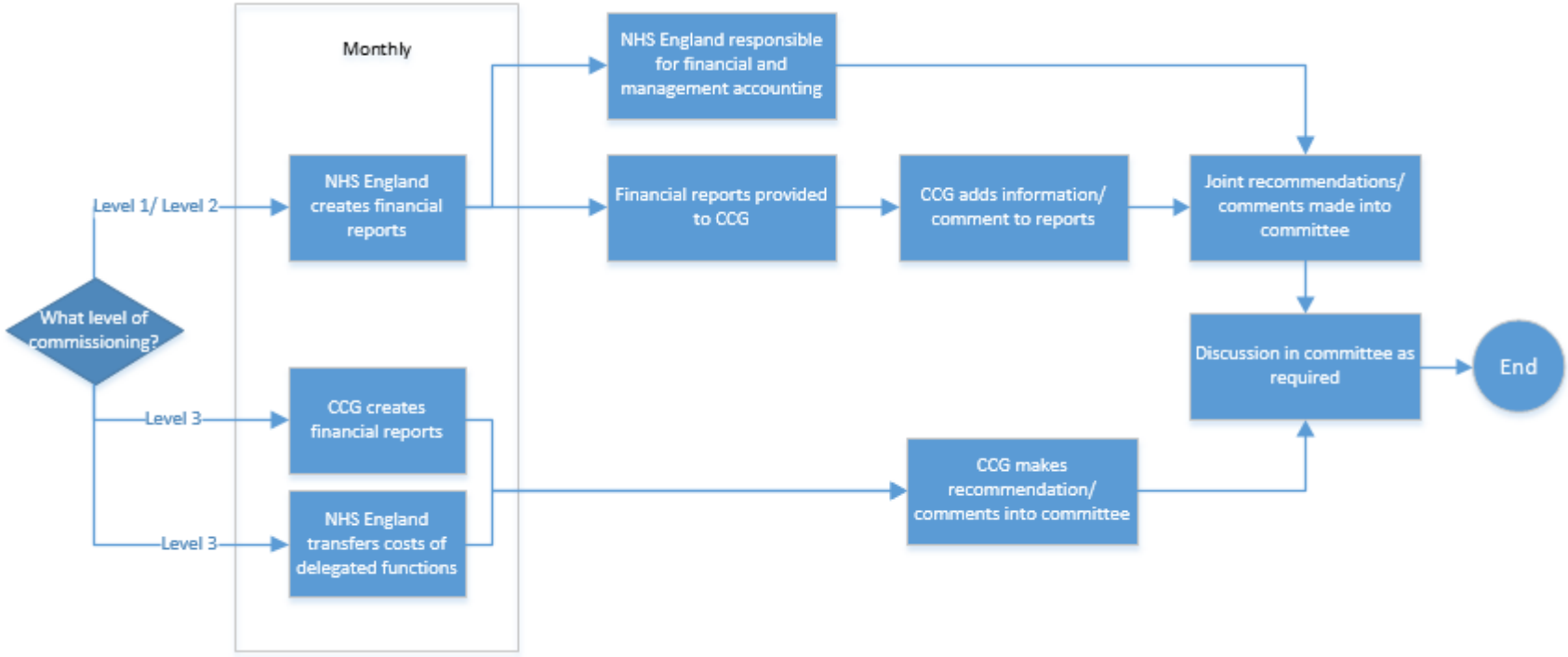


Figure 7: Process map showing financial processes

Strategy and policy

2.4 Other potential Committee responsibilities

In addition to the above standard processes, there are other Primary Care elements which the Committee is expected to be involved in. Some of these areas are listed below however it should be noted that further discussions are required as to how these would be enacted and supported between NHS England and the CCGs at different co-commissioning levels. Further delegation from NHS England to CCGs will not be made without agreement, and without consideration of the resource implications of such delegation.

Item	Committee Requirement
Appeals and disputes	The committee is asked to note the standard operating procedure for managing appeals and disputes submitted by GPs in relation to their GP contract.
Counter Fraud	Ensuring that proper processes are in place to prevent fraud within the NHS
Interpreting services	Ensure that patients can access interpreting services when using GP practices.
Occupational Health	The committee shall ensure that GPs have access to occupational health services in accordance with national guidance
Controlled drugs reporting	The Committee is responsible for ensuring that practices are complying with legal requirements for use of controlled drugs and that CCGs and NHSE have proper controls in place to maintain patient safety. The RT will carry out reporting, analysis and compliance that aids this.
Safeguarding	To set policy and to set the expectation that GP Practices have effective safeguarding systems in place in accordance with statutory requirements, national guidance and Pan London Policy/ Procedures. The CCG will proactively support Primary Care to improve well-being of children and adults, through the provision of training and good practice guidance, and in logging safeguarding issues; providing assurance to NHSE, whose role it is to ensure compliance with safeguarding standards. Further detail on responsibilities for safeguarding are provided under Annex 8.
Incident management	For both serious and non-serious incident management, the Committee is responsible for ensuring that there are proper processes in place for the reporting and review of incidents, so that they can be identified and managed. The CCG and NHS E will support and contribute to investigations, as required.
Domestic Homicide Reviews	The Committee will ensure that GPs contribute to domestic homicide reviews, where necessary. The CCG and NHS E will support this where their resources are appropriate. Further detail on responsibilities for safeguarding are provided under Annex 8.
Communications	For CCGs at level 3 delegation, lead responsibility will be determined by what is appropriate, on the merits of each communication. NHS England remain responsible for communications for CCGs at level 2 delegation.

Figure 8: Other potential Committee responsibilities

3. Governance and people

3.1 Committee constitution

While much of the decision-making processes will be determined by Committees/ Joint Committees, the constitution of the Committees themes have been set by NHSE, as a condition of co-commissioning. The following are the criteria for a Committee (for Level Three co-commissioning), and for a Joint Committee (for Level Two co-commissioning).

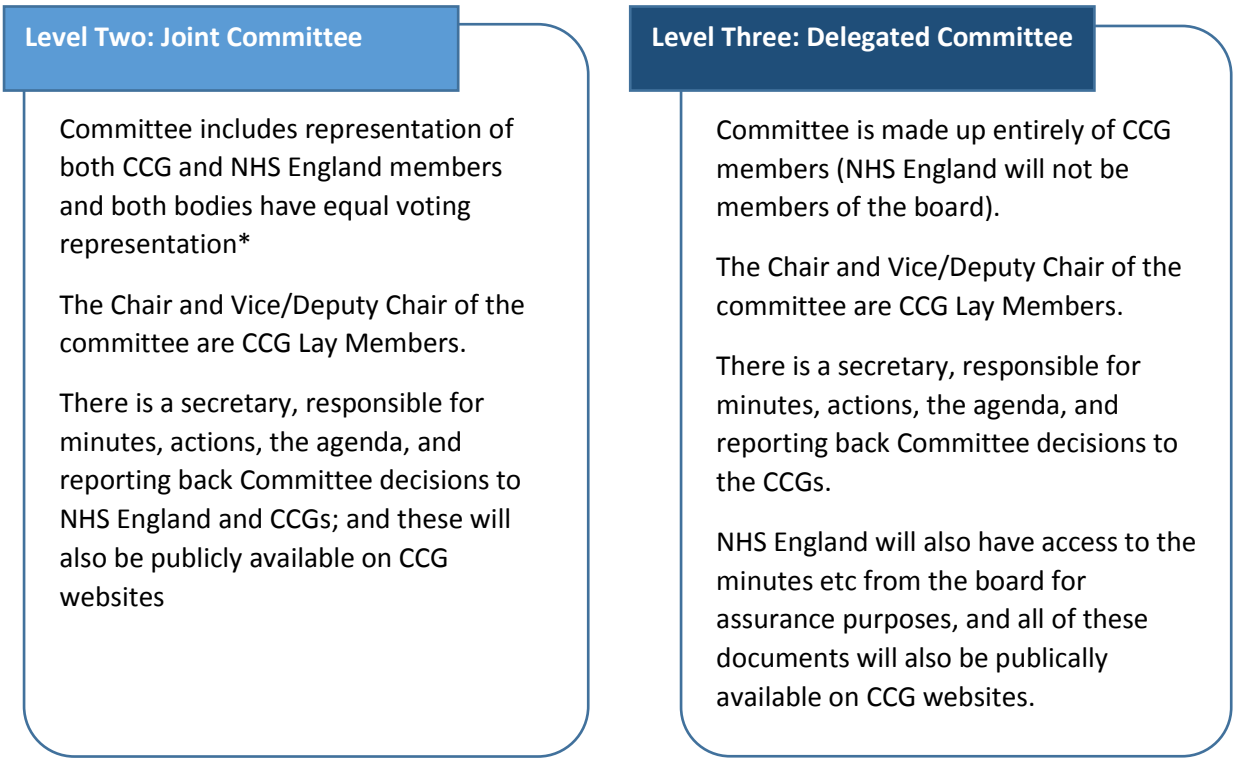


Figure 9: Committee and Joint Committee constitution

Other Committee attendees

In the interests of transparency and the mitigation of conflicts of interest, other interested local representative bodies have the right to join the joint committee as non-voting attendees, such as LMC, HealthWatch and Health and Wellbeing members. Invitees should be determined in line with national guidance, and local terms of reference. Attendees should be agreed so as to support alignment in decision making across the local health and social care system. Other organisations may be invited, and as the committee meets openly it is likely that members of the public and others will attend.

3.2 Committee resourcing

There will not be a nationally-determined model of resourcing for co-commissioning, and there is a recognition of the additional workload these new ways of working will result in. We

expect, therefore, local dialogue between CCGs and their regional teams to determine how the Committees can access the existing primary care team support, recognising that

- CCGs are taking on significant responsibilities from NHSE, and therefore will require access to a fair share of the regional team's primary care commissioning staff resources
- Area teams need to retain a degree of this resource, in order to safely and effectively continue with their remaining responsibilities.

Currently, there is no possibility of additional administrative resources from NHS England at this time, but this will be kept under review.

4. Processes & Capabilities

4.1 Meeting process:

It is proposed that the method of operating the committee should follow processes already established in CCG's. The below illustrates a standard process for meeting setup:

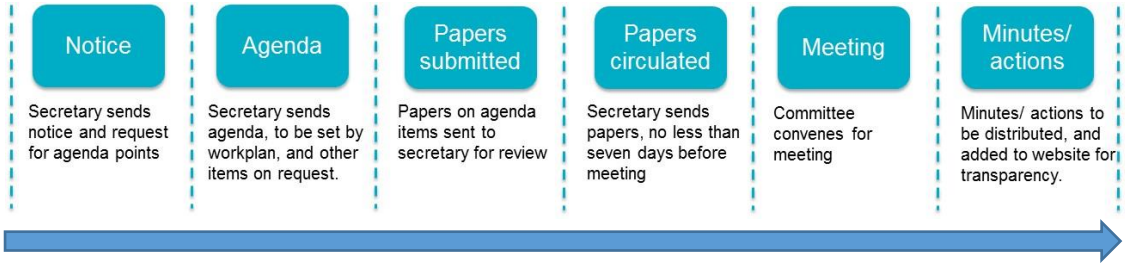


Figure 10: Meeting process map

4.1.1 Agenda contents

It will be important for engagement between NHS England and CCGs ahead of meetings, particularly in cases where a particularly significant matter is on the agenda to be discussed. This may involve the need for additional meetings, or for information from NHS England to inform thinking. This will be particularly important for delegated commissioning, where NHS England will not be participating in the committee discussion. Each Committee should set out how this engagement will take place, as well as when, in the standard meeting process set out above (Figure 10), submissions will be accepted for discussion at each meeting.

In general, clear and active engagement with NHS England, as well as the Committee sub groups, will help inform the content of the agenda we expect that agendas are likely to have the following components:

- *Standard agenda items*, which might involve items that can be expected at each meeting, such as an overview of finance and performance reports.

- *Work-plan items*, such as a review of the annual budget or developing a Primary Care Strategy, which is determined by the known upcoming work
- *Any other items*, which could include submissions from NHSE, sub groups, and the CCG.

There will also need to be a determination for whether part of the meeting needs to be in private. The process for determining the privacy of meetings is set out in 4.2, below.

The schedule of Committee meetings in 2015/16 can be found in Annex 6.

4.2 Meeting Papers

As outlined in the reporting section on page 21, papers created by NHS England should be submitted to the committee secretary 4 days before the papers are circulated in order to allow time for them to be reviewed and comments and adjustments made.

It is expected according to standard meeting processes that papers may be circulated a week before the meeting, although this should be determined by each committee and referenced in their terms of reference.

It is important that requirements in terms of papers and presenters is made clear by the time the agenda is finalised. Working groups and sub-committees should have clarity regarding upcoming meetings and how work should feed into these boards, including the timelines required.

Delegated CCGs should also ensure that where advice, recommendations or papers are required from NHS England, that this is sought and discussed in advance. The CCG may or may not request NHS England presents the paper at the committee.

4.3 Meeting in private:

As standard, the Committee meetings will be held in public. However, the Committee may require to close part of the meeting on account of the matters to be discussed. Only members of NHS statutory bodies, that are bound by standard NHS confidentiality agreements are expected toattend the closed part of meetings. Only attendees of the private part of the meeting will receive the papers for that part of the agenda. If necessary it may be important to redact names and other details from the minutes.

It may be appropriate for the committee to seek the views of the audit chairs once a definition of this policy has been created for each committee. Below is some guidance which Committees may wish to consider:

- Whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings; or
- If the discussion is commercially sensitive; or
- Where the matter being discussed is part of an ongoing investigation; or

- For any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

The provision for private meetings should only be used where required (as per the criteria above). Where the discussion is not as sensitive, other mechanisms could potentially be used, such as anonymising the reports. Additionally, Members of the Committee shall respect confidentiality requirements as set out in the CCG Constitution and Standing Orders.

5. Annexes

Annex Introduction

The annexes included with this document aim to provide further detail to elements of the Operating model where it is too detailed to include in the main body of the text. These are not meant to be read as continuous chapters, but are included as reference material if required. A short description of the purpose of each annex is included in a table below:

Annex Reference/ Name	Purpose
Annex 1: Detailed processes – including differences in responsibility by delegation level	This is the detailed memorandum of understanding aiming to outline the relative responsibilities of the CCG, NHS England and "the committee". The committee includes both joint and delegated committees. This can be used if more detail is required on process and ownership, however it is suggested that where activities are unclear it may be beneficial to discuss with an NHS England or CCG colleague.
Annex 2: 13Z – CCG Statutory duties	This lists the duties which effect the CCG that NHS England does not have liability for under section 13Z. This is included for its reference to roles and responsibilities.
Annex 3: Performer Contract Decision Making Process	This process aims to outline the decision making process specifically related to contract decisions arising from performer issues. It links into the overall decision making process flows (section 2).
Annex 4: NHS England (London) Primary Care Commissioning Team Org Chart	This annex provides detail of the target organisational structure of the pan London commissioning and contracting team, including the support available to the different SPG areas.
Annex 5: PCIF Bid Process	This annex outlines the Primary Care Infrastructure fund bid process.
Annex 6: Standard Report Formats	There are several different types of reports which will be sent to the committee. In order to ensure the committee are familiar with the standard report format and content, these are included here for reference.
Annex 7: Meeting Frequency	This calendar outlines the planned committees happening throughout the year. This provides an opportunity to understand when committees in other areas will be convened.
Annex 8: Safeguarding – responsibilities at different levels of	This annex provides a high level analysis of responsibilities related to safeguarding at different

CCG co-commissioning delegation	levels of co-commissioning:

5.1 Annex 1: Detailed processes

The tables below set out the key Co-Commissioning responsibilities and tasks of the Committee, the CCGs and NHS England.

	Responsibilities			Tasks/ Standard		
Definition	**The Committee**	**CCG**	**NHS E**	**The Committee**	**CCG**	**NHS E**
1. Determination of key decisions/ requests						
Determination to secure services through an APMS contract either a consequence of a practice vacancy, a finding that there are inadequate services in the area or following a contract expiration	To decide whether it is appropriate to undertake a procurement to appoint an APMS provider where there is a vacancy or a contract has expired. In making this decision the Committee must ensure that it is a viable and vfm service that will meet the needs of the current and future population, addresses inequalities, improves quality choice and access. The Committee is responsible for ensuring that appropriate engagement processes are in place to support decision making	To secure & provide, to the RT, local intelligence and feedback to support decision making. The CCG shall also provide relevant local strategic context to support decision making. The CCG may, if appropriate, agree additional resourcing for the service. To work jointly with the RT and local representative to identify new or alternative solutions to address the practice vacancy and additional local KPI requirements.	To secure & provide necessary information to support decision : - performance and service data; - equality impact assessment; - needs assessment; - available funding, including transitional funding; -service viability; - feedback from stakeholders and the CCG; -relevant guidance. To implement the decision of the Committee. To work jointly with the RT and local representative to identify new or alternative solutions to address the practice vacancy	Tasks: 1. Determine whether procurement is the best option in the interests of patients and the public and that no other options are viable to secure adequate services 2. Assure that correct processes have been followed, particularly in relation to patient and stakeholder engagement; 3. Confirm that the contract is affordable; 4. Confirm that the service is viable 5. Set tolerances for the cost and timeframe for implementation. 6. Ensure that an equality impact assessment has been undertaken 7. Ensure that the proposed procurement processes are undertaken in accordance with SFI's and regulations. Standard: Maintain a record of the decision, particularly in relation to potential conflicts of interest; Notify RT of decision with details of agreed funding and tolerances for implementation;	Tasks: 1. Provide local intelligence to the RT to support their report: 2. Provide relevant information about local strategies to be included in the RT report: 3. Where necessary present paper to The Committee, with RT 4. Where appropriate, secure additional CCG funding to support a new service prior to the Committee's determination 5. Provide relevant specifications and data to support local KPI's. Standard: To provide relevant information to the RT within 15 WD's of the request. To ensure that the Committee has information to support their decision making, including confirmation of any funding the CCG intends to make available for the service.	Tasks: 1. Undertake required needs assessment, feasibility analysis, financial modelling and impact assessments to support the decision making process. 2. Implement an appropriate engagement plan. 3. Work jointly with the CCG to identify any local KPI's or other commissioning opportunities. 4. Identify and secure any additional resources required to support options. 5. Establish a procurement project team to implement the Committee's decision, if required. 6. To maintain and update a database of fixed term contracts. 7. To procure the service in accordance with directions, regulations and guidance. Standard: To process in accordance with regulatory requirements, Relevant SFI's and agreed procurement processes.
Procurement of new Services under APMS agreements	The Committee is responsible for approving a preferred provider following procurement process following the evaluation process	The CCG is responsible for providing local standards and specifications to address local issues of access, quality and choice	The RT shall develop and implement procurement policies & programmes aimed RT securing new APMS providers.		Tasks: Develop local standards and KPI's to be incorporated into APMS contracts. Support providers to ensure optimum delivery. Communicate with local stakeholders as required.	Tasks: Develop London standards and KPI's to be incorporated in APMS Contracts. Standard: Use standard frameworks to secure services and ensure good value for money - Support providers to ensure optimum delivery. Standard: Procure APMS in line with the agreed commissioning strategy - Initiate formal procurement activity for each APMS scheme, within terms of any national procurement support. - Sign off/ finalise contracts with preferred bidder. - Agree/ implement the local mobilisation plan. - Undertake appropriate checks prior to service commencement (for example, premises inspection). - Make provision for emergency primary medical care services in the event of an unforeseen circumstance.
Determination of a requests; **- to close a branch practice;** **-for practice mergers;** **-PMS partnerships;** **-List Closures;** **-Rent Reviews**	To consider and determine requests in a timely manner following appropriate consultation and in accordance with statutory requirements and agreed policy; ensuring that any decision will secure continuity of services and provide benefits for patients and the public. The Committee will pay due considerations to Strategic imperatives and Statutory	To secure & provide, to the RT, local intelligence and feedback to support decision making. The CCG shall also provide relevant local strategic context to support decision making.	To secure & provide necessary information to support decision: - performance and service data; - feedback from stakeholders and the CCG; -relevant guidance. To implement the decision of the Committee.	Tasks: 1. Determine request; 2. Assure that correct processed have been followed, particularly in relation to patient and stakeholder engagement; 3. Provide minutes and decision rationale 4. Ensure continuity services as a consequence of their decision: 5. Maintain records of all decisions; 6. Respond to questions and queries relevant to the decision, including FOI requests.. Standard: Provide decision and rationale within 5 WD of the meeting:	Tasks: 1. Provide local intelligence to the RT to support their report: 2. Provide relevant information about local strategies to be included in the RT report: 3. Work jointly with RT to ensure patient benefit and service continuity; 4. Where necessary present paper to The Committee, with RT . Standard: All requested information to be provided within 10 WD: To make available relevant staff for meetings and case conferences pertinent to the decision	Tasks: 1. Processing the application; 2. Engagement/consulation with stakeholders and patients; 3. Notifying the CCG and The Comittee secretariate ; 4. Preparing & presenting the report to the Comittee, using agreed format; 5. Issue decision letters/ notices; 6. Suport any practice closure using agreed protocol; 7. Updating databases and notifying 111 via CSU. Standard: To process in accordance with:

	Responsibilities			Tasks/ Standard		
Definition	**The Committee**	**CCG**	**NHS E**	**The Committee**	**CCG**	**NHS E**
	requirements to secure primary care services to meet the current and future needs of the population.			- Ensure that service continuity is not compromised as a consequence of their decision: - Ensure patient and public benefits are secured: - Acknowledge all queries within 5 WD offering full response within 20 WD: - Comply with FOI timescales		- National & London SOP; - Regulations- Contract and Patient Public engagement
GP Practices list maintenance	The Committee is responsible for decisions on any ad hoc list maintenance requests and for the setting of cleansing periods		NHS England is responsible for coomissioning a process of practice list maintenance in accordance with national guidance as stated in Schedule 2 Part 1 Section 3.1.7 of the Delegation Agreement and will liaise with NHS Shared Business services and any other external partner as part of that.			
Issue of Contract Breach Notice	To determine whether a provider has breached the terms of their contract and to make a proportionate decision as to whether: -a remedial or breach notice is warranted; -the practice should be asked to submit a improvement plan; -no action is required under the circumstances. To review outcome of remediation /improvement plans.	To identify & manage any resultation risk to services they commission as a consequence of an adverse finding. To provide support or facilitation for any relevant improvement plan/actions	To investigate concerns and provide evidence where a contract has been breached together with any mitigation offered by the provider using an agreed London template: To implement decisions	Tasks: 1. Review evidence and confirm that a contract has been breached; 2. determine the most appropriate and proportionate response to the breach taking account of relevant mitigation . Standard: Provide decision and rationale within 5 WD of the meeting: Ensure that service continuity is not compromised as a consequence of their decision: Ensure that there is a formal review of the outcome of all remediation and improvement plans.	Tasks: The CCG may be informed of concerns when a finding has been made, if it is relevant to any contract held between them and the provider. .	Tasks: 1. Identify concerns: 2. Investigate concerns: 3. Notify the provider of concerns and any evidence to support they have breached the contract: 4. Present evidence of the breach to the The Comittee along with any mitigation provided by the provider: 5. Issue notices to the provider: 6. follow up remedial actions /action plans 7. liaise with the CQC and carry out actions to support registration 8. Produce format for local notices and breaches. Standard: Contract Regulations; National SOP Local protocols
Contract Termination	Determine the appropriateness of contract termination	To identify & manage any resultation risk to services they commission as a consequence of an adverse finding. To provide support or facilitation for any relevant improvement plan/actions	To investigate concerns and provide evidence where a contract has been breached together with any mitigation offered by the provider using an agreed London template: To implement decisions	Tasks: 1. Review evidence and confirm that a contract has been breached; 2. determine the most appropriate and proportionate response to the breach taking account of relevant mitigation . Standard: Provide decision and rationale within 5 WD of the meeting: Ensure that service continuity is not compromised as a consequence of their decision: Ensure that there is a formal review of the outcome of all remediation and improvement plans.	Tasks: The CCG may be informed of concerns when a finding has been made, if it is relevant to any contract held between them and the provider. . Standard:	Tasks: Develop contract termination documentation, systems and processes. - Prepare Reports and Evidence for the Committee, securing necessary legal advice. - Issue termination notices. - Develop action plans to manage termination of contracts and implement in consultation with and supported by stakeholders. Update the contractor database with sanction information.

	Responsibilities			Tasks/ Standard		
Definition	**The Committee**	**CCG**	**NHS E**	**The Committee**	**CCG**	**NHS E**
Contractual Payments	The Committee is responsible for assuring that systems and processes are in place to ensure accurate and prompt payments to GP Practices in accordance with Contracts, Agreements, The SFE and SFI's	The CCG is responsible for notifying the Committee of any systematiic failure to promptly pay GP Providers in accordance with the Contract / Agreements and SFE, setting out how this is to be addressed	NHS E is responsible for notifying the Committee of any systematiic failure to promptly pay GP Providers in accordance with the Contract / Agreements and SFE, setting out how this is to be addressed	Tasks: 1. Review evidence and confirm that a contract has been breached;2. determine the most appropriate and proportionate response to the breach taking account of relevant mitigation . Standard: Provide decision and rationale within 5 WD of the meeting:Ensure that service continuity is not compromised as a consequence of their decision:Ensure that there is a formal review of the outcome of all remediation and improvement plans.	Tasks: The CCG may be informed of concerns when a finding has been made, if it is relevant to any contract held between them and the provider.	Tasks: - Agree appropriate contract variations (for example, list size changes) including their input to payment systems. - Calculate any agreed local quality and outcomes framework arrangement. - Calculate the impact of key performance indicators on contractual payments (alternative provider medical services contracts). - Determine entitlements to personal allowances (for example, seniority/ locum reimbursement). - Calculate and pay enhanced services that are specified nationally.- Calculate payments for GP registrars in respect of salary, mileage and travel grants. - Calculate prescribing and dispensing drug payments. - Calculate entitlements under the GP retainer/ GP returner and flexible career schemes.- Calculate payments in respect of the dispensary service quality scheme. Administer superannuation regulations, including all deductions, in relation to joiners, leavers, retirements, increased benefits, adjustments and pay these to the pensions division. - Administer and validate GP annual certificates. - Administer GP locum and GP- Solo contributions. - Provide the NHS pension assurance statement.- For suspended contractors, ascertain the individual's entitlements, advise the contractor, validate all documentation, and adjust payment accordingly.
Disputes and Appeals	The Committee is responsible for agreeing a policy and procedure for managing appeals and disputes submitted by GP's in relation to their GP Contract. This includes ensuring there is a local res.olution process and that a Panel is established to consider disputes and appeals where local resolution is not sucessful.			Tasks: The Committee shall establish a Panel who will consider any appeal or dispute.. Standard: The Committee shall ensure that all decisions are made in accordance with the Contract Regulations,SFE, SOP and previous determinations.		Tasks: The RT shall : 1. Ensure that contractors receive a clear and concise notice setting out any determination under the contract; 2. Implement local resolution where a contractor disputes a determination; 3. Where Local Resolution is not successful notify the Committee of the need to establish a Panel; 4. Provide a report to the Panel setting out their rationale and evidence in support of their decision; 5. Present evidence & representations to the Panel 6. Notify the contractor of the outcome; 7. Provide information as required by the Litigation authority in relation to any appeal

2. Financial processes

Determine total budget requirements for all primary care services, including premises and information technology ***Level 3 delegated CCGs***	The Committee is responsible for ensuring that financial balance is secured and maintained.	Under Delegated Arrangements the CCG CFO will approve the financial plan plus any in year revisions	NHS E will carry out the day to day financial management tasks, including the production of monthly reports showing spending vs the agreed budget and variance analysis. NHSE will develop the annual fianncial plans within the region's allocaiton and overall PC plan, under the oversight of the CCG.	Tasks: Ensure apprpriate financial controls are in place to securely manage the budgets.. Standard: Operates in accordance with NHSE or CCG SFIs.	Tasks: Where CCGs have full delegation: a) Maintain control total for revenue and capital limits and agreement of RFTs b) Financial Planning & Reporting including monthly board report, external reports, financial plan submissions and in year review of plans, budget setting & team co-ordination, month end overview. non ISFE reports to region, QIPP reporting. Standard:	Tasks: a) Maintain control total for revenue and capital limits and agreement of RFTs b) Financial Planning & Reporting including input to monthly board report, external reports, financial plan submissions and in year review of plans, budget setting & team co-ordination, month end overview. non ISFE reports to region, QIPP reporting.

	Responsibilities			Tasks/ Standard		
Definition	**The Committee**	**CCG**	**NHS E**	**The Committee**	**CCG**	**NHS E**
Management Accounts ***Level 3 delegated CCGs***	The Committee will: - review the financial reports; - Make decisions to address financial deficits; - Approve any payments additional to those in the financial plan	The CCG will scrutinise the financial reports prepared by the RT and will ensure that the appropriate decisions are brought to the attention of the Committee	NHS E will provide appropriate monthly financial reports to enable budget holders to monitor and take decisions on the budgets,		Tasks: Where CCGs have full delegation: The production of monthly & quarterly CCG management reports at GP practice or locality level to ensure robust financial forecasts and analyse varainces to ensure any variances are explained: Month end procedures a) complete regular task file b) variance analysis & narrative c) accruals & prepayments d) monthly year end forecasts at practice level or locality level and input to system e) meet with budget holders f) Practice list size analysis by CCG locality for GM/system report downloads g) Quarterly forecasting on CQRS(inform forecasting h) additional year end tasks including working papers and support to AOB process i) liaise with internal and external audit as required.. Standard:	Tasks: The production of monthly & quarterly management reports at GP practice or locality level to ensure robust financial forecasts and analyse varainces to ensure any variances are explained: Month end procedures a) complete regular task file b) variance analysis & narrative c) accruals & prepayments d) monthly year end forecasts RT practice level or locality level and input to system e) meet with budget holders f) Practice list size analysis by CCG locality for GM/system report downloads g) Quarterly forecasting on CQRS(inform forecasting h) additional year end tasks including working papers and support to AOB process i) liaise with internal and external audit . Standard:
Financial systems and BI ***Level 3 delegated CCGs***	The Committee shall assure that appropriate systems and SOPS are in place to manage and maintain financial control in line with the relevant financial instructions	The CCG will ensure correct calculations and payments are carried out in line with the contracts by ensuring that the RT team provides has appropriate internal and external audit arrangements in place audit	NHS England is responsible for the correct calculation of payments to all contractors in line with their contracts	Tasks: . Standard:	Tasks: Where CCGs have full delegation: Ensuring compliance with central requests and timelines and utilising their system and BI reports to best effect: a) Financial System Management including setting up new ISFE reports, locality reporting, controls, exception reporting liaison with with RT finance department. . Standard:	Tasks: Ensuring compliance with central requests and timelines and utilising the system and BI reports to best effect: a) Set up new suppliers or amend existing suppliers on ISFE e.g changes to bank account details, and to reflect practice mergers b) Financial System Management including setting up new reports, locality reporting to CCGs, controls, exception reporting d)Liaison with SBS and central NHS England . Standard:

3. Strategy and policy

Develop and agree a Primary Care Strategy (SPG)	The Committee to: - approve strategy and, - provide oversight to development and implementation	To contribute information & resources to: -support strategy development, -implement plans and strategies, - contribute resources to facilitate joint working To ensure primary care strategies are aligned to CCG strategies and plans To develop and implement engagement plans in line with primary care strategy.	To contribute information & resources to: -support strategy development, -implement plans and strategies, - contribute resources to facilitate joint working To develop and implement engagement plans in line with primary care strategy.	Standard: Engage and consult with key stakeholders, including patients, carers and the public in relation to priority areas for improvement,Ensure that the London Specifications / Framework is integrated into Local CCG and SPG Strategies, Ensure that primary care is integrated into local joint strategic needs assessment planning processes, Integrate and align primary care strategies with health and well being strategies, Integrate and align primary care strategies with CCG and SPG strategies, particularly in relation to urgent care and collaborative care		
Primary Premises Plan /Strategy	The Committee is responsible for reviewing and determining business cases for new premises developments in accordance with local CCG premises development plans, national guidance and primary care directions	The CCG is responsible for developing local Strategies and Development Plans in conjunction with NHS E and NHS property holding organisations (Trusts, NHS PS and CHP)	The RT is responsible for providing information to CCG's and other organisations to support the development of strategic premises plans			

	Responsibilities			Tasks/ Standard		
Definition	**The Committee**	**CCG**	**NHS E**	**The Committee**	**CCG**	**NHS E**
Workforce Audit and planning	The Committee shall ensure that appropriate workforce audit and planning is place to support service delivery	The CCG to undertake local audits as required	The RT shall implement the national workforce audit and is responsible for ensuring that all practices submit their return			
GP Provider Development - Organisation Structures	The Committee is responsible for determining responses to requests to close or merge practices	To support the below : - performance and service data; - feedback from stakeholders and the CCG; -relevant guidance. To implement the decision of the Committee. The CCG will consult with local stakeholders to arrive at a final decision.	To secure & provide necessary information to support decision : - performance and service data; - feedback from stakeholders and the CCG; -relevant guidance. To implement the decision of the Committee.	Standard: The Committee shall ensure that all decisions in relation to mergers, closures and procurement support the London and Local aims for provider development		
Develop and agree outcome frameworks for GP Services ***For Level 2 CCGs NHS E remain ultimately accountable***	The Committee shall agree an outcome framework for GPs services that enables continuous quality improvement and that it is aligned to national and local strategies. The framework shall be based on the national primary care GPOS and High performance indicators plus any local outcome and indicators set by the CCG	The CCG shall make available performance against locally agreed outcome and indicators required under the framework as required	NHSE shall make available practice and CCG performance against national GPOS and High Level indicators via the Primary Care Web-Tool		Tasks: The CCG developf a local Outcomes Framework under the guidance of The Committee by -Collecting and validating performance data againt locally agreed outcomes and standards - Providing locally agreed performance reports Undertake Service reviews : LIS (or LES) Specifications . Standard:	Tasks: The RT will support the development of a local Outcomes Framework under the guidance of The Committee by -Collecting and validating performance data againt nationally agreed outcomes and standards - Providing nationally agreed performance reports on an annual or quaterly basis via the Primary Care Web Tool Undertake service reviews :GP Contracts, Advanced Services & DES. Standard:
Planning PMS Review	The Committee shall oversee the implementation of the national PMS review to ensure that all contracts are reviewed within the national timescales and that agreements are varied to reflect new prices and premium payments	Delegated CCGs shall lead on the development and implementation of Local PMS Premium specifications and payments.	NHS England shall be responsible for the PMS Programme for Greater Involvement (Level 1) and Joint Commissioning (Level 2) CCGs. They may also be asked to support the PMS review for delegated CCGs		Tasks: The CCG developf a local Outcomes Framework under the guidance of The Committee by -Collecting and validating performance data againt locally agreed outcomes and standards - Providing locally agreed performance reports Undertake Service reviews : LIS (or LES) Specifications .	Tasks: Financial Review, contract review, engagement (public and stakeholder), implementation of agreement changes
Securing Quality Improvement ***For Level 2 CCGs NHS E remain ultimately accountable***	The Committee is responsible for review and approval of all Local Improvement Schemes (LES's). The Committee is responsible for review and approval of the use of APMS to secure quality improvement under collaborative arrangements	The CCG will develop and lead the implementation of local schemes /Local Enhanced Services aimed at improving the quality in primary care. This will include development of clinical leadership and of peer support for practices.	The RT shall make available information to support quality improvement, and will support the CCG in the implementation of local schemes.		Tasks: Develop and implement local improvement schemes /Local Enhanced Services aimed at improving quality in primary care. -- Procurement and implementation of collaborative services aimed RT quality improvement under APMS arrangements. - Support and develop peer support for practices and practice staff. - Support and develop clinical leadership Standard: LCSF	Tasks: The RT will incorporate any Local Incentive Schemes into the provider contracts as stated in Schedule 2 Part 1 Sections 2.11 The RT will negotiate, in partnership with clinical commissioning groups, quality improvement plan with each practice. Standard:

	Responsibilities			Tasks/ Standard		
Definition	**The Committee**	**CCG**	**NHS E**	**The Committee**	**CCG**	**NHS E**
Securing Directed Enhanced Provision	The Committee shall review uptake and performance of all national DES and where necessary direct CCG's and RT's to take action to improve uptake or develop alternative local schemes	To support implementation as directed within the specifications	To support implementation as directed within the specifications. To provide information to the Committee on uptake and performance		Tasks: The CCG shall support local implemenation and training as required under the national specification. Standard:	Tasks: The RT will disseminate all national DES specifications to practices together with local implementation guidance and a sign up sheet in accordance with the national timetable/ MOU (KPI's). Standard:
Securing Advanced Service Provision	The Committee shall review uptake and performance of all additional service provision and where necessary direct CCG's and RT's to take action to improve uptake or develop alternative local schemes	To provide information to the Committee about uptake and performance of non GP providers, making recommendations where additional services should be commissioned	To provide information to the Committee about uptake and performance of GP (& Pharmacy) providers, making recommendations where additional services should be commissioned	Tasks: Where necessary to direct the CCG or RT to take action to improve service provision. Standard:	Tasks: Procure additional services from non GP providers where practices do not wish to undertake them. Standard:	Tasks: Agree opt outs from the general medical services contract. Discuss locally the provision of additional services (where practices wish not to undertake them) with clinical commissioning groups. Standard:
Development of Policies and Procedures	The Committee shall approve all Local and endorse all London policies procedures in line with regulations					Tasks: Develop and maintain policies and procedures in line with regulations. Standard:
Contract Maintenance	The Committee shall ensure that the RT and CCG maintain all GP contracts in line with national and local variations and that systems are place to implement material changes		The RT will be responsible for the carrying out of several responsibilities specifically highlighted in the Delegation Agreement, including: 1. Managing Contract Variations Schedule 2 Part 1 Section 2.4.3 The RT shall report, by exception, any failure to properly maintain contract documentation and provide an action plan to address this oversight			Tasks: - Issue national standard contract variations in line with changes to regulations. - Produce and issue local contractor specific variations (including, partnership changes, relocations, and mergers). - Implement changes to relevant systems to contractor payments. - Raise contract variations which may have a significant impact on the delivery of patient services and finances with localities and commissioners. - Maintain the contractor data base, including hard copies of all signed contracts for primary care providers, pertinent to the geographical area covered by the local regional team (including contract variations and breaches).

	Responsibilities			Tasks/ Standard		
Definition	**The Committee**	**CCG**	**NHS E**	**The Committee**	**CCG**	**NHS E**
Quality Assurance GP Services ***For Level 2 CCGs NHS E remain ultimately accountable***	The Committee will reiveiw reports to ensure GP's services are safe and meet all national and local standards. This will be monitored through an annual report on performance and the use of exception reports as required or as a result of a critical incident - Monitor activity on performers lists alongside practice performance data to generate a complete picture of quality		The RT will provide a regular quality report, based on the national framework to The Committee to support locality-wide quality assurance of primary care. This will include exception reports as required.		Tasks: Support practices and performers in the achievement of their quality improvement plan. Standard:	Tasks: The RT shall, using the nationa GPOS, High Level indicators, practice E-Delarations & CQC reports: 1. Collate Compliance Reports 2. Assess practice performance from analysed data and identify priorities for further interrogation 3. Provide an Annual 4. Performance Report and any exception reports 4. Conduct contractual compliance and quality reviews, developing and agreeing action plans to address performance issues with contractors.. - Support each clinical commissioning group in the development of a primary medical care quality improvement strategy involving all practices . - The RT will support the CCG with information to establish any cause for concern and act accordingly, including a quality review where necessary and performance management arrangements for poorly performing practices, as set out in Schedule 2 Part 1 Section 6.2. In particular the RT will ensure that: 1. It maintains regular and effective colaboration withe the CQC and responds to CQC assessments as set out in Schedule 2 Part 1 Section 6.2.1 / 6.2.2 / 6.2.3 2. Ensure and Monitor Practice remedial action plans as set out in Schedule 2 Part 1 Section 6.2.4 .
Develop processes and systems to ensure fair, open and transparent decision making		The CCG is responsible for implementing processes and systems as required by the Committee	The RT is responsible for implementing processes and systems as required by the Committee			
4. Other						
Counter fraud	To ensure that proper processes are in place to prevent fraud within the NHS		Implementation of the Deloitte Counter-Fraud service			Tasks: Issue notification of stolen prescription forms or persons attempting to obtain drugs by deception, to GPs, pharmacists, counter fraud, drug squads and other interested parties.
Interpreting Services	To ensure that patients have access to interpreting services when using GP practices					
FOI ***For Level 2 CCGs NHS E remain ultimately accountable***		Dependant on source of information as to owner of FOI responsibility			Tasks: To provide any information that the CCG holds about GP services as requested under the FOI act. Standard:	Tasks: To provide any information that the RT holds about GP services as requested under the FOI act.
Occupational Health	The Committee shall ensure that GP practices have access to occupational health services in accordance with national guidance					Tasks: To secure contracts for OH; To make prompt payments under the contract.

	Responsibilities			Tasks/ Standard		
Definition	**The Committee**	**CCG**	**NHS E**	**The Committee**	**CCG**	**NHS E**
EPRR	The Committee shall ensure that the RT and CCG develop strategies and plans to respond to rising tides, major incidents and service failure.					- Responding to local service disruption. - Responding to major service disruption. - Planning for major service disruption. - Flu Pandemic Planning. - Other Public Health Responses (e.g Ebola). - Issuing Communications to practices.
Implementation of Premises Directions	Approval of DV Rent Reviews, responding reimbursement appeals; Approval of discretionary payments for SDLT, Legal Fees and Development costs to practices; Procurement of Support for the Development of Strategic business cases; Aprroval of improvement grants; Approval of business cases for new premises / expansion; Approval of capital schemes; Approval of business cases for new premises /expansion		The RT shall bring to The Committee's attention as part of the regular reporting any matters requiring decision in relation to the Premises Cost Directions Functions (Schedule 2 Part 2 Section 7 and) including but not limited to: - new payments applications - existing payments revisions		Tasks: The CCG will respond to any requests from NHS England for relvant information to support the assurance of primary care commissioning .. Standard:	Tasks: The RT will provide sufficient information to support The Committee's decision. Following decision from The Committee the RT is responsible for carrying out all subsequent payments (Delegation Agreement Section 13.2.2). The RT must liaise where appropriate with NHS Property Services Ltd., Community Health Partnerships Ltd and NHS Shared Business Services. Standard:
Information sharing	The Committee is responsible for ensuring that information relevant to the assure the quality of primary care commissioning is shared in accordance with legislation and guidance.	The CCG is responsible for making availabe any information required to assure the quality of primary care commissioning as provided within IG rules	The RT is responsible for making availabe any reasonable and available information required to support primary care commissioning.		Tasks: The CCG will respond to any requests from NHS England for relvant information to support the assurance of primary care commissioning .. Standard:	Tasks: The RT will respond to any requests from NHS England around information sharing as specified and will be responsible for auditing and ensuring that providers accurately record and report information as set out in Schedule 2 Part 1 Section 5.1.4. Standard:
Controlled drugs reporting	The Committee is responsible for ensuring that practices are complying with legal requirements for use of controlled drugs and CCGs and NHSE have proper controls in place to maintain patient safety		The RT will carry out any reporting, analysis, complance or investigations involving controlled drugs as specified in Schedule 3 Section 8.5		Tasks: The CCG shall 1. Analyse prescribing data available as set out in Schedule 3 section 8.5.4 2. Complete the periodic self assessments / self declarations as set out in Schedule 3 Section8.5. 3. Report all incidents and other concerns to NHS Englands CDAO as set out by Schedule 3 Section 8.5.3.	Tasks: The RT will support The Committee to comply with its obligations under Controlled Drugs regulations by: 1. Reporting all complaints as set out by Schedule 3 Section 8.5.2
Safeguarding – children	To ensure that GP Practices have effective safeguarding systems in place in accordance with statutory requirements and national guidance and Pan London Policy and Procedures . Ensure appropriate response from primary care to safeguarding enquiries and serious case reviews (including approval of IMRs)	Support and facilitate Primary Care to proactivley improve the safety and well being of children registered within the practice setting, providing assurance to NHSE that practices are compliant with safeguarding standards.	To monitor and review compliance with safeguarding standards			Tasks: The RT will ensure that: 1. GP Contracts include requirements for safeguarding; and 2. GP practices annually declare compliance; The RT shall provide representation at the LSCB. The RT shall approve GP IMRs. Standard:

	Responsibilities			Tasks/ Standard		
Definition	**The Committee**	**CCG**	**NHS E**	**The Committee**	**CCG**	**NHS E**
Safeguarding – adult	To ensure that GP Practices have effective safeguarding systems in place in accordance with statutory requirements, national guidance and Pan London Policy and Procedures Ensure appropriate response from primary care to safeguarding enquiries and serious case reviews (including approval of IMRs)	Support and facilitate Primary Care to proactivley improve the safety and well being of those adults most vulnerable registered within the practice setting, providing assurance to NHSE that practices are compliant with safeguarding standards.	To monitor and review compliance with safeguarding standards			Tasks: The RT will ensure that: 1. GP Contracts include requirements for safeguarding; and 2. GP practices annually declare compliance; The RT shall approve GP IMRs. Assure primary care relating to safeguarding and MCA awareness, including oversight of training compliance.. Ensure primary care adheres to the pan london policy for safeguarding adults. Representation at LSAB to provide assurance to board around primary care services.. Assure primary care relating to safeguarding and MCA awareness, including oversight of training compliance.. Ensure primary care adheres to the pan london policy for safeguarding adults.
Domestic homicide	Ensure that GPs contribute to domestic homicide reviews – where relevant and where necessary take action to remedy any oversight.	To support practices in undertaking DHR where resources are held by the CCG	To support practices in undertaking DHR where resources are not held by the CCG			Tasks: Provide funding and advice where resources are not held by the CCG Provide representation at DHR Panels.
Serious incidents	The Committee shall processes are in place to report and review incidents so that serious incidents can be identified and managed. This includes reviewing the outcome of SI investigations and where necessary make recommendations to improve patient safety	To support and contribute to investigations	To support and contribute to investigations. To monitor compliance			Tasks: The RT will ensure that: 1. GP Contracts include requirements for reporting incidents; and 2. GP practices annually declare compliance; - Provide Advice and guidance to primary care practitioners and practice staff who wish to report an incident; Co-ordinate SI case management, including evaluation of final report; Liaison with NHS England Performance and Revalidation team regarding performance concerns.
Incident management	The Committee shall ensure that there are proper processes in place for GP practices to report incident (subject to a national review) and shall review reports on incidents at least once annually or where necessary by exception. The Committee shall make recommendations where necessary as a consequence on incident reports	To support and contribute to investigations	To support and contribute to investigations. To monitor compliance			Tasks: The RT will ensure that: 1. GP Contracts include requirements for incident management; and 2. GP practices annually declare compliance; Regularly log into the NRLS site to access any eForms (reported incidents); Ensure reported incidents are assessed to determine if SIs – and manage accordingly; Provide expert guidance on NRLS form/function.
Central Alerting System (CAS) Alerts	The Committee shall ensure that processes are in place to ensure that CAS alerts are disseminated in accordance with guidance.		To monitor compliance			Tasks: The RT will ensure that: 1. GP Contracts include requirements for incident management; and 2. GP practices annually declare compliance; Regularly log into the NRLS site to access any eForms (reported incidents); Ensure reported incidents are assessed to determine if SIs – and manage accordingly; Provide expert guidance on NRLS form/function.
Engagement and Consultation ***For Level 2 CCGs NHS E remain ultimately accountable***	The Committee shall ensure that all parties comply with statutory requirements to consult and engage with stakeholders. This is includes reporting to Local OSC, Healthwatch and HWB	For undertaking local engagement Engagement related to strategic planning Engagement linked to chnages in urgent care or LES	Engagement and consultation associated with changes to GP services, including: -closures, - premises development, - mergers			Tasks: Consultation with LMC Presentations to OSC. HWB and Healthwatch Notification letters to patients Consultation letters to patients and stakeholders.

5.2 Annex 2: Section 13Z - CCG statutory duties

Arrangements made under section 13Z do not affect NHS England liability for exercising any of its functions, and in turn, CCG must comply with its statutory duties, and 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).

Still subject to any directions and decisions made by NHSE or by the Secretary of State.

5.3 Annex 3: Performer Contract Decision Making Process

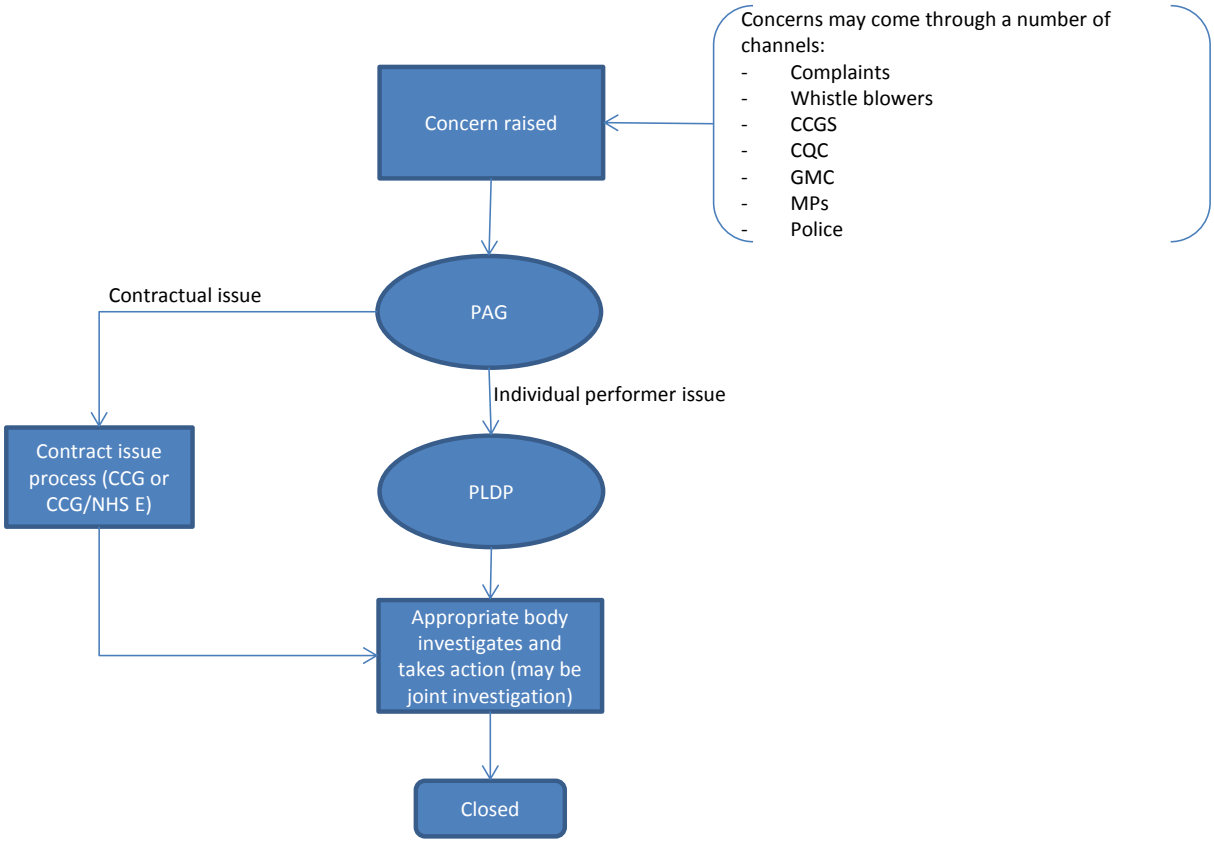


Figure 11 – Interface between the Performer Management and Contract Issue processes

Interface between the Performer Management and Contract Issue processes

Concerns about performer performance may come to NHS England's attention through a number of channels, including:

- Complaints from patients;
- Whistleblowers;
- CCGs;
- CQC;
- GMC or other professional regulator;
- MPs; or
- The Police.

Responsibility for Performer List Management

NHS England retains the responsibility for Performers being admitted to the National Performers List. The National Health Service (Performers Lists) (England) Regulations 2013 entrusts the responsibility for managing the performers lists to NHS England. Issues raised are triaged by the performance advisory groups (PAGs) within regional teams. Where the issue raised may have an impact on the performance of a contract, PAG will escalate information relating to the contractual impact, to the appropriate CCG (Level 3 delegation) and NHS England body (Level 2 delegation).

For issues with a contractual impact, the PAG may carry out a joint investigation with the CCG, with the PAG considering performer issues, and the CCG considering contractual issues. If action is considered to be necessary under the performers' lists regulations, the case is referred to a PLDP.

Commissioner Involvement

Where there are no contractual issues arising, commissioners may choose to receive a quarterly report, for information only, on performer performance issues which provides an overview of the numbers of issues by CCG, and key themes of issues arising. This may be submitted to part one of committee meetings.

Commissioner involvement is expected in instances where poor individual performance will have a contractual impact. Incidents which affect the medical services contract will be discussed at a joint committee or sub-committee, depending on the timeline for providing a response, with a decision provided for the contractual action taken to be taken.

Only information relevant to the contractual impact of issues should be shared. Discussion of sensitive issues should be carried out in a private pre-meeting, or submitted to a private part two committee to maintain confidentiality and to allow for the relevant information to be made available, discussed and any actions agreed. The decisions made on contractual actions should be reported in part one of committee meetings.

Performer List Decisions

NHS England has established performers lists decision panels (PLDPs) within regional teams in order to support its responsibility in managing performance of primary care performers. The role of the PLDP is to make decisions under the performers lists regulations. As a retained role of NHS England, there is no basis for CCG involvement in this process.

5.4 Annex 4: NHS England Primary Care Commissioning Org Chart

Figure 12: Current NHS England (London) GP Primary Care Commissioning Organisation Structure

5.5 Annex 5: PCIF Bid Process

Primary Care Infrastructure Fund (PCIF) bids – a model approval and prioritisation process

This process is included to provide a guide to CCGs on how they may wish to manage the approval and prioritisation of PCIF bids.

Summary

Bids against the PCIF fund are due to be returned to NHS England by 16th Feb 2015. There is a very tight programme for regional teams to sift and assess the bids and recommend support against the agreed assessment criteria in time for a ministerial announcement on the use of the initial £250m during March 2 015.

Each NHS England sub-regional team will ensure that they have a robust process in place that enables them to collate and review bids and provide a recommendation to their regional team. The regional director, supported by a member of the NHS England Project Appraisal Unit, will decide which bids will be supported and will allocate each bid to one of four categories:

- Supported as a priority investment in 2015/16
- Supported subject to clarification of specific issues but deliverable in 2015/16
- Supported in principle but subject to further work up and submission against the 2016/17 PCIF
- Not supported

Regions will produce a brief summary of the bid and submit this report to the national panel by 4 March 2015.

Funds will be allocated to each region so that decisions about bids can be made in regions under the terms of their delegated authority.

Process

The process described here outlines a methodology that is supported by the national project team as one that will provide the necessary assurance whilst aligning to existing governance regimes. Regions may flex this methodology to align with their own existing processes whilst ensuring that they continue to work within the confines of their delegated authority. There are nationally agreed approval criteria that are provided as part of the PCIF toolkit.

There will be a concentration of work within a very short period of time to collate, analyse and recommend support for the PCIF bids received by the sub-regional teams from the national programme team whilst recognising that there will also be a cross over between the criteria for qualification for the PCIF, the Prime Minister's Challenge Fund (PMCF) and the general NHS England capital programme. To enable that, and the ongoing project management of the PCIF to work effectively, it is recommended that local teams consider the procurement of a programme management resource for receiving, collating, recording and managing the whole process, including providing relevant professional premises advice to validate reliability of cost and specification of bids. This resource will be critical to the success of the programme.

The flow diagram attached (Figure 1) describes how the process from receipt of bid to scheme completion is managed. The flow diagram attached (Figure 2) describes the process as recommended in the draft primary care infrastructure Principles of Best Practice document (PoBP) for local determination of business as usual (BAU) schemes submitted as PIDs, improvement grants or business cases.

The PoBP (currently in draft awaiting publication) recommends a primary care screening panel, accountable to the sub-regional team's business case and capital investment pipeline group (or equivalent title), to be set up and take responsibility for assessing and assuring all schemes presented to the sub-regional/regional team, including those supported by improvement grant applications, PIDs, and business cases (see figure 2). The principle described in this draft including the membership and responsibility assigned to the screening panel can be used to form a local sub-regional/regional panel to review the PCIF bids and recommend support to the regional team based on the approval criteria issued by the national team.

The membership of the PCIF screening panel can be flexed to suit local arrangements but the suggested membership will include a senior primary care manager, a senior finance officer, a professional premises adviser and relevant representatives from CCGs. The screening panel can call upon other colleagues as necessary to support its work. This may include an invitation to a representative officer of the Local Medical Committee (LMC). For the purposes of managing the PCIF timelines, it is recommended that LMCs are invited to a meeting – in advance of the PCIF screening panel meeting – in order to share the scope of the bids that have been submitted and to the process by which bids are being assessed. The intention behind this meeting will be to demonstrate that the process that the Regional or sub-regional offices have used are fair and transparent.

It is expected that the regional team will perform the necessary assurance against the national criteria and confirm their support for the bids with assistance and support for this part of the process by a member of the NHS England Project Appraisal Unit. Bids, sorted into the four categories identified above and endorsed by the regional team, are to be forwarded to the national panel by 4th March 2015.

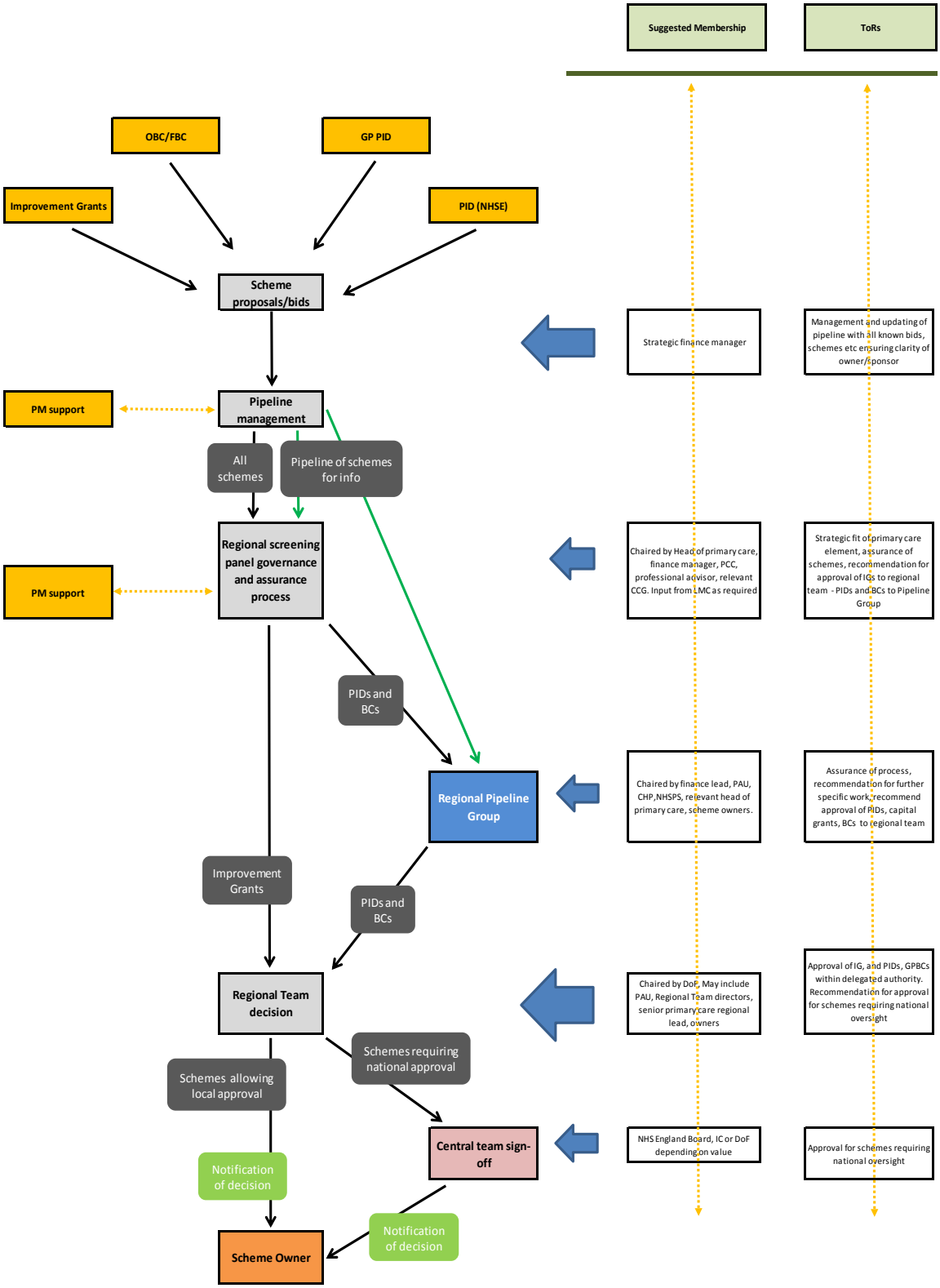
The national programme team will review and assess those returns and use the information to reconcile to the original allocation of funds to regions/sub-regions.

At this point a local assurance process will be followed for those bids that require further development. A suggested regional BAU process is described in Figure 2. This may include reaffirming alignment with strategic estates and service plans and determining what further work is required to move the bid into an approvable form. Following the national programme team's assessment, improvement grant requests that comply with the NHS (GMS Premises Costs) Directions 2013 may be approved by the regional/sub-regional team on recommendation from the screening panel. The pipeline group will be responsible for further assurance and recommendation for approval and prioritisation by the regional team for significant grant or investment proposals via its established approval structures.

It should be noted that proposals that are commissioner led, require capital other than that allowed under the Premises Costs Directions, (for example bullet payments into otherwise revenue funded schemes, or improvement grants in excess of 66% of total cost) or require CHP or NHSPS commitments will require approval from the NHS England central team.

Suggested BAU investment assurance and governance process for regional/sub-regional teams

(Based on the process identified in draft Primary Care infrastructure Principles of Best Practice)



5.6 Annex 6: Standard report formats

The standard report formats, included in this Annex, are provided to give guidance to Committees on the information that will be made available by NHS England.

List closure

REQUEST TO CLOSE PATIENT LIST

Practice Name and address		**Contract (GMS/PMS)**	GMS	**Raw list size**	4950 (April 14)	**CCG Area**	Ealing

Date Application made:	Initial application received June 2014. Commissioning Manager worked with practice to help find solutions. Update application was received in July and August 2014.	Regional team	North West London
Report template completed by	B Johnson	Date completed	26 August 2014

	Assessment Criteria	**Guidance Notes/Evidence that needs to be attached**	**Presentation of Case**
1.	Reasons for applying to close practice's register to new registration.	Application to close practice list template completed by contractor.	
2.	What options have the practice considered, rejected or implemented to relieve the difficulties they have encountered about their open list and, if any were implemented? Details of success in reducing or erasing such difficulties?		
3.	Has the practice had any discussions with their registered patients about their difficulties in maintaining an open list? If yes, practice to provide a summary of same, including whether registered patients thought the list of patients should or should not be closed.		•
4.	Has the practice spoken with other contractors in the practice area		

	concerning their difficulties maintaining an open list? If yes, practice to provide a summary of same of discussions, including whether other contractors thought the list of patients should or should not be closed?		
5.	How long does the practice wish their list of patients to be closed? (This period must be more than three months and less than 12 months).		
6.	What reasonable support does the practice consider the RT would be able to offer, which would enable the list of patients to remain open or the period of proposed closure to be minimised?		
	What plans does the practice have to alleviate the difficulties they are experiencing in maintaining an open list, which you could be implemented when the list of patients is closed, so that list could reopen at the end of the proposed closure period?		
	Does the practice have any other information to bring to the attention of the RT about this application?		
	RT recommendation to the Panel		

Date of PCC Decision Making Group (DMG)		Outcome:	Approved / Approved with Conditions/ Rejected
Feedback from PCC DMG			
Panel Members:			

Mergers between practices

London Regional Teams

Criteria for considering a request for Practice Merger

Practice Name & Address (1)		Contract **GMS E87067**	Raw list size **01/07/2014 6172**	Borough – CCG area - **West London**
Practice Name & Address(2)		Contract	Raw list size	Borough –

		GMS E87699	**01/07/2014 3048**	CCG area – **West London**

Date Application made:	**20/08/2014**	Regional team	**North West London**
Report template completed by	**Rachel Ryan**	Date completed	**22/09/2014**

The Principles of Cooperation and Competition 2010 were replaced by the NHS Procurement, Patient Choice and Competition Regulations 2013. Monitor acts as the Regulator since 1.4.2013.
Principle 10 of the earlier document stated:
Mergers including vertical integration between providers are permissible when there remains sufficient choice and competition or where they are otherwise in patients' or taxpayers' interests for example because they will deliver significant improvements in the quality of care.

This is not written succinctly in the 2013 Regulations but an overarching guide suggests that the individual components are all still relevant within the full 76 page guide
http://www.monitor.gov.uk/sites/default/files/publications/SubstantiveGuidanceDec2013_0.pdf

Assessment Criteria	Guidance Notes/Evidence that needs to be attached	Presentation of Case
Background in respect of each of the practices	Include relevant background – number of clinical providers and support staff, teaching practice, opening hours, distance between sites	
Information about local demography	Include - Information about local practices - Geographical location and distance - Would a merger result in significant reduction in patient choice	
What are the strategic benefits of agreeing a merger and do they meet the criteria set out above	For example - Services provided from one fit for purpose site in either the short or long term - Longer opening hours - Access to a wider range of services - Within easy reach - Financial savings as a result of the merger - Improved IT access - Improved workforce capability	**Existing patients' access to single service including consistent provision across**: ***Home visits; booking appointments; additional & enhanced hours: opening hours; extended hours; single IT & phone system; premises facilities:*** *(Amended for brevity)*
Performance of the individual Contractors within each practice	Are any providers linked to the existing Contracts voluntarily not working, suspended by the GMC or NHS England, or unable to work by virtue of Bail conditions.	No
Practice performance	Evidence should include information for the past three years in relation to	

	- QOF - GPOS /GPHLI performance - Contractual sanctions And, where applicable, evidence that action plans are in place and being actioned Feedback from NHS choices	
Will the merger result in services being provided from premises that are fit for purpose in accordance with minimum standards set out in 2013 GMS Premises Costs Directions, or that have a Business Plan to achieve within no more than 12 months	Provide available information about the premises and any commitments made by the Contractor to address outstanding issues within the required timeframe. Outcome of infection control visit and outcome of CQC inspection if either or both have been undertaken.	
Has specified a clear plan of service improvements that will arise as a result of the merger	A business case should be supplied by the practice that sets out their future plans. At the minimum this should include a commitment that GP premises and phone lines will be open throughout core hours	
What is the CCG's view of the proposed merger?	Include both the primary care lead and the IT lead (if applicable) in the discussion.	
RT recommendation to the Panel (will be subject to patient engagement)	Any other relevant information not included elsewhere e.g. proposed start date patient engagement proposals	

Date of PCC Decision Making Group (DMG)	*29/09/2014*	Outcome: ***Please delete as appropriate***	Approved / Approved with Conditions/ Rejected
Feedback from PCC DMG: ***Please insert***			
Panel Members: ***Please insert***			

Contract termination – e.g. Death/ Bankruptcy/ CQC

BRIEFING TITLE	XX Medical Practice		
TO:	DMG		
DATE:	6/3/2015	AUTHOR:	
Purpose	To brief the DMG on the current position regarding the bankruptcy of XX and the actions taken.		
Background			
Comments:			
Current status			
Next Steps			
Recommendation			

Changes to Contract Signatories

London Regional Teams

Single Handed PMS Practices - Criteria for allowing an additional clinical Contract signatory

Practice Name		Raw list size	
Single Handed PMS Provider's name		CCG	
Date Application made:		Regional team	
Report template completed by		Date completed	
Date of PCC Decision Making Group (DMG)		Outcome:	Approved / Approved with Conditions/ Rejected
Panel Members:			

All of the following criteria will need to be met for the application to be approved:

Assessment Criteria	Guidance Notes/Evidence that needs to be attached	Presentation of Case
There is a strategic need for the practice to be retained, from an RT & CCG perspective	Include relevant background – number of wte providers, teaching practice, local demography, has this practice had multiple Contract signatories in the past. Evidence of feedback from the CCG Detail the links to the primary care strategic direction locally e.g. information about relationship with local practices, new developments, engagement with CCG priorities	
Performance of the single handed Contractor does not give cause for concern.	If any provider linked to the Contract is voluntarily not working, suspended by the GMC or NHS England, or unable to work by virtue of Bail conditions this would automatically give cause for concern.	
Practice performance does not give cause for concern	Evidence should include information for the past three years in relation to - QOF - GPOS /GPHLI performance - Contractual sanctions And, where applicable, evidence that action plans are in place and being actioned Feedback from NHS choices	
Has premises that are fit for purpose in accordance with minimum standards set out in 2013 GMS Premises Costs Directions, or has Business Plan to achieve within no more than 12 months	Provide available information about the premises and any commitments made by the Contractor to address outstanding issues within the required timeframe. Outcome of infection control visit and outcome of CQC inspection if either or both have been undertaken.	
Has specified a clear plan of service	A business case should be supplied by the practice that sets out their future	

improvements that will arise as a result of changes in numbers of partners	plans. (It is not expected that an application which facilitates 24 hour retirement of the Contractor will meet the criteria) At the minimum this should include a commitment that GP premises and phone lines will be open throughout core hours	
Has a list size that can demonstrably sustain proposed WTE extra partner increase,	The business case should demonstrate this. (This would typically be 5000+ patients)	
CV of proposed new provider does not give commissioners cause for concern	The CV should be attached. If the proposed new provider is not yet known it is possible to approve the request subject to review of the CV prior to final approval.	
RT recommendation to the Panel	Any other relevant information not included elsewhere	

Application approved*	
Application approved subject to following conditions*	PCC DMG TO INCLUDE CONDITIONS
Application rejected *	PCC DMG TO INCLUDE REASONS WHY

Contractual Issues of Concern

London Regional Teams

Request for PCC DMG to consider a contractual issue of concern and to make recommendations

Practice Name		Raw list size	
Weighted list size		CCG	
Contract Type		Regional team	
Report template completed by		Date completed	
Date of PCC Decision Making Group (DMG)		Outcome:	
Panel Members:			
Issue for consideration: Include current position, relevant background information and recommendations for consideration			

Relevant background information to support the decision making process

Include relevant background – number of wte providers, teaching practice, local demography, has this practice had multiple Contract signatories in the past. Evidence of feedback from the CCG Detail the links to the primary care strategic direction locally e.g. information about relationship with local practices, new developments, engagement with CCG priorities	
If any provider linked to the Contract is voluntarily not working, suspended by the GMC or NHS England, or unable to work by virtue of Bail conditions this would automatically give cause for concern.	
Evidence should include information for the past three years in relation to - QOF - GPOS /GPHLI performance	

- Contractual sanctions And, where applicable, evidence that action plans are in place and being actioned Feedback from NHS choices	
Provide available information about the premises and any commitments made by the Contractor to address outstanding issues within the required timeframe. Outcome of infection control visit and outcome of CQC inspection if either or both have been undertaken.	
Any other relevant information not included elsewhere	

Recommendations made by the PCC DMG

Request to issue breach over quality

Date:

1. Contractor type

General Practice	Community Dentist	Community Pharmacist	Community Optometrist
General Practice			

2. Area

3. Practice code

4. Practice Name

5. Name/position of lead officer

6. Permission being sought

Issue of remedial breach notice	

7. Local Resolution – LMC involvement

Yes	

8. Summary of case for issuing notice

9. Name/position of determining officer

10. Permission to proceed

Yes	No

11. Determining officer's comments

12. Date of determination

13. S

Local Improvement Scheme: NHS England Assessment Template
The template should be submitted with the full specification.

	CCG to complete for each LIS scheme	NHS England to complete – at the point of assessment
Title of scheme		
CCG name		
Named Commissioner		
Status of CCG Approval of Scheme **Either** **1. Approved by CCG subject to NHS England approval** **2. Draft yet to be considered by CCG Governance structure**		
Has the CCG consulted with the LMC? **NB. NHS England cannot approve schemes unless the LMC has reviewed and commented**		
What was the outcome of LMC engagement?		
Does the Scheme fit strategic and/or commissioning priorities of CCG? **CCGs need to specify the link to their primary care strategic priorities.**		
CCGs should specify whether the scheme supports improvement in the quality of primary medical care services under the following categories? **1. Reducing variation in quality** **2. Improving quality** **3. Undertaking clinical audit** **4. Peer review** **5. Other**		
Does the scheme have clear, measurable processes and/or clinical outcomes? **NB. These need to be articulated**		

clearly and process outcomes should show how progress will be tracked against milestones throughout the year in order to demonstrate how the expected outcomes will be achieved.		
Is the scheme rewarding outcomes? NB. NHS England cannot approve schemes that do not reward outcomes.		
Is there any overlap with what is paid for under the Primary Medical Care Contract, DES, QOF? NB NHS England cannot approve duplicate payments but there will be situations where a LIS scheme is paying for work in excess of existing arrangements		
What are the proposed Contractual arrangements? e.g. SLA, Letters of Intent, National Contract (not mandated)		
What is the total financial value of the scheme?		
What is the payment structure? NB. Itt is expected that there will be a payment that is only realised on achievement of key deliverables. i.e. not all of the payment will be made 'up front'		
What are the arrangements if outcomes are not achieved? e.g. Clawbacks or no achievement payment released		
Is participation in the scheme optional or mandatory for CCG member practices? If other scenarios apply, please specify		
FOR NHS ENGLAND USE ONLY		
Does remuneration and pricing model appear reasonable (when compared with specification requirements)?		
Assessor recommendation to the PCC Decision Making Group (PCC DMG)		

Comments/Feedback following the PCC DMG		
Assessor recommendation to the PCC Decision Making Group		
Approved by NHS England: Yes/No: Date		
CCG Informed: Yes/No: Date		

Deputy Head of Primary Care for Relevant CCG Area is responsible for arranging feedback to lead CCG Commissioner

Performer Performance Template

The template below is used for summarising performer performance cases for consideration by PDLP. NHS England retains the responsibility for Performers being admitted to the National Performers List.

Only information relevant to the contractual impact of issues should be shared with CCGs. Discussion of sensitive issues should be carried out in a private pre-meeting, or submitted to a private part two committee to maintain confidentiality and to allow for the relevant information to be made available, discussed and any actions agreed. The decisions made on contractual actions should be reported in part one of committee meetings.

Submission for PLDP – Dr X

Case Ref:

Date:

Prepared by

Introduction & Background

Summary of individual and their professional role(s).

Summary of alleged incident(s).

Summary of Issues Identified

Detail of alleged incident(s).

Individual's version of events, actions taken, and mitigations.

Other parties notified.

Summary of any press interest.

Framework and Regulatory Reference

Consideration of risk and impact against relevant Framework or Regulatory criteria.

Options for the Performers List Decision Panel

There are a number of options open to the PLDP under the Terms of Reference:

a. Take no further action and refer back to the PAG for case closure.
b. Refer for further investigation or monitoring and, if agreed, delegate the actions to PAG.
c. Consider referral to the primary care contracts team for consideration under the relevant contract regulations.

d. Refer to the relevant regulatory body.
e. Refer to the police.
f. Refer to NHS Protect
g. Refer to any other organisation for remediation or intervention agreed
h. Agree an action plan for remediation of the primary care performer or pharmacy contractor when appropriate, including a reporting process for monitoring of the implementation of the action plan.
i. Request the issue of an alert through the agreed NHS England mechanism according to the Healthcare Professionals Alert Notice Direction (2006).
j. Take action by invoking the NHS (Performers Lists) (England) Regulations 2013.

The PLDP is recommended to consider option (x)

5.7 Annex 7: Year Plan: Meeting frequency

		Agreed meeting/ report frequency	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
Committee/ Joint Committee meeting schedule	North Central London											19th Jan		15th Mar
	City and Hackney													
	North West London	Monthly		21st May			20th Aug*	17th Sep	29th Oct	19th Nov		21st Jan	25th Feb	24th Mar
	South West London	TBC						3rd Sep		12th Nov		14th Jan		10th Mar
	South East London	Monthly			2nd June		6th Aug	29th Sep					11th Feb	17th Mar
	Tower Hamlets (WEL)	Monthly	28th Apr	26th May	23th Jun	28th Jul	25th Aug	22th Sep	27th Oct	24th Nov	22th Dec	5th Jan		
	Waltham Forest (WEL)	Monthly		6th May	3rd Jun	8th July	5th Aug	2nd Sep	7th Oct	4th Nov	2nd Dec	6th Jan	3rd Feb	2nd Mar
	Newham (WEL)	Monthly												
	WEL	Quarterly		14th May										
	BHR	Monthly			10th June	8th July	5th Aug	5th Sep					10th Feb	9th Mar

Key

 Planned meeting

 Forecast meeting

5.8 Annex 8 - Safeguarding – responsibilities at different levels of CCG co-commissioning delegation

The table below provides a high level analysis of responsibilities related to safeguarding at different levels of co-commissioning:

Task	Level 1	Level 2	Level 3
IMR sign off	Outcome of report shared with CCG	Joint sign off process	CCG sign off
Named GPs* – role transfer Financial transfer Recruitment Training	MOU in place Costs stay with NHS England Management of recruitment process responsibility stays with NHS England Responsibility for training sits with NHS England	MOU in place Costs stay with NHS England HR process with NHS England, joint appointment panel Responsibility for training sits with NHS England	MOU in place TBC Recruitment process and appointment panel under CCG control Responsibility for training sits with CCG
LSCB attendance	Based on risk based approach NHS England and CCG attendance	Based on risk based approach NHS England and CCG attendance	Based on risk based approach CCG attendance
Domestic homicide	NHS England attends panel and supports GP to complete IMR if required Report shared with CCG	Attendance at panel and support to GP to complete IMR negotiated with CCG	CCG attends panel and supports GP to complete IMR if required
Performance issues	NHS England leads on any performance issues	NHS England leads on any performance issues	NHS England leads on any performance issues
CQC safeguarding issues in practices	NHS England follow up individual issues raised by CQC with practices. Themes/trends undertaken by with CCG	NHS England and/or CCG, by negotiation, follow up individual issues raised by CQC with practices Themes/trends shared with CCG	CCG follow up individual issues raised by CQC with practices Themes/trends shared with CCG
Primary care safeguarding quality assurance	NHS England responsibility	Jointly NHS England and CCG responsibility	CCG responsibility
Quality improvement	CCG responsibility, working with NHS England	CCG responsibility, working with NHS England	CCG responsibility, working with NHS England

*dependent on each regional arrangements

Further detail related to the functions expected of fully delegated (level 3 CCGs) is shown below. The Nursing directorate would retain oversight of these responsibilities, and it is important to note that the tasks might vary dependant on area etc:

Summary of responsibilities	Overview of tasks (not exhaustive)
• Provide advice for GPs undertaking investigations relating to primary care safeguarding issues	• Approval final IMRs or investigations including DH panels • Ensure any actions resulting from investigations
• Manage named GP roles	• Recruit, line manage and provide training for role
	• Represent health system at safeguarding boards
• Contribute to the system wide oversight of safeguarding	• Undertake safeguarding assurance of practices. Follow up on practice issues identified at CQC inspections, review trends and themes
• Quality monitoring and improvement of primary care	