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NHS
Wolverhampton
Clinical Commissioning Group

Meeting of the Primary Care Joint Commissioning Committee (Public)
Tuesday 7th March 2017 at 2.00 pm in the Stephenson Room, Technology Centre, Wolverhampton Science Park, Stephenson Room
A G E N D A

1	Welcome and Introductions	All	Verbal
2	Apologies	Chair	Verbal
3	Declarations of Interest	All	Verbal
4	Minutes of the meeting held on 7th February 2017	Chair	1 - 6
5	Matters arising from the minutes	Chair	Verbal
6	Committee Action Points	Chair	7 - 8
7	NHS England Update	Alastair McIntyre	Verbal
8	NHS England Finance Update	Charmaine Hawker	9 - 18
9	Wolverhampton CCG Update	Mike Hastings	Verbal
10	Primary Care Programme Board Update	Manjeet Garcha	19 - 24
11	Primary Care Operational Management Group Update	Mike Hastings	25 - 28
12	Primary Care Medical Services Delegation Agreement	Peter McKenzie	29 - 120
13	General Practice Forward View Implementation Plan	Steven Marshall	121 - 160
14	Any other Business	Chair	Verbal
15	Date of next meeting		

Tuesday 4th April 2017 at 2.00pm in the Marston Room, Technology Centre, Wolverhampton Science Park

For further information on this agenda or about the meeting generally, or to submit apologies for absence, please contact Laura Russell on 01902 444613 or e-mail laura.russell4@nhs.net or email

MEMBERSHIP	
Wolverhampton CCG	Ms P Roberts (Chair) Dr David Bush Dr Manjit Kainth Dr Salma Reehana Steven Marshall Manjeet Garcha Peter Price
NHS England	Alastair McIntyre Gill Shelley Anna Nicholls
Patient Representatives	Sarah Gaytten Jenny Spencer
Invitees (Non-Voting)	Elizabeth Learoyd (Healthwatch) Ros Jervis (Health and Wellbeing Board)

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP
PRIMARY CARE JOINT COMMISSIONING COMMITTEE

Minutes of the Primary Care Joint Commissioning Committee Meeting (Public)
Held on Tuesday 7th February 2017, Commencing at 2.00 pm in the in the Stephenson Room, 1st Floor, Technology Centre, Wolverhampton Science Park

MEMBERS ~
Wolverhampton CCG ~

		Present
Pat Roberts	Chair	Yes
Dr David Bush	Governing Body Member / GP	No
Dr Manjit Kainth	Locality Chair / GP	Yes
Dr Salma Reehana	Locality Chair / GP	No
Steven Marshall	Director of Strategy & Transformation	Yes
Manjeet Garcha	Executive Lead Nurse	No
Peter Price	Lay Member (Vice Chair)	Yes

NHS England ~

Alastair McIntyre	Locality Director	No
Gill Shelley	Senior Contract Manager (Primary Care)	Yes
Anna Nicholls	Contract Manager (Primary Care)	Yes
Karen Payton	Senior Finance Manager (Primary Care)	Yes

Independent Patient Representatives ~

Jenny Spencer	Independent Patient Representative	Yes
Sarah Gaytten	Independent Patient Representative	Yes

Non-Voting Observers ~

Ros Jervis	Service Director Public Health and Wellbeing	No
Elizabeth Learoyd	Chief Officer – Wolverhampton Healthwatch	Yes
Dr Gurmit Mahay	Vice Chair – Wolverhampton LMC	No
Jeff Blankley	Chair - Wolverhampton LPC	No

In attendance ~

Mike Hastings	Associate Director of Operations (WCCG)	Yes
Peter McKenzie	Corporate Operations Manager (WCCG)	Yes
Jane Worton	Primary Care Liaison Manager (WCCG)	Yes
Claire Skidmore	Chief Finance and Operating Officer (WCCG)	Yes
Helen Hibbs	Chief Accountable Officer	No
Sarah Southall	Head of Primary Care	Yes
Laura Russell	Primary Care PMO Administrator (WCCG)	Yes

Welcome and Introductions

PCC297 Ms Roberts welcomed attendees to the meeting and introductions took place.

Apologies for absence

PCC298 Apologies were submitted on behalf of Dr Helen Hibbs, Alastair McIntyre, Manjeet Garcha and Jeff Blankley.

Declarations of Interest

PCC299 Dr Kainth declared that, as GPs they had a standing interest in all items related to primary care.

Ms Gaytten and Ms Spencer declared that, in their role as employees of the University of Wolverhampton, they worked closely with practices to arrange placements for student nurses and therefore had a standing interest in items related to primary care.

As these declarations did not constitute a conflict of interest, all participants remained in the meeting whilst these items were discussed.

RESOLVED: That the above is noted.

Minutes of the Meeting Held on 3rd January 2017

PCC300 RESOLVED:

That the minutes of the previous meeting held on 3rd January 2017 were approved as an accurate record.

Matters arising from the minutes

PCC301 There were no matters arising from the minutes.

RESOLVED: That the above is noted.

Committee Action Points

PCC302 **Minute Number PCC176 – Premises Charges (Market Rent Reimbursement)**

Ms Payton informed the Committee the National Team have developed local process and procedures. The application will be sent from The NHS England's Premises Team for circulation and should be returned to them once completed.

Minute Number PCC302 – Premises Charges (Rent Reimbursement)
Awaiting the new cost directives to provide clarity on rent reimbursement in relation to when Practices allow other service providers to be use their rooms such as midwives.

Minute Number PCC186a – NHS England Update – Primary Care Update
Mr Hastings confirmed the CCG Primary Care Commissioning Activity return had been shared with the Committee on the 4th January 2017.

Minute Number PCC211 - Vertical Integration
Mr Hastings shared with the Committee the VI assurance visit minutes on the 4th January 2017 and stated there had been a further meeting on the 31st January 2017.

Minute Number PCC283 – Wolverhampton CCG Update
Ms Southall confirmed an evaluation report on the two extended opening hours scheme will be provided at the March and May Committee Meetings.

RESOLVED: That the above is noted.

NHS England Update – Primary Care Update

PCC303 Ms Shelley advised the Committee they receive their updates from the Regional and National Team and no updates have been provided.

Ms Shelley stated the contract changes have been agreed between NHS Employers and the General Practitioners Committee (GPC) and will be published shortly. There a number of changes within the contract in particular the following;

1. The Avoiding Unplanned Admissions (AUA) will be abolished.
2. Extended hours will only be offered to those Practices who do not close on the afternoon. This will take affect form October 2017.

Discussions took place on how extended hours will affect those groups of practices who are starting to work collaboratively, if an individual practice did not work afternoons. It was highlighted at present this is very high level and further detail will follow shortly.

RESOLVED: That the above is noted.

NHS England Finance Update

PCC304 Ms Payton informed the Committee there was no update at present as they are working through the month 10 position and a report will be provided at the next meeting.

RESOLUTION: Month 10 position to be provided at the March Meeting.

Wolverhampton CCG Update

PCC305 Mrs Southall provided the following update on the work being progressed within Primary Care;

- The Members meeting had taken place on 25th January 2017 where an update was given on the group working being undertaken. This included an update on VI and a joint presentation from Primary Care Home 1 and 2 regarding how they are moving towards working on scale. An update was also provided on the work progressing with the Medical Chamber Model.
- The General Practice Five Year Forward Plan for the CCG has been submitted to NHS England. The implementation on plan on how this will be delivered will be shared at the March meeting.
- Conclusion on WIFI access and recognition has been received Nationally as the CCG is one of the first in the Country to roll out within Practices and Communities.
- There are two practices who are undertaking the GP Practice resilience Programme and the Memorandum of Understanding is currently being discussed between the Provider and the Practice.
- Expressions of Interest for the Time for Care Programme are currently being received.
- Reception and Admin Training funding has been received with the aim to develop a 3 year programme with the initial session starting in March 2017.

RESOLUTION: Mrs Southall to provide the General Practice Five Year Forward Plan to the March Meeting.

Primary Care Programme Board Update

PCC306 Ms Roberts shared the report on behalf of Manjeet Garcha in her absence and asked if the Committee had any questions.

It was asked if the Social Prescribing Service would be signposting from clinics as well as Practices. It was confirmed it's currently from GP Practices.

Discussions took place regarding Community Equipment Procurement as at the PPG and Citizens Forum patients were confused as what was included under

community equipment. It was advised this was a joint procurement with the City Of Wolverhampton Council and it covered all equipment.

RESOLVED: That the above is noted.

Primary Care Operational Management Group Meeting

PCC307 Mr Hastings presented the Primary Care Operational Management Group report which provides an overview of the discussions that have taken place at their meeting on the 23rd January 2017. The following items were reported upon;

- An update was provided on the GP Five Year Forward View training programme and it was highlighted a Band 7 role will be recruited to support the programme of work going forward.
- A team has been established to support the Practices to help patients to sign up to online access.
- The collaborative contract review visit programme continues and positive feedback has been received from the Practices.
- The revised Zero Tolerance Specification written jointly with the CCG and NHS England was shared and discussed.
- An update was provided on full delegation a number of handover meetings have been taking place with NHS England to ensure the CCG are ready for full delegation from the 1st April 2017. Mr McKenzie highlighted a report will need to come to the March Meeting outlining the agreement which sets out the powers formally delegated to the CCG and those that have been reserved by NHS England.

RESOLUTION: Mr McKenzie to provide a report to the March Meeting on the full delegation agreement as this will need formal sign off by the Committee.

Any Other Business

PCC308 There were no further discussion items raised by Committee.

RESOLVED: That the above is noted.

PCC309 **Date, Time & Venue of Next Committee Meeting**
Tuesday 7th March 2018 at 2.00pm in the Stephenson Room, 1st Floor, Technology Centre, Wolverhampton Science Park

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Primary Care Joint Commissioning Committee Actions Log

Open Items

Action No	Date of meeting	Minute Number	Item	By When	By Whom	Action Update
35a	**02.08.16**	**PCC176**	**Premises Charges (Market Rent Reimbursement)** Ms Nicholls to look into support available to GP practices with increased premises charges and provide an update at the September 2016 Committee meeting.	February 2017	Gill Shelley / Anna Nicholls	06.09.16 - Mr Hastings agreed to chase Anna Nicholls regarding this action. 04.10.16 - Ms Shelley confirmed that details on the management of transitional funding are to be confirmed and would provide an update at the next meeting. 01.11.16 - It was advised NHSE are still awaiting the financial processes, Ms McGee agreed to take back to Charmaine Hawker as its non-recurrent funding for this financial year 2016/2017. 06.12.16 - Ms Payton informed the Committee they are still seeking further advice as NHS England have not been notified and once this is received it will be shared with the CCG. 03.01.17 - It was confirmed NHS England are still awaiting further assurance from the National Guidance. It was agreed as the Local Medical Committee had raised this initial concern and the CCG needed to inform them of this position. 08.02.17 - Ms Payton informed the Committee the National Team have developed local process and procedures. The application will be sent

						from The NHS England's Premises Team for circulation and should be returned to them once completed.
35b	**08.02.17**	**PCC302a**	**Premises Charges (Rent Reimbursement)**	March 2017	NHS England	08.02.17 - Awaiting the new cost directives to provide clarity on rent reimbursement in relation to when Practices allow other service providers to be use their rooms such as midwives.
49	**03.01.17**	**PCC283**	**Wolverhampton CCG Update** Ms Southall to provide Evaluation Reports on extended opening hours at the March and May Meetings.	March 2017 and May 2017	Sarah Southall	08.02.17 - Ms Southall confirmed an evaluation report on the two extended opening hours scheme will be provided at the March and May Committee Meetings.
50	**08.02.17**	**PCC304**	**NHS England Finance Update** The Month 10 position to be provided at the March Meeting.	March 2017	NHS England Finance	
51	**08.02.17**	**PCC305**	**Wolverhampton CCG Update** Mrs Southall to provide the General Practice Five Year Forward Plan to the March Meeting.	March 2017	Sarah Southall	
52	**08.02.17**	**PCC307**	**Primary Care Operational Management Group Meeting** Mr McKenzie to provide a report to the March Meeting on the full delegation agreement as this will need formal sign off by the Committee.	March 2017	Peter McKenzie	

NHS
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WOLVERHAMPTON CCG

PRIMARY CARE JOINT COMMISSIONING COMMITTEE
Tuesday 7th March 2017

Title of Report:	**Wolverhampton CCG 2016/17 GP Services Month 10 Finance Report**
Report of:	Emma Cox
Contact:	Emma Cox
Primary Care Joint Commissioning Committee Action Required:	For Noting
Purpose of Report:	To outline the Month 10 position for Wolverhampton GP Services 2016/17 budget
Public or Private:	This Report is intended for the public domain
Relevance to CCG Priority:	
Relevance to Board Assurance Framework (BAF):	Domain 3 – Financial Management
• **Domain 1:** A Well Led Organisation	
• **Domain 2a:** Performance – delivery of commitments and improved outcomes	
• **Domain 2b:** Quality (Improved Outcomes)	
• **Domain 3:** Financial Management	This report provides information on the 2016/17 GP Services Month 10 Position and 2017/18 GP Services Allocations.
• **Domain 4:** Planning (Long Term and Short Term)	

• **Domain 5:** Delegated Functions	

ATTACHED:

Wolverhampton CCG 2016/17 GP Services Month 10 Finance Report

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Clinical Commissioning Group

REPORT SIGN-OFF CHECKLIST

This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.

	Details/ Name	Date
Clinical View	**N/A**	
Public/ Patient View	**N/A**	
Finance Implications discussed with Finance Team	**N/A**	
Quality Implications discussed with Quality and Risk Team	**N/A**	
Medicines Management Implications discussed with Medicines Management team	**N/A**	
Equality Implications discussed with CSU Equality and Inclusion Service	**N/A**	
Information Governance implications discussed with IG Support Officer	**N/A**	
Legal/ Policy implications discussed with Corporate Operations Manager	**N/A**	
Signed off by Report Owner (Must be completed)	**Charmaine Hawker**	**23/02/2017**

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NHS England

Wolverhampton CCG 2016/17 GP Services Month 10 Finance Report

Wolverhampton CCG GP Services Budget

Month 10 2016/17

Version number: 1

First published: 22.02.2017

Prepared by: Emma Cox, NHS England West Midlands

The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.

Contents

1 2016/17 GP Services

The allocation to fund GP Services relating to Wolverhampton CCG for 2016/17 as at month 10 is £33.1m. The forecast outturn is £33.1m delivering a breakeven position.

The planning metrics for 2016/17 are as follows;

- Contingency delivered across all expenditure areas of 0.5%
- Non Recurrent Transformation Fund of 1%

The CCG is not required to deliver a surplus of 1% on their GP Services Allocations, this remains with NHS England West Midlands.

There table below shows the revised forecast for month 10;

	Month 7 FOT	Month 10 FOT	Variance
	£'000s	£'000s	£'000s
General Practice APMS	2,275	2,268	7
General Practice GMS	19,653	19,631	22
General Practice PMS	1,798	1,786	12
QOF	3,472	3,541	-69
Enhanced Services	1,562	1,569	-7
Dispensing/Prescribing Fees	222	227	-5
Premises Cost Reimbursements	2,753	2,771	-18
Other Premises	105	88	17
Other GP Services	666	660	6
PMS Premium	311	311	0
1% Non Recurrent Transformation Fund	341	341	0
0.5% Contingency	34	0	34
TOTAL	**33,192**	**33,192**	**0**

A full forecast review has been carried out in month 10 which includes the following updates;

- Recalculation of Global Sum Payments, PMS and APMS Contract payments based on the January 2017 updated list sizes. This is the final list change for the financial year.
- Review of DES Forecasts based on activity to date.
- Review of Premises Forecasts based on payments to date.
- Review of Locum reimbursements (maternity/paternity etc.) based on approved applications.
- Review of Seniority actual payments for quarters one to three.
- Review of QOF payments and inclusion of growth for year-end achievement.

This has resulted in a drawdown of the £34k contingency that remained at month 7.

2 Access to 2016/17 Primary Care Reserves

The forecast outturn includes a 1% Non-Recurrent Transformation Fund, and a 0.5% contingency in line with the 2016/17 planning metrics.

In line with national guidance the 1% Non-Recurrent Transformation Fund must remain uncommitted to support cost pressures within the wider health economy.

The 0.5% contingency has now been fully utilised at month 10.

The forecast outturn includes the assumption that all of the PMS Premium available will be fully utilised. The CCG are mobilising plans to ensure expenditure is incurred and the CCG is asked to ensure that wherever possible payments are processed prior to the 31st March 2017 any year-end accrual for reserves spend is not expected to be material.

3 2017/18 GP Services Allocations

The allocation to fund GP Services relating to Wolverhampton CCG for 2017/18 is £34.83m.

Financial plans have been completed and submitted using planning assumptions based on the outcome of the GP Contract Negotiations;

- 1% pay uplift and 1.4% uplift on expenses.
- 51.6p per patient for indemnity costs (based on registered population).
- Increase in the fee for Learning Disability Health Check Scheme from £116 to £140.
- Avoiding Unplanned Admissions DES ceases 31st March 2017, and will be recycled into the Global Sum payment.
- Increase to the maximum Locum payment for sickness leave increases to £1,734.18 per week, and the removal of the ability to pro rata payments for both sickness and parental leave.
- Increase in global sum funding for contractual changes that help identify patients subject to oversees charges and NHS Digital Workforce Census data collection.
- Business Improvement District Levies and CQC fees to now be included as reimbursable costs to GP Practices.

The Global Sum value for 2017/18 incorporating the changes to the GP contract is yet to be confirmed and this is expected in March 17.

NHS E West Midlands will work with the CCG during April and May 2017 to ensure the CCG are fully funded for delegation based on the final 2016/17 outturn.

4 GP Forward View Investments

Annexe 6 of the Operational Planning Guidance detailed the GP Forward View funding which is being made available to CCGs and NHE England for investment.

Following this guidance NHS England Central Team has provided some indicative budgets on a CCG basis for 2017/18 and 2018/19.

The table below details the indicative funding for Wolverhampton CCG;

	2017/18	2018/19
	£'000s	£'000s
Online Consultations	70	92
Training Care Navigators and Medical Assistants	46	46
Access Funding	0	968
ETTF	£718k over two years	*

*Please note that ETTF Cohort 2 schemes are supported in principle but are still subject to a further approval process. Funding is from April 17 to March 19.

5 Conclusion

NHS England West Midlands will be monitoring the financial position of the GP Services budget allocated the CCG and will report any adverse variance accordingly on a quarterly basis; including the use of reserves and contingency funding.

6 Recommendations

The Committee is asked to:

- Note the contents of this report.
- Continue to mobilise plans for the PMS Premium investment to ensure expenditure is incurred by the 31st March 2017.

Charmaine Hawker
Head of Finance (Direct Commissioning/Primary Care Assurance)
NHS England West Midlands

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

PRIMARY CARE JOINT COMMISSIONING COMMITTEE
7th March 2017

Title of Report:	**Update Report on Primary Care Programme Board Activity February 2017 (PCPB)**
Report of:	Manjeet Garcha Chair PCPB
Contact:	Manjeet Garcha
Primary Care Joint Commissioning Committee Action Required:	☐ **Decision** ☒ **Information**
Purpose of Report:	To update the PCJCC on PCPB activity for February 2017
Public or Private:	Public
Relevance to CCG Priority:	1,2a,2b,3,4 &5
Relevance to Board Assurance Framework (BAF):	Outline which Domain(s) the report is relevant to and why – See Notes for further information
• **Domain 5:** Delegated Functions	**Domain 5: Delegated functions**: When approved this will include primary care and may, in time, include other services. This is in addition to the assurances needed for out-of-hours Primary Medical Services, given this is a directed rather than delegated function.

NHS
Wolverhampton
Clinical Commissioning Group

1. BACKGROUND AND CURRENT SITUATION

1.1. The Primary Care Programme Board meets monthly and it was agreed that there will be a monthly summary report presented to the PCJCC.

2. MAIN BODY OF REPORT

Summary of activity discussed on 7th March 2017.

2.1.1 All currently active work streams are being progressed well with dates for reviews and benefit realisation analysis planned on the key planner

2.1.2 The revised project list for 2017/18 were reviewed and agreed.

2.1.3 The National Maternity Review, Better Birth Recommendations assurance report was presented for information. This included a self-assessment against the key recommendations. This was undertaken jointly by the CCG Maternity Commissioner and RWT Head of Midwifery. The work required is being progressed.

2.1.4 An update was received on the paperless e-referral system to RWT (Advice and Guidance) went live for Neurology on 8th February. The only outstanding speciality now is geriatrics and this is being progressed.

2.1.5 Verbal update given on the Consultant Connect Programme, a discussion took place regarding work RWT are already doing regarding providing 8am-8pm access to consultants and how this needs to be taken into account when considering Consultant Connect. Further detail to be presented at next meeting.

2.1.6 A&E frequent service user update given in relation to A&E funded scheme which is currently on hold due to information sharing agreement issues and due to WMAS staff being pulled to focus on front line service delivery. Group discussed that scheme was unlikely to make any savings due to patient co-hort predominately having mental health, alcohol and substance misuse issues, but would still be kept on the list to pursue as progress is made with IG and WMAS having more capacity.

2.1.7 Slippage was reported for the Anti-Coagulation project. This is being addressed.

2.1.8 The Risk Register was discussed, all risks are to be kept updated and leads will ensure this is maintained. No issues were agreed for escalation to the QIPP Board.

2.1.9 The QIPP Plan for the PCDB was discussed and the need to continue to address the QIPP unallocated deficit reiterated and it was agreed that it would be useful to see a list schemes/areas that contribute towards unallocated QIPP to ensure any areas that have been identified have been captured. No exceptions or risks to the Primary Care Delivery Board work were identified.

2.1.10 Contract Register, Commissioning Intentions, Commissioning Intentions and Engagement Documents to support the contract discussions were presented to the board. The contract register is to be presented as a standing item.

2.2 CLINICAL VIEW

Clinical view is afforded by the Director of Nursing and Quality and also Dr Dan De Rosa, CCG Chair. All papers are shared with Dr DeRosa for opportunity to comment if attendance at meetings proves difficult due to surgery commitments.

3. PATIENT AND PUBLIC VIEW

3.1 The PCPB ensures that all schemes have an EIA completed and patient and public views are sought as per requirement. Where this is not evident, there is a requirement made to have in place before further work is commenced or the project is moved to the next stage.

4. RISKS AND IMPLICATIONS

Key Risks

4.1 The PCPB has reviewed its risk register and it is in line with the CCG requirement.

5.0 **Financial and Resource Implications**

5.1 All exceptions are reported to the QIPP Board and full discussion held re risk and mitigation.

6.0 **Quality and Safety Implications**

6.1 Quality and Risk Team are fully sighted on all activity and the EIAs include a Quality Impact Assessment. The process for this has changed to allow Quality to be more integral into the business case development rather than a policing action and all QIAs are signed off by the CCG Head of Quality and Risk.

7.0 Equality Implications

7.1 A robust system has been put in place whereby all schemes have a full EIA undertaken at the scoping stage.

8.0 Medicines Management Implications

8.1 There are no implications in this report regarding medicines management; however, full consultation is sought with Head of Medicines Management for all schemes presented.

9.0 Legal and Policy Implications

9.1 There are no legal implications.

10.0 RECOMMENDATIONS

10.1 To **RECEIVE** and **Note** the actions being taken.

Name: Manjeet Garcha
Job Title: Director of Nursing and Quality
Date: 28th February 2017

NHS
Wolverhampton
Clinical Commissioning Group

REPORT SIGN-OFF CHECKLIST

This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.

	Details/ Name	Date
Clinical View	M Garcha Dr De Rosa	7th February 2017
Public/ Patient View		
Finance Implications discussed with Finance Team	QIPP BOARD	Feb 2017
Quality Implications discussed with Quality and Risk Team	M Garcha	Feb 2017
Medicines Management Implications discussed with Medicines Management team	nil	NA
Equality Implications discussed with CSU Equality and Inclusion Service	J Herbert	NA
Information Governance implications discussed with IG Support Officer		
Legal/ Policy implications discussed with Corporate Operations Manager		
Signed off by Report Owner (Must be completed)	M Garcha	28th Feb 2017

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NHS
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WOLVERHAMPTON CCG

PRIMARY CARE JOINT COMMISSIONING COMMITTEE
Tuesday 7th March 2017

Title of Report:	**Primary Care Operational Management Group Update**
Report of:	Sarah Southall – Head of Primary Care, Wolverhampton CCG
Contact:	Sarah Southall – Head of Primary Care, Wolverhampton CCG
Primary Care Joint Commissioning Committee Action Required:	☐ **Decision** ☒ **Assurance**
Purpose of Report:	To provide an update on the Primary Care Operational Management Group
Public or Private:	The report is suitable for the Public meeting.
Relevance to CCG Priority:	
• **Domain 4:** Planning (Long Term and Short Term)	Planning for the CCG Primary Care provision to be fit for purpose in line with NHSE recommendations.
• **Domain 5:** Delegated Functions	Fulfilling the delegated responsibility of jointly managing primary care.

NHS
Wolverhampton
Clinical Commissioning Group

1. BACKGROUND AND CURRENT SITUATION

1.1. The Primary Care Operational Management Group met on Tuesday 21st February 2017 and this report is a summation of the discussions which took place.

2. MAIN BODY OF REPORT

2.1 Zero Tolerance Service Specification

Further the CCG Zero Tolerance Service Specification being agreed a policy and procedural notes was shared with the group for comment. Practices were due to be approached to determine expressions of interest to deliver the service.

2.2 General Practice Forward View Implementation Plan Update

An update was provided on the training programme associated with the General Practice Forward View. The Care Navigation and Signposting Training Programme for Admin and Receptionists have been confirmed as four half day sessions and details will be circulated to the Practices.

2.3 Full Delegation

The group were informed the CCG were still awaiting an update Primary Care Hub Memorandum of Understanding. The second handover meeting with NHS England has taken place and plans continue to be progressed. An internal Task and Finish Group has been arranged for the 27th February 2017.

2.4 Primary Care Quality Update

Discussions took place regarding the Friends and Family data submission and those Practices not submitting data which continues to fluctuate. The group discussed how they will continue to monitor and evaluate the results receive into more meaningful data. The recent infection prevention audit results were shared which outlined improvement from previous months.

2.5 Safeguarding/SEND Notes of Meeting and Proposed Processes

The group were provided with an update and proposed processes for payment of Safeguarding and SEND reports for Primary Care. It was confirmed there would be Team W session in May and June which will focus on the process and the completion of reports.

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2.6 **Demand Management Plan**

The revised Demand Management Plan will be shared at the next Primary Care Operational Management Group Meeting in March 2017.

2.7 **Extend Opening - Christmas and New Year Opening CCG Scheme**

The group were presented with the evaluation on the performance of the CCG funded Primary Care Medical Care Services during Christmas and New Year period for 2016/17. The pilot consisted of 5 GP Practices covering Primary Care Home(s) who dealt with 465 patients during the period of which 446 were GP appointments and 19 were nurse appointments. A patient satisfaction survey was undertaken with 138 responses received which is a 29.7% return rate and provided and overall positive response.

3. RECOMMENDATIONS

3.1 The Committee is asked to note the progress made by the Primary Care Operational Management Group.

Name: Sarah Southall
Job Title: Head of Primary Care
Date: 27th February 2017

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NHS
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Clinical Commissioning Group

WOLVERHAMPTON CCG

PRIMARY CARE JOINT COMMISSIONING COMMITTEE
7 MARCH 2017

Title of Report:	**Primary Medical Services – Delegation Agreement**
Report of:	Corporate Operations Manager, WCCG
Contact:	Peter McKenzie
Primary Care Joint Commissioning Committee Action Required:	☐ **Decision** ☒ **Assurance**
Purpose of Report:	To provide the committee with details of the delegation agreement between NHS England and the CCG for Primary Medical Services
Public or Private:	This report is suitable for the Public Domain
Relevance to CCG Priority:	Supporting the continued improvement and development of Primary Care in Wolverhampton
Relevance to Board Assurance Framework (BAF):	Outline which Domain(s) the report is relevant to and why – See Notes for further information
• **Domain 5:** Delegated Functions	The Subcontracting arrangement falls under the purview of the powers delegated to the CCG by NHS England.

NHS
Wolverhampton
Clinical Commissioning Group

1. BACKGROUND AND CURRENT SITUATION

1.1. Following approval of the CCG's application to move to full delegation of Primary Medical Services, the CCG is required to enter into a delegation agreement with NHS England that details the extent of the functions delegated to it.

1.2. The delegation agreement is a nationally set framework for delivery of the delegated services and must be signed by the CCG before 8 March 2017. Whilst it is not possible for the agreement to be amended locally, the agreement has been reviewed as part of the on-going preparation for full delegation and this summary is provided for the Committee's information and assurance.

2. DELEGATION AGREEMENT STRUCTURE

2.1. The delegation agreement sets out both the services to be delivered by the CCG and those that will remain reserved to NHS England. These are set out in detail in separate schedules to the agreement.

2.2. The key services delegated to the CCG are:-

- Decisions in relation to Enhanced Services and Local Incentive Schemes (including the design of such schemes);
- Decisions in relation to the establishment of new GP practices (including branch surgeries), practice mergers and the potential closure of GP practices;
- Decisions about 'discretionary' payments;
- Decisions about commissioning urgent care (including home visits as required) for out of area registered patients;
- Planning primary medical care services in the Area, including carrying out needs assessments and reviews of primary medical care services in the Area;
- Decisions in relation to the management of poorly performing GP practices and including, liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the performers list);
- Management of Delegated Funds;
- Premises Costs Directions Functions; and
- Co-ordinating a common approach to the commissioning of primary care services with other commissioners in the Area where appropriate;

2.3. The services reserved to NHS England include management of the performers list, capital expenditure functions and managing complaints. The delegation agreement also set outs that NHS England may ask the CCG to provide administrative support with the reserved functions and will share information to support NHS England in the delivery of these functions.

2.4. Other areas set out in the delegation agreement include further detail around information sharing, financial roles and responsibilities and staffing provision for delivery of the delegated functions. This sets out a range of options from secondment of NHS England staff to the CCG creating new roles to deliver the delegated functions.

3. ASSURANCE FOR DELEGATED FUNCTIONS

3.1. One of the key areas set out in the agreement is the approach that will be taken by NHS England to ensure that the CCG is delivering the delegated functions in an effective manner. It therefore sets out that the CCG will prepare, within two months of the delegation, a plan setting out its approach to delivering the functions for the next two years. This plan must set out how the CCG will deliver these functions in line with the mandate set by the Department of Health for NHS England and any other specific objectives set for primary care commissioning.

3.2. Work is underway to produce this plan as part of the CCG's preparation for full delegation and it will be submitted to the Primary Care Commissioning Committee for approval. The plan will reflect the work in teams across the CCG to prepare for the additional responsibilities that will be required. The plan will also reflect the on-going support that will be provided by the NHS England Primary Care hub, particularly in terms of transactional support for contacting and finance.

3.3. In addition to the production of the plan, the CCG will be required to produce an annual report on the delivery of the delegated functions for NHS England each year. This will need to reflect the work undertaken by the CCG to discharge the functions delegated to by NHS England and support both the CCG and NHS England with their broader annual reporting requirements.

4. NEXT STEPS

4.1. The delegation agreement will need to be signed and returned to NHS England by 8 March 2017. This will then confirm the CCG's readiness to assume full delegation of primary medical services on 1 April 2017.

4.2. As highlighted above, work is already underway to prepare the plan required to outline the CCG's approach to delivery of these function. Following 1 April and the formal establishment of the Primary Care Commissioning Committee, this plan will be submitted for formal ratification.

5. CLINICAL VIEW

5.1. Not applicable.

6. PATIENT AND PUBLIC VIEW

6.1. Not applicable.

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7. RISKS AND IMPLICATIONS

Key Risks

7.1. Risks associated with the assumption of Full Delegation of Primary Medical Services are being considered as part of the ongoing preparation process. As part of the review of risk management arrangements across the CCG, risks will be allocated to the Primary Care Commissioning Committee to review in detail, in particular those risks associated with full delegation.

7.2. Work is still underway as part of the overall risk review to refine the detail of risks allocated to the committee. In summary however, it is likely that the key risks will relate to the impact on staffing resources of assuming additional responsibilities and ensuring that effective information is in place to support the delivery of these functions. Full details of these risks and the mitigations in place to manage them will be provided in due course.

Financial and Resource Implications

7.3. There are no specific financial or resource implications arising from this report. The financial and resource implications of full delegation are being considered as part of the preparation for 1 April. The delegation agreement sets out the financial responsibilities placed on the CCG as a result of full delegation and the arrangements in place to support this.

Quality and Safety Implications

7.4. There are no specific quality and safety implications arising from this report. The CCG has discussed with NHS England how the additional responsibilities in relation to commissioning primary care and supporting improvements in quality will be delivered as part of the preparation for full delegation.

Equality Implications

7.5. There are no equality implications arising from this report.

Medicines Management Implications

7.6. The delegation agreement set outs responsibilities for the CCG in assisting NHS England's controlled drugs accountable officer as a delegated commissioner. These responsibilities will be met within the medicines management team.

Legal and Policy Implications

7.7. The CCG must sign the delegation agreement to formally assume responsibility for commissioning primary medical services on behalf of NHS England in line with the national guidance on co-commissioning.

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8. RECOMMENDATIONS

That the Committee

- **Notes that the CCG will sign the delegation agreement in line with national guidance.**
- **Notes the ongoing work to prepare for full delegation of primary medical services, including the preparation of a plan for discharge of the delegated functions.**

Name Peter McKenzie
Job Title Corporate Operations Manager
Date: February 2017

ATTACHED: Outline Delegation agreement

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Clinical Commissioning Group

REPORT SIGN-OFF CHECKLIST

This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.

	Details/ Name	Date
Clinical View	**N/a**	
Public/ Patient View	**N/a**	
Finance Implications discussed with Finance Team	**N/a**	
Quality Implications discussed with Quality and Risk Team	**N/a**	
Medicines Management Implications discussed with Medicines Management team	**N/a**	
Equality Implications discussed with CSU Equality and Inclusion Service	**N/a**	
Information Governance implications discussed with IG Support Officer	**N/a**	
Legal/ Policy implications discussed with Corporate Operations Manager	**N/a**	
Signed off by Report Owner (Must be completed)	**Peter McKenzie**	**28/02/2017**

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Delegation Agreement

1. Particulars

1.1. This Agreement records the particulars of the agreement made between NHS England and the Clinical Commissioning Group named below.

Area	**[Insert Area]**
Clinical Commissioning Group	**[Insert Name]**
CCG Representative	**[Insert details of name of manager of this Agreement for the CCG]**
CCG Address for Notices	**[Insert Address]**
Date of Agreement	**[Leave Blank]**
Delegation	**means the delegation made by NHS England to the CCG of certain functions relating to primary medical services under section 13Z of the NHS Act and effective from 1 April 2015 (as amended pursuant to the Delegation)**
NHS England Representative	**[Insert details of name of manager of this Agreement for NHS England]**
Local NHS England Team	**[Insert Details]**
NHS England Address for Notices	**[Insert Address]**

1.2. This Agreement comprises:

1.2.1. the Particulars (Clause 1);
1.2.2. the Terms and Conditions (Clauses 2 to 24 and Schedule 1 to Schedule 6 and Schedule 8 to this Agreement); and
1.2.3. the Local Terms (Schedule 7).

Signed by	**NHS England** **Paul Bauman (for and on behalf of NHS England)**
Signed by	**[Insert name] Clinical Commissioning Group** **[Insert name of Authorised Signatory] [for and on behalf of] [ ]**

Terms and Conditions

A. Introduction

2. Interpretation

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

2.2. If there is any conflict or inconsistency between the provisions of this Agreement and the provisions of the Delegation, the provisions of the Delegation will prevail.

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

2.3.1. the Particulars and Terms and Conditions (Clauses 1 to 24 and, in particular, clause 8.7);
2.3.2. Schedule 1 to Schedule 6 and Schedule 8 to this Agreement; and
2.3.3. Schedule 7 *(Local Terms)*.

2.4. This Agreement and any ancillary agreements it refers to constitute the entire agreement and understanding between the Parties relating to the Delegation and supersedes all previous agreements, promises and understandings between them, whether written or oral, relating to its subject matter.

3. Background

3.1. NHS England has delegated the Delegated Functions to the CCG under section 13Z of the NHS Act and as set out in the Delegation.

3.2. Arrangements made under section 13Z of the NHS Act may be made on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the CCG.

3.3. This Agreement sets out the arrangements that apply in relation to the exercise of the Delegated Functions by the CCG.

3.4. For the avoidance of doubt, functions relating to the commissioning of primary care pharmacy, dental and optical contracts are not delegated to the CCG under the Delegation. The Delegation relates only to the delegation and reservation of primary medical services commissioning functions as set out in this Agreement.

4. Term

4.1. This Agreement has effect from the date set out in paragraph 5 of the Delegation and will remain in force unless terminated in accordance with clause 17 *(Termination)* below.

5. Principles

5.1. In performing their obligations under this Agreement, NHS England and the CCG must:

5.1.1. at all times act in good faith towards each other;
5.1.2. at all times exercise functions effectively, efficiently and economically;
5.1.3. act in a timely manner;
5.1.4. share information and best practice, and work collaboratively to identify solutions, eliminate duplication of effort, mitigate risk and reduce cost;
5.1.5. at all times observe relevant statutory powers, requirements and best practice to ensure compliance with applicable laws and standards including those governing procurement, and Information Law; and
5.1.6. have regard to the needs and views of the other Party and as far as is lawful and reasonably practicable, take such needs and views into account.

B. Role of the CCG

6. Performance of the Delegated Functions

6.1. The role of the CCG will be to exercise the Delegated Functions in the Area.

6.2. The Delegated Functions are the functions set out in Schedule 1of the Delegation and being:

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

6.2.1.1. decisions in relation to Enhanced Services;
6.2.1.2. decisions in relation to Local Incentive Schemes (including the design of such schemes);
6.2.1.3. decisions in relation to the establishment of new GP practices (including branch surgeries) and closure of GP practices;
6.2.1.4. decisions about 'discretionary' payments;
6.2.1.5. decisions about commissioning urgent care (including home visits as required) for out of area registered patients;

6.2.2. the approval of practice mergers;
6.2.3. planning primary medical care services in the Area, including carrying out needs assessments;
6.2.4. undertaking reviews of primary medical care services in the Area;
6.2.5. decisions in relation to the management of poorly performing GP practices and including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the performers list);
6.2.6. management of the Delegated Funds in the Area;
6.2.7. Premises Costs Directions Functions;
6.2.8. co-ordinating a common approach to the commissioning of primary care services with other commissioners in the Area where appropriate; and
6.2.9. such other ancillary activities that are necessary in order to exercise the Delegated Functions.

6.3. Schedule 2 *(Delegated Functions)* sets out further detail in relation to the Delegated Functions and the exercise of such Delegated Functions.

6.4. The CCG agrees that it must perform the Delegated Functions in accordance with:

6.4.1. the Delegation;
6.4.2. the terms of this Agreement;
6.4.3. all applicable Law;
6.4.4. the CCG's constitution;
6.4.5. Statutory Guidance; and
6.4.6. Good Practice.

6.4A The CCG must have due regard to Guidance and Contractual Notices.

6.5. Without prejudice to clause 6.4, the CCG agrees that it must perform the Delegated Functions in such a manner as to ensure NHS England's compliance with NHS England's statutory duties in respect of the Delegated Functions and to enable NHS England to fulfil its Reserved Functions.

6.6. When performing the Delegated Functions, the CCG will not do anything, take any step or make any decision outside of its delegated authority as set out in the Delegation.

6.7. Without prejudice to any other provision in this Agreement, the CCG must comply with the NHS England central finance team's operational process (as such process is updated from time to time) for the reporting and accounting of the Delegated Funds. In particular, the CCG will be required to permit the NHS England central finance team and/or their agents and contractors authorised by them to have the ability to access the CCG ledger to provide the services required to deliver financial support and assistance to the CCG necessary to enable them to manage the Delegated Funds and exercise the Delegated Functions. NHS England and the CCG will agree any accruals to be made including any adjustments related to the relevant Financial Year expenditure to ensure no net financial impact or gain on the CCG.

6.8. The decisions of the CCG in exercising the Delegated Functions will be binding on the CCG and NHS England.

7. Committee

7.1. The CCG must establish a committee to exercise its Delegated Functions.

7.2. The structure and operation of the committee must be constituted so as to take into account Guidance issued by NHS England including the *revised statutory guidance on managing conflicts of interest for CCGs* https://www.england.nhs.uk/commissioning/pc-co-comms/coi/

C. Functions reserved to NHS England

8. Performance of the Reserved Functions

8.1. The role of NHS England will be to exercise the Reserved Functions.

8.2. Subject to clause 8.3, the Reserved Functions are all of NHS England's functions relating to primary medical services other than the Delegated Functions and including those functions set out in Schedule 2of the Delegation and being:

8.2.1. management of the national performers list;
8.2.2. management of the revalidation and appraisal process;
8.2.3. administration of payments in circumstances where a performer is suspended and related performers list management activities;
8.2.4. Capital Expenditure Functions;
8.2.5. Section 7A Functions;
8.2.6. functions in relation to complaints management;
8.2.7. decisions in relation to the GP Access Fund; and
8.2.8. such other ancillary activities that are necessary in order to exercise the Reserved Functions.

8.3. For the avoidance of doubt, the Parties acknowledge that the Delegation may be amended and additional functions may be delegated to the CCG, in which event consequential changes to this Agreement

shall be agreed with the CCG pursuant to clause 22 *(Variations)* of this Agreement.

8.4. Schedule 3 *(Reserved Functions)* sets out further detail in relation to the Reserved Functions.

8.5. To support and assist NHS England in carrying out the Reserved Functions, the CCG will share information with NHS England in accordance with section E *(Information)* below.

8.6. NHS England will work collaboratively with the CCG when exercising the Reserved Functions, including discussing with the CCG how it proposes to address GP performance issues.

8.7. If there is any conflict or inconsistency between functions that are named as Delegated Functions and functions that are named as Reserved Functions then such functions shall be interpreted as Reserved Functions.

8.8. The Parties acknowledge that, as at the date of this Agreement, the CCG shall provide administrative and management services to NHS England in relation to certain Reserved Functions and that such administrative and management services are as follows:

8.8.1. the administrative and management services in relation to the Capital Expenditure Functions and the Capital Expenditure Funds as more particularly set out in clauses 13.13 to 13.16; and

8.8.2. the administrative and management services in relation to the Section 7A Functions and Section 7A Funds as more particularly set out in clauses 13.17 to 13.20.

8.9. The Parties further acknowledge that NHS England may ask the CCG to provide certain administrative and management services to NHS England in relation to other Reserved Functions as more particularly set out in clauses 13.21 to 13.23. Such administrative and management services shall only be provided by the CCG following agreement by the CCG.

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

D. Commissioning

9. Monitoring and Reporting – General Requirements

9.1. The CCG must comply with any reporting requirements under:

9.1.1. this Agreement (including, without limitation, as required by clause 9 *(Monitoring and Reporting – General Requirements)*, clause 12 *(Public Information and Access Targets)*, clause 13 *(Financial Provisions and Liability)*, clause 14 *(Claims and Litigation)* and Schedule 2 Part 1 paragraph 2 *(Primary Medical Services Contract Management)* and paragraph 5 *(Information Sharing with NHS England))*;

9.1.2. the CCG Assurance Framework; and

9.1.3. the CCG's constitution.

9.2. NHS England shall monitor the exercise and carrying out of the Delegated Functions by the CCG under the terms of this Agreement and as part of the CCG Assurance Framework.

9.3. The CCG will notify NHS England of all primary medical services commissioning committee meetings at least seven (7) days in advance of such meetings and NHS England will be entitled to attend such meetings at its discretion.

9.4. The CCG must provide to NHS England:

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

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

9.5. Nothing in this Agreement shall affect NHS England's power to require information from the CCG under sections 14Z17, 14Z18, 14Z19 and 14Z20 of the NHS Act.

E. Information

10. Information Sharing and Information Governance

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

10.2. NHS England and the CCG will enter into a Personal Data Agreement that will govern the processing of Relevant Information that identifies individuals under this Agreement. A template Personal Data Agreement is set out in Schedule 4 *(Further Information Sharing Provisions)*.

10.3. The Personal Data Agreement:

10.3.1. sets out the relevant Information Law and best practice, including the requirements of the NHS Digital IG Toolkit;

10.3.2. sets out how that law and best practice will be implemented, including responsibilities of the Parties to co-operate properly and fully with each other;

10.3.3. identifies the Relevant Information that may be processed, including what may be shared, under this Agreement;

10.3.4. identifies the purposes for which the Relevant Information may be so processed and states the legal basis for the processing in each case;

10.3.5. states who is/are the data controller/s and, if appropriate, the data processor/s of Personal Data;

10.3.6. sets out what will happen to the Personal Data on the termination of this Agreement (with due regard to clause 17 (*Termination)* of the Agreement); and

10.3.7. sets out such other provisions as are necessary for the sharing of Relevant Information to be fair, lawful and meet best practice.

10.4. NHS England and the CCG will share all Non-Personal Data in accordance with Information Law and their statutory powers as set out

in section 13Z3 (for NHS England) and section 14Z23 (for the CCG) of the NHS Act.

10.5. The Parties agree that, in relation to information sharing and the processing of Relevant Information under the Delegation and this Agreement, they must comply with:

10.5.1. all relevant Information Law requirements including the common law duty of confidence (unless disapplied by statute) and other legal obligations in relation to information sharing including those set out in the NHS Act and the Human Rights Act 1998;

10.5.2. Good Practice; and

10.5.3. relevant guidance (including guidance given by the Information Commissioner, the Caldicott Principles, the requirements of the NHS Information Governance Toolkit to level 2, and guidance issued further to sections 263 and 265 of the HSCA) and consistent with guidance issued under section 13S of the NHS Act to providers.

11. IT inter-operability

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

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

12. Public Information and Access Targets

12.1. The CCG must promptly make available to NHS England such information as is required in respect of the Delegated Functions to ensure NHS England's discharge of its statutory duties.

12.2. The CCG must ensure that all new Primary Medical Services Contracts contain appropriate provisions such that the CCG is able to discharge its obligations in clause 12.1.

12.3. The CCG must ensure that any information provided under this Agreement complies with all relevant national data sets issued by NHS England and NHS Digital.

F. General

13. Financial Provisions and Liability

Notification of the Delegated Funds and Adjustments to the Delegated Funds

13.1. NHS England will, in respect of each Financial Year, notify the CCG of the proportion of the funds allocated to NHS England by the Secretary of State pursuant to Chapter 6 of the NHS Act and which are to be paid to the CCG for the purpose of meeting expenditure in respect of the Delegated Functions for that Financial Year (the **"Delegated Funds"**).

13.2. Except in relation to pooled funds and subject to the terms of this clause 13 *(Financial Provisions and Liability)* and, in particular, clause 13.4, the CCG must use the Delegated Funds to meet expenditure in respect of the exercise of the Delegated Functions. Without prejudice to the generality of the foregoing, the CCG must make:

13.2.1. all payments in relation to the Primary Medical Services Contracts including payments in relation to QOF and implementing financial adjustments or sanctions (including in relation to breaches of provider obligations); and

13.2.2. all payments under the Premises Costs Directions.

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

13.3.1. in order to take into account any monthly adjustments or corrections to the Delegated Funds that NHS England considers appropriate (following discussions with the CCG), including without limitation adjustments following any changes to the Delegation or Delegated Functions (including changes

pursuant to paragraph 6 or paragraph 16 of the Delegation), changes in allocations, changes in contracts or otherwise;

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

13.3.3. to take into account any Losses arising under clause 13.35;

13.3.4. to take into account any Claim Losses;

13.3.5. to take into account any adjustments that NHS England considers appropriate (including without limitation in order to make corrections or otherwise to reflect notional budgets) to reflect funds transferred (or that should have been transferred) to the CCG in respect of the Delegated Funds and/or funds transferred (or that should have been transferred) to the CCG and in respect of which the CCG has management or administrative responsibility under clauses 13.13 to 13.23 of this Agreement; or

13.3.6. in order to ensure compliance by NHS England of its obligations under the NHS Act (including without limitation, Chapter 6 of the NHS Act) or the HSCA or any action taken or direction made by the Secretary of State under the NHS Act or the HSCA.

13.3A NHS England acknowledges that the intention of clause 13.3 is to reflect genuine corrections and adjustments to the Delegated Funds and may not be used to change the allocation of the Delegated Funds unless there are significant or exceptional circumstances that would require such corrections or adjustments (including but not limited to a change in the mandate published by the Department of Health or other external factors).

13.4. The CCG acknowledges that it must comply with its statutory financial duties, including those under sections 223H and 223I of the NHS Act to the extent that these sections apply in relation to the receipt of the Delegated Funds.

13.5. The CCG acknowledges its duty under section 14S of the NHS Act to assist and support NHS England in discharging its duty under section 13E so far as relating to securing continuous improvement in the quality of primary medical services and agrees that it shall take this duty into

account in relation to the exercise of the Delegated Functions and the use of the Delegated Funds.

13.6. The CCG must ensure that it uses the Delegated Funds in such a way as to ensure that NHS England is able to fulfil its functions, including without limitation the Reserved Functions, effectively and efficiently in accordance with this Agreement.

13.7. NHS England may in respect of the Delegated Funds:

13.7.1. notify the CCG of the capital resource limit and revenue resource limit that will apply in any Financial Year;

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

13.7.3. by notice, require the CCG to take such action or step in respect of the Delegated Funds, in order to ensure compliance by NHS England of its duties or functions under the NHS Act or the HSCA (including without limitation, Chapter 6 of the NHS Act) or any action taken or direction made by the Secretary of State under the NHS Act or the HSCA (including, without limitation, Chapter 6 of the NHS Act).

13.8. Schedule 5 *(Financial Provisions and Decision Making Limits)* sets out further financial provisions in respect of the exercise of the Delegated Functions and, in particular, Table 1 in Schedule 5 *(Financial Provisions and Decision Making Limits)* sets out certain financial limits and approvals required in relation to the exercise of the Delegated Functions. NHS England's Standing Financial Instructions shall be updated accordingly.

Payment and Transfer

13.9. The CCG acknowledges that the Delegated Funds do not form part of and are separate to the funds allocated annually under section 223G of the NHS Act (the **"Annual Allocation"**).

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

13.11. Without prejudice to any other obligation upon the CCG, the CCG agrees that it must deal with the Delegated Funds in accordance with:

13.11.1. the terms and conditions of this Agreement;

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

13.11.3. any Capital Investment Guidance or Primary Medical Care Infrastructure Guidance;

13.11.4. any Guidance or Contractual Notice issued by NHS England from time to time in relation to the Delegated Funds (including in relation to the form or contents of any accounts in relation to the Delegated Funds); and

13.11.5. the HM Treasury guidance *Managing Public Money* (dated July 2013 and found at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212123/Managing_Public_Money_AA_v2_-_chapters_annex_web.pdf).

13.12. Without prejudice to any other obligation upon the CCG, the CCG agrees that it must provide all information, assistance and support to NHS England in relation to the audit and/or investigation (whether internal or external and whether under Law or otherwise) in relation to the use of or payment of the Delegated Funds and the discharge of the Delegated Functions.

Administrative and/or Management Services and Funds in relation to the Capital Expenditure Functions

13.13. The Parties acknowledge that the Capital Expenditure Functions are a Reserved Function.

13.14. The Parties further acknowledge that:

13.14.1. accordingly, the Delegated Funds do not include any funds in respect of amounts payable in relation to the Capital Expenditure Functions (**"Capital Expenditure Funds"**); and

13.14.2. NHS England remains responsible and accountable for the discharge of the Capital Expenditure Functions and nothing in clauses 13.13 to 13.16 shall be construed as a divestment or delegation of NHS England's Capital Expenditure Functions.

13.15. Without prejudice to clause 13.14 above, the CCG will comply with any Guidance issued in relation to the Capital Expenditure Functions and shall (on request from NHS England) provide the following administrative services to NHS England in respect of the Capital Expenditure Funds:

13.15.1. the administration and payment of sums that NHS England has approved as payable in relation to the Capital Expenditure Functions;

13.15.2. if requested by NHS England and taking into account (i) any other support or services provided to NHS England by NHS Property Services Limited or otherwise and (ii) any Guidance issued in respect of the Capital Expenditure Functions, the provision of advice and/or recommendations to NHS England in respect of expenditure to be made under the Capital Expenditure Functions; and

13.15.3. such other support or administrative assistance to NHS England that NHS England may reasonably request in order to facilitate the discharge by NHS England of its responsibilities under or in respect of the Capital Expenditure Functions.

13.16. NHS England may, at the same time as it transfers the Delegated Funds to the CCG under clause 13.10, transfer to the CCG such amounts as are necessary to enable the discharge of the CCG's obligations under this clause 13 *(Financial Provisions and Liability)* in respect of the Capital Expenditure Functions.

Administrative and/or Management Services and Funds in relation to Section 7A Functions

13.17. The Parties acknowledge that the Section 7A Functions are part of the Reserved Functions.

13.18. The Parties further acknowledge that:

13.18.1. accordingly, the Delegated Funds do not include any funds in respect of amounts payable in relation to the Section 7A Functions (whether such arrangements are included in or under Primary Medical Services Contracts or not) (**"Section 7A Funds"**); and

13.18.2. NHS England remains responsible and accountable for the discharge of the Section 7A Functions and nothing in this clause 13 *(Financial Provisions and Liability)* shall be construed as a divestment or delegation of the Section 7A Functions.

13.19. The CCG will provide the following services to NHS England in respect of the Section 7A Funds:

13.19.1. the administration and payment of sums that NHS England has approved as payable under or in respect of arrangements for the Section 7A Functions; and

13.19.2. such other support or administrative assistance to NHS England that NHS England may reasonably request in order to facilitate the discharge by NHS England of its responsibilities under or in respect of the Section 7A Funds.

13.20. NHS England shall, at the same time as it transfers the Delegated Funds to the CCG under clause 13.10, transfer to the CCG such amounts as are necessary to enable the discharge of the CCG's obligations under this clause 13 *(Financial Provisions and Liability)* in respect of the Section 7A Funds.

Administrative and/or Management Services and Funds in relation to other Reserved Functions

13.21. NHS England may ask the CCG to provide certain management and/or administrative services to NHS England (from a date to be notified by NHS England to the CCG) in relation to:

13.21.1. the carrying out of any of the Reserved Functions; and/or

13.21.2. without prejudice to the generality of clause 13.21.1, the handling and consideration of complaints.

13.22. If NHS England makes such a request to the CCG, then the CCG will, but only if the CCG agrees to provide such services, from the date requested by NHS England, comply with:

13.22.1. provisions equivalent to those set out above in relation to the Capital Expenditure Functions (clauses 13.13 to 13.16) and the Section 7A Functions (clauses 13.17 to 13.20) including in relation to the administration of any funds for such functions but only to the extent that such provisions are relevant to the management or administrative services to be provided; and

13.22.2. such other provisions in respect of the carrying out of such management and administrative services as agreed between NHS England and the CCG.

13.23. If NHS England asks the CCG to provide certain management and administrative services in relation to the handling and consideration of complaints and if the CCG agrees to provide such management and administrative services (with such agreement to be recorded as a variation pursuant to clause 22 *(Variations)*) then:

13.23.1. NHS England may, in any Contractual Notice issued by NHS England in respect of such service (and as referred to in clause 13.22.2), specify procedures and responsibilities of the CCG and NHS England in relation to such complaints under the Complaints Regulations and all other Law; and

13.23.2. such Contractual Notice may specify procedures in relation to the provision of an annual report to the Chief Executive of NHS England, procedures in relation to the approval of decisions in relation to complaints and/or the appointment of a responsible person by NHS England pursuant to the Complaints Regulations;

13.23.3. such services shall be arrangements made under the provisions of Regulation 3 of the Complaints Regulations; and

13.23.4. provided that any Contractual Notice issued pursuant to this clause shall be discussed and agreed with the CCG prior to the issue of the Contractual Notice by NHS England.

Pooled Funds

13.24. The CCG may, for the purposes of exercising the Delegated Functions under this Agreement, establish and maintain a pooled fund in respect of any part of the Delegated Funds with NHS England in accordance with section 13V of the NHS Act except that the CCG may only do so if NHS England (at its absolute discretion) consents in writing to the establishment of the pooled fund (including any terms as to the governance and payments out of such pooled fund).

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

Business Plan, Commissioning Plan and Annual Report

13.26. Within two (2) months of the date of the Delegation and thereafter three (3) months before the start of each Financial Year, the CCG must prepare a plan setting out how it proposes to exercise the Delegated Functions in that Financial Year and in each of the next two (2) Financial Years (or over such longer period as NHS England may require).

13.27. The plan must, in particular, explain how the CCG proposes to ensure NHS England's compliance with its duties in relation to the Delegated Functions under the NHS Act, including without limitation:

13.27.1. sections 223C *(expenditure)*, 223D *(controls on total resource use)* and 223E *(additional controls on resource use)* of the NHS Act; and

13.27.2. sections 13E *(duty as to improvement in quality of services)*, 13G *(duty as to reducing inequalities)* and 13Q *(public involvement and consultation)* of the NHS Act.

13.28. The plan must include the following:

13.28.1. details of how the CCG proposes to exercise the Delegated Functions in that Financial Year and in each of the next two (2) Financial Years; and

13.28.2. details of how the CCG proposes to ensure NHS England's compliance with its duties to achieve any objectives and

requirements relating to the Delegated Functions which are specified in the mandate published by the Department of Health to NHS England for the first Financial Year to which the plan relates; and

13.28.3. any other information or detail that NHS England considers necessary to ensure NHS England's compliance with its obligations under section 13T of the NHS Act or any other provision of the NHS Act or other Law.

13.29. The CCG must revise the plan at the request of NHS England and submit a revised plan to NHS England before the date specified by NHS England from time to time.

13.30. As soon as practicable after the end of each Financial Year (and in any event within two (2) months of the end of each Financial Year or such longer period as NHS England may specify), the CCG must provide to NHS England a report on how the CCG has exercised the Delegated Functions during the previous Financial Year.

13.31. The report referred to in clause 13.30 above must include sufficient detail to ensure NHS England's compliance with its statutory obligations under section 13U of the NHS Act.

13.32. Following receipt of the report referred to in clause 13.30 above, NHS England may (at its absolute discretion) require such further information from the CCG as NHS England considers necessary to ensure NHS England's compliance with its obligations under section 13U of the NHS Act.

13.33. The CCG shall comply with any Contractual Notices issued from time to time by NHS England in relation to the inclusion of information in relation to the Delegated Functions in any plan prepared by the CCG under section 14Z11 of the NHS Act or in any report prepared under section 14Z15 of the NHS Act.

Risk sharing

13.34. In accordance with section 13Z(6) of the NHS Act, NHS England retains liability in relation to the exercise of the Delegated Functions and

nothing in this Agreement affects the liability of NHS England in relation to the Delegated Functions.

13.34A For the avoidance of doubt, NHS England retains liability in respect of any Losses arising in respect of NHS England's negligence, fraud, recklessness or deliberate breach in respect of the Delegated Functions and, if the CCG suffers any Losses in respect of such actions by NHS England, NHS England shall make such adjustments to the Delegated Funds (or other amounts payable to the CCG) in order to reflect any Losses suffered by the CCG (except to the extent that the CCG is liable for such Loss pursuant to clause 13.35).

13.35. The CCG is liable (and shall pay) to NHS England for any Losses suffered by NHS England that result from or arise out of the CCG's negligence, fraud, recklessness or deliberate breach of the Delegation (including any actions that are taken that exceed the authority conferred by the Delegation) or this Agreement and, in respect of such Losses, NHS England may, at its discretion and without prejudice to any other rights, either require payment from the CCG or make such adjustments to the Delegated Funds pursuant to clause 13.3. The CCG shall not be liable to the extent that the Losses arose prior to the date of this Agreement.

13.36. Nothing in this clause 13 *(Financial Provisions and Liability)* or this Agreement shall affect or prejudice NHS England's right to exercise its rights (whether arising under administrative law, common law or statute) in relation to actions or steps of the CCG, including any actions or steps that exceed the authority conferred by the Delegation or are a breach of the terms and conditions of this Agreement.

14. Claims and Litigation

14.1. Schedule 2 *(Delegated Functions)* sets out further detail in relation to the performance management of the Primary Medical Services Contracts.

14.2. Nothing in this clause 14 *(Claims and Litigation)* shall be interpreted as affecting the reservation to NHS England of the Reserved Functions

(including the reservation to NHS England of all functions in relation to the performers list activities).

14.3. Except in the circumstances set out in clause 14.7 and subject always to compliance with this clause 14 *(Claims and Litigation)*, the CCG shall be responsible for and shall retain the conduct of any Claim.

14.4. The CCG must:

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

14.4.2. without prejudice to clause 14.4.1, in respect of legal advice or assistance in relation to a Claim, comply with any requirements of NHS England from time to time (whether set out in a policy issued pursuant to clause 14.4.1 or otherwise) in relation to the use of solicitors or barristers and, at the date of this Agreement, NHS England's requirement is that a CCG must obtain prior approval from NHS England in respect of the firm of solicitors instructed to provide legal advice or assistance in relation to a Claim;

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

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

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

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

14.5. NHS England shall use its reasonable endeavours to keep the CCG informed in respect of the conduct and/or outcome of the Claim except that NHS England shall have no obligation to do so due to any administrative or regulatory requirement, the requirement of any insurer or the NHSLA or for any other reason that NHS England may consider necessary or appropriate, at its absolute discretion, in relation to the conduct of that Claim or related matter.

14.6. Subject to clause 14.4 and Schedule 5 *(Financial Provisions and Decision Making Limits)* the CCG is entitled to conduct the Claim in the manner it considers appropriate and is also entitled to pay or settle any Claim on such terms as it thinks fit.

NHS England Stepping into Claims

14.7. NHS England may, at any time following discussion with the CCG, send a notice to the CCG stating that NHS England will take over the conduct of the Claim and the CCG must immediately take all steps necessary to transfer the conduct of such Claim to NHS England. In such cases, NHS England shall be entitled to conduct the Claim in the manner it considers appropriate and is also entitled to pay or settle any Claim on such terms as it thinks fit.

NHS England Stepping out of Claims

14.8. NHS England may, at any time after it has exercised its rights set out in clause 14.7 above and following discussion with the CCG, send a notice to the CCG stating that the CCG will be required to take over the conduct of the Claim from NHS England and NHS England must immediately take all steps necessary to transfer the conduct of such Claim to the CCG. In such cases, the CCG shall be entitled to conduct the Claim in the manner it considers appropriate in accordance with its obligations under this clause 14 *(Claims and Litigation)* and subject to Schedule 4 *(Further Information Sharing Provisions)* and Schedule 5 *(Financial Provisions and Decision Making Limits)*.

Claim Losses

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

14.10. If the CCG considers that, as a result of a Claim Loss, the Delegated Funds will be insufficient to meet the Claim Loss as well as discharge the Delegated Functions, then the CCG shall immediately notify NHS England and the Parties shall meet to discuss and agree any adjustment that may be needed pursuant to clause 13.3 (and taking into account any funds, provisions or other resources retained by NHS England in respect of such Claim Losses).

14.11. The CCG acknowledges that NHS England will pay to the CCG the funds that are attributable to the Delegated Functions. Accordingly, the CCG acknowledges that the Delegated Funds are required to be used to discharge and/or pay any Claim Losses. NHS England may, in respect of any Claim Losses, at its discretion and without prejudice to any other rights, either require payment from the CCG for such Claim Losses or pursuant to clause 13.3 make such adjustments to the Delegated Funds to take into account the amount of any Claim Losses (other than any Claim Losses in respect of which NHS England has retained any funds, provisions or other resources to discharge such Claim Losses). For the avoidance of doubt, in circumstances where NHS England suffers any Claim Losses, then NHS England shall be entitled to recoup such Claim Losses pursuant to clause 13.3. If and to the extent that NHS England has retained any funds, provisions or other resources to discharge such Claim Losses, then NHS England may either use such funds to discharge the Claim Loss or make an upward adjustment to the amounts paid to the CCG pursuant to clause 13.3.

15. Breach

15.1. If the CCG does not comply with the Delegation or the terms of this Agreement, then NHS England may:

15.1.1. exercise its rights under this Agreement; and/or

15.1.2. take such steps as it considers appropriate under the CCG Assurance Framework.

15.2. Without prejudice to clause 15.1, if the CCG does not comply with the Delegation or the terms of this Agreement (including if the CCG

exceeds its delegated authority under the Delegation), NHS England may (at its sole discretion):

15.2.1. waive such non-compliance in accordance with clause 15.3 and the Delegation;
15.2.2. ratify any decision in accordance with paragraph 15 of the Delegation;
15.2.3. revoke the Delegation and terminate this Agreement in accordance with clause 17 *(Termination)* below;
15.2.4. exercise the Escalation Rights in accordance with clause 16 *(Escalation Rights)*; and/or
15.2.5. exercise its rights under common law.

15.3. NHS England may waive any non-compliance by the CCG with the terms of this Agreement provided that the CCG provides a written report to NHS England pursuant to clause 15.4 and, after considering the CCG's written report, NHS England is satisfied that the waiver is justified.

15.4. If:

15.4.1. the CCG does not comply (or the CCG considers that it may not be able to comply) with this Agreement and/or the Delegation; or
15.4.2. NHS England notifies the CCG that it considers the CCG has not complied, or may not be able to comply with, this Agreement and/or the Delegation,

then the CCG must provide a written report to NHS England within ten (10) days of the non-compliance (or the date on which the CCG considers that it may not be able to comply with this Agreement) or such notification pursuant to clause 15.4.2 setting out:

15.4.3. details of and reasons for the non-compliance (or likely non-compliance) with the Agreement and/or the Delegation; and
15.4.4. a plan for how the CCG proposes to remedy the non-compliance.

16. Escalation Rights

16.1. If the CCG does not comply with this Agreement and/or the Delegation, NHS England may exercise the following Escalation Rights:

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

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

16.2. Nothing in clause 16 *(Escalation Rights)* will affect NHS England's right to revoke the Delegation and/or terminate this Agreement in accordance with clause 17 *(Termination)* below.

17. Termination

17.1. The CCG may:

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

17.1.2. terminate this Agreement

with effect from midnight on 31 March in any calendar year, provided that:

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

17.1.4. the CCG meets with NHS England within ten (10) Operational Days of NHS England receiving the notice set out at clause 17.1.3 above to discuss arrangements for termination and transition of the Delegated Functions to a successor commissioner,

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

17.2. NHS England may revoke the Delegation at midnight on 31 March in any year, provided that it gives notice to the CCG of its intention to terminate the Delegation on or before 30 September in the year prior to the year in which the Delegation will terminate, and in which case clause 17.4 will apply.

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

17.3.1. the CCG acts outside of the scope of its delegated authority;
17.3.2. the CCG fails to perform any material obligation of the CCG owed to NHS England under the Delegation or this Agreement;
17.3.3. the CCG persistently commits non-material breaches of the Delegation or this Agreement;
17.3.4. NHS England is satisfied that its intervention powers under section 14Z21 of the NHS Act apply;
17.3.5. to give effect to legislative changes;
17.3.6. failure to agree to a National Variation in accordance with clause 22 *(Variations)*;
17.3.7. NHS England and the CCG agree in writing that the Delegation shall be revoked and this Agreement shall terminate on such date as is agreed; and/or
17.3.8. the CCG merges with another CCG or other body.

17.4. This Agreement will terminate immediately upon revocation or termination of the Delegation (including revocation and termination in accordance with this clause 17 *(Termination)*) except that the Survival Clauses will continue in full force and effect. This Agreement shall not terminate immediately if the Delegation is amended by a revocation and re-issue of an amended Delegation.

17.5. Upon revocation or termination of the Delegation and this Agreement (including revocation and termination in accordance with this clause 17 *(Termination)*), the Parties must:

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

17.5.2. implement and comply with their respective obligations under the plan for transition agreed in accordance with clause 17.5.1 above; and

17.5.3. use all reasonable endeavours to minimise any inconvenience or disruption to the commissioning of healthcare in the Area.

17.6. Without prejudice to clause 15.3 and for the avoidance of doubt, NHS England may waive any right to terminate this Agreement under this clause 17 *(Termination)*.

18. Staffing

18.1. The Parties acknowledge and agree that the CCG may only engage staff to undertake the Delegated Functions under one of the following three staffing models:

18.1.1. "Model 1 – Assignment" under the terms of which the staff of NHS England remain in their current roles and locations and provide services to the CCG under a service level agreement;

18.1.2. "Model 2 – Secondment" under the terms of which certain staff of NHS England are seconded to the CCG (and, for the avoidance of doubt, such secondments will terminate on revocation or termination of the Delegation); or

18.1.3. "Model 3 – Employment" under the terms of which the CCG may create new posts within the CCG to undertake the Delegated Functions provided that the CCG may only do so if it first offers to existing staff of NHS England an opportunity to

apply for such posts and such staff must be appointed if they are deemed appointable,

together, the **"Staffing Models"**.

18.2. The CCG and NHS England, must within six (6) months of the date of this Agreement, agree which of the Staffing Models (set out at clauses 18.1.1 to 18.1.3 above) will be adopted by the CCG and the date on which such Staffing Model shall take effect.

18.3. In the absence of any agreement under clause 18.2, and up until such date as the CCG's preferred Staffing Model shall take effect (as referred to in clause 18.2 above), Model 1 described in clause 18.1.1 above will apply. The terms on which Model 1 will apply are set out in Schedule 8 *(Assignment of NHS England Staff to the CCG)*.

18.4. The CCG must comply with any Guidance issued by NHS England from time to time in relation to the Staffing Models and such Guidance may make changes to the Staffing Models from time to time.

18.5. For the avoidance of doubt, any breach by the CCG of the terms of this clause 18 *(Staffing)*, including any breach of the Guidance issued in accordance with clause 18.4 above, will be a breach of the terms and conditions of this Agreement for the purposes of clauses 13.3 and 13.35.

18.6. Without prejudice to clause 18.7, it is the understanding of the Parties that the provisions of the Transfer Regulations will not operate to transfer the employment of any staff of NHS England or any other party to the CCG on the commencement of the Delegation and this Agreement.

18.7. The Parties acknowledge that if at any time before or after the revocation or termination of the Delegation and this Agreement the Transfer Regulations do apply, the Parties must co-operate and comply with their obligations under the Transfer Regulations.

19. Disputes

19.1. This clause does not affect NHS England's right to take action under the CCG Assurance Framework.

19.2. If a dispute arises out of or in connection with this Agreement or the Delegation (**"Dispute"**) then the Parties must follow the procedure set out in this clause:

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

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

19.2.3. if the people referred to in clause 19.2.2 are for any reason unable to resolve the Dispute within twenty (20) days of it being referred to them, the Parties may attempt to settle it by mediation in accordance with the CEDR model mediation procedure. Unless otherwise agreed between the Parties, the mediator must be nominated by CEDR Solve. To initiate the mediation, a Party must serve notice in writing (**"ADR notice"**) to the other Party to the Dispute, requesting a mediation. A copy of the ADR notice should be sent to CEDR Solve. The mediation will start not later than ten (10) days after the date of the ADR notice.

19.3. If the Dispute is not resolved within thirty (30) days after service of the ADR notice, or either Party fails to participate or to continue to participate in the mediation before the expiration of the period of thirty (30) days, or the mediation terminates before the expiration of the period of thirty (30) days, the Dispute must be referred to the Secretary

of State, who shall resolve the matter and whose decision shall be binding upon the Parties.

20. Freedom of Information

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

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

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

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

20.2.3. subject only to clause 14 *(Claims and Litigation)*, each Party acknowledges that the final decision as to the form or content of the response to any request is a matter for the Party to whom the request is addressed.

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

21. Conflicts of Interest

21.1. The CCG must comply with its statutory duties set out in:

21.1.1. Chapter A2 of the NHS Act (including those statutory duties relating to the management of conflicts of interest as set out at section 14O of the NHS Act);

21.1.2. the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013/500; and

21.1.3. Regulation 24 of the Public Contracts Regulations 2015/102,

and must perform its obligations under this Agreement in such a way as to ensure NHS England's compliance with its statutory duties in relation to conflicts of interest.

21.2. The CCG must have regard to all relevant guidance published by NHS England in relation to conflicts of interest in the co-commissioning context.

22. Variations

22.1. The Parties acknowledge that, under paragraph 16 of the Delegation, the Delegation may be reviewed and amended from time to time and that such amendments may be effected by a revocation and re-issue of an amended Delegation.

22.2. The Parties acknowledge that, under paragraph 6 of the Delegation, certain additional functions may be delegated from time to time by NHS England to the CCG on a date or dates to be notified to the CCG by NHS England in accordance with clause 8.3. If NHS England amends the Delegation and/or delegates additional functions to the CCG, then NHS England and the CCG shall agree such consequential changes to this Agreement pursuant to this clause 22 *(Variations)*.

22.3. Subject to clauses 22.4 to 22.10 below, a variation of this Agreement will only be effective if:

22.3.1. it is materially in the form of the template variation agreement set out at Schedule 6 *(Template Variation Agreement)*; and

22.3.2. it is signed by NHS England and the CCG (by their Agreement Representatives or other duly authorised representatives).

22.4. The Parties may not vary any provision of this Agreement if the purported variation would contradict or conflict with the Delegation.

22.5. NHS England may notify the CCG of any proposed National Variation by issuing a National Variation Proposal by whatever means NHS England may consider appropriate from time to time.

22.6. The CCG will be deemed to have received a National Variation Proposal on the date that it is issued by NHS England.

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

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

22.8.1. that it accepts the National Variation Proposal; or

22.8.2. that it refuses to accept the National Variation Proposal, and setting out reasonable grounds for that refusal.

22.9. If the CCG accepts the National Variation Proposal in accordance with clause 22.8.1, the CCG agrees (without delay) to take all necessary steps (including executing a variation agreement) in order to give effect to any National Variation by the date on which the proposed National Variation takes effect as set out in the National Variation Proposal.

22.10. If the CCG refuses to accept the National Variation Proposal in accordance with clause 22.8.2 or to take such steps as set out in clause 22.9, NHS England may terminate this Agreement and revoke the Delegation in accordance with clause 17.3.6.

23. Counterparts

23.1. This Agreement may be executed in counterparts, each of which shall be regarded as an original, but all of which together shall constitute one agreement binding on both of the Parties.

24. Notices

24.1. Any notices given under this Agreement must be in writing, must be marked for the appropriate department or person and must be served by hand, post or email to the following address:

24.1.1. in the case of NHS England, to NHS England's address for notices set out in the Particulars; or

24.1.2. in the case of the CCG, to the CCG's address for notices set out in the Particulars.

24.2. Notices sent:

24.2.1. by hand will be effective upon delivery;
24.2.2. by post will be effective upon the earlier of actual receipt or five (5) working days after mailing; or
24.2.3. by email will be effective when sent (subject to no automated response being received).

24.3. NHS England may, at its discretion, issue Contractual Notices from time to time relating to the manner in which the Delegated Functions should be exercised by the CCG.

24.4. NHS England may, at its discretion, issue Guidance from time to time, including any protocol, policy, guidance or manual relating to the exercise of the Delegated Functions under this Agreement. NHS England acknowledges that in considering the need and/or content of new Guidance it will engage appropriately with CCGs.

Schedule 1
Definitions and Interpretation

In this Agreement, the following words and phrases will bear the following meanings:

Agreement	means this agreement between NHS England and the CCG comprising the Particulars, the Terms and Conditions and the Schedules;
Agreement Representatives	means the CCG Representative and the NHS England Representative as set out in the Particulars;
APMS Contract	means an agreement made in accordance with section 92 of the NHS Act;
Assigned Staff	means those NHS England staff as agreed between NHS England and the CCG from time to time;
Caldicott Principles	means the patient confidentiality principles set out in the report of the Caldicott Committee (December 1997 as amended by the 2013 Report, The Information Governance Review – "*To Share or Not to Share?"*) and now included in the NHS Confidentiality Code of Practice, as may be amended from time to time;
Capital	shall have the meaning set out in the Capital Investment Guidance or such other replacement Guidance as issued by NHS England from time to time;
Capital Expenditure Functions	means those functions of NHS England in relation to the use and expenditure of Capital funds (but excluding the Premises Costs Directions Functions);
Capital Investment Guidance	means any Guidance issued by NHS England from time to time in relation to the development, assurance and approvals process for proposals in relation to: • the expenditure of Capital, or investment in property, infrastructure or information and technology; or • the revenue consequences for commissioners or

third parties making such investment;

CCG Assurance Framework	means the assurance framework that applies to CCGs pursuant to the NHS Act;
Claims	means, for or in relation to the Primary Medical Services Contracts (a) any litigation or administrative, mediation, arbitration or other proceedings, or any claims, actions or hearings before any court, tribunal or any governmental, regulatory or similar body, or any department, board or agency or (b) any dispute with, or any investigation, inquiry or enforcement proceedings by, any governmental, regulatory or similar body or agency;
Claim Losses	means all Losses arising in relation to any Claim;
Complaints Regulations	means the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009/309;
Contractual Notice	means a contractual notice issued by NHS England to the CCG or all CCGs (as the case may be) from time to time and relating to the manner in which the Delegated Functions should be exercised by the CCG, in accordance with clause 24.3;
CQC	means the Care Quality Commission;
Data Controller	shall have the same meaning as set out in the DPA;
Data Subject	shall have the same meaning as set out in the DPA;
Delegated Functions	means the functions delegated by NHS England to the CCG under the Delegation and as set out in detail in this Agreement;
Delegated Funds	shall have the meaning in clause 13.1;
DPA	means the Data Protection Act 1998;

Enhanced Services	means the nationally defined enhanced services, as set out in the Primary Medical Services (Directed Enhanced Services) Directions 2014 or as amended from time to time, and any other enhanced services schemes locally developed by the CCG in the exercise of its Delegated Functions (and excluding, for the avoidance of doubt, any enhanced services arranged or provided pursuant to the Section 7A Functions);
Escalation Rights	means the escalation rights as defined in clause 16 *(Escalation Rights)*;
Financial Year	shall bear the same meaning as in section 275 of the NHS Act;
GMS Contract	means a general medical services contract made under section 84(1) of the NHS Act;
Good Practice	means using standards, practices, methods and procedures conforming to the law, reflecting up-to-date published evidence and exercising that degree of skill and care, diligence, prudence and foresight which would reasonably and ordinarily be expected from a skilled, efficient and experienced commissioner;
Guidance	means any protocol, policy, guidance or manual (issued by NHS England whether under this Agreement or otherwise) and/or any policy or guidance relating to the exercise of the Delegated Functions issued by NHS England from time to time, in accordance with clause 24.4;
HSCA	means the Health and Social Care Act 2012;
Information Law	the DPA, the EU Data Protection Directive 95/46/EC; regulations and guidance made under section 13S and section 251 of the NHS Act; guidance made or given under sections 263 and 265 of the HSCA; the Freedom of Information Act 2000; the common law duty of confidentiality; the Human Rights Act 1998 and all other applicable laws and regulations relating to processing of

	Personal Data and privacy;
Law	means any applicable law, statute, bye-law, regulation, direction, order, regulatory policy, guidance or code, rule of court or directives or requirements of any regulatory body, delegated or subordinate legislation or notice of any regulatory body (including, for the avoidance of doubt, the Premises Costs Directions, the Statement of Financial Entitlements Directions and the Primary Medical Services (Directed Enhanced Services) Directions 2014 as amended from time to time);
Local Incentive Schemes	means an incentive scheme developed by the CCG in the exercise of its Delegated Functions including (without limitation) as an alternative to QOF;
Local Terms	means the terms set out in Schedule 7 *(Local Terms)*;
Losses	means all damages, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services) proceedings, demands and charges;
National Variation	an addition, deletion or amendment to the provisions of this Agreement mandated by NHS England (whether in respect of the CCG or all or some of other Clinical Commissioning Groups) including any addition, deletion or amendment to reflect changes to the Delegation, changes in Law, changes in policy and notified to the CCG in accordance with clause 22 *(Variations)*;
National Variation Proposal	a written proposal for a National Variation, which complies with the requirements of clause 22.7;
Need to Know	has the meaning set out in paragraph 6.2 of Schedule 4 *(Further Information Sharing Provisions)*;
NHS Act	means the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012 or other legislation from time to time);

NHS England	means the National Health Service Commissioning Board established by section 1H of the NHS Act, also known as NHS England;
Non-Personal Data	means data which is not Personal Data;
Operational Days	a day other than a Saturday, Sunday or bank holiday in England;
Particulars	means the Particulars of this Agreement as set out in clause 1 *(Particulars)*;
Party/Parties	means a party or both parties to this Agreement;
Personal Data	shall have the same meaning as set out in the DPA and shall include references to Sensitive Personal Data where appropriate;
Personal Data Agreement	means the agreement governing Information Law issues completed further to Schedule 4 *(Further Information Sharing Provisions)*;
Personnel	means the Parties' employees, officers, elected members, directors, voluntary staff, consultants, and other contractors and sub-contractors acting on behalf of either Party (whether or not the arrangements with such contractors and sub-contractors are subject to legally binding contracts) and such contractors' and their sub-contractors' personnel;
PMS Contract	means an arrangement or contract for the provision of primary medical services made under section 83(2) of the NHS Act (including any arrangements which are made in reliance on a combination of that section and other powers to arrange for primary medical services);
Premises Agreements	means tenancies, leases and other arrangements in relation to the occupation of land for the delivery of services under the Primary Medical Services Contracts;
Premises Costs	means the National Health Service (General Medical

Directions	Services Premises Costs) Directions 2013, as amended;
Premises Costs Directions Functions	means NHS England's functions in relation to the Premises Costs Directions;
Primary Medical Care Infrastructure Guidance	means any Guidance issued by NHS England from time to time in relation to the procurement, development and management of primary medical care infrastructure and which may include principles of best practice;
Primary Medical Services Contracts	means: • PMS Contracts; • GMS Contracts; and • APMS Contracts, in each case as amended or replaced from time to time and including all ancillary or related agreements directly relating to the subject matter of such agreements, contracts or arrangements but excluding any Premises Agreements;
GP Access Fund	Means the former Prime Minister's challenge fund, announced in October 2013 to help improve access to general practice and stimulate innovative ways of providing primary care services;
Principles of Best Practice	means the Guidance in relation to property and investment which is to be published either before or after the date of this Agreement;
QOF	means the quality and outcomes framework;
Relevant Information	means the Personal Data and Non-Personal Data processed under the Delegation and this Agreement, and includes, where appropriate, "confidential patient information" (as defined under section 251 of the NHS Act), and "patient confidential information" as defined in the 2013 Report, The Information Governance Review – "*To Share or Not to Share?"*);

Reserved Functions	means the functions relating to the commissioning of primary medical services which are reserved to NHS England (and are therefore not delegated to the CCG under the Delegation) and as set out in detail in clause 8.2 and Schedule 3 *(Reserved Functions)* of this Agreement;
Secretary of State	means the Secretary of State for Health from time to time;
Section 7A Functions	means those functions of NHS England exercised pursuant to section 7A of the NHS Act relating to primary medical services;
Section 7A Funds	shall have the meaning in clause 13.18.1;
Sensitive Personal Data	shall have the same meaning as in the DPA;
Specified Purpose	means the purpose for which the Relevant Information is shared and processed, being to facilitate the exercise of the CCG's Delegated Functions and NHS England's Reserved Functions as specified in paragraph 2.1 of Schedule 4 *(Further Information Sharing Provisions)* to this Agreement;
Statement of Financial Entitlements Directions	means the General Medical Services Statement of Financial Entitlements Directions 2013, as amended or updated from time to time;
Statutory Guidance	means any applicable health and social care guidance, guidelines, direction or determination, framework, standard or requirement to which the CCG and/or NHS England have a duty to have regard, to the extent that the same are published and publicly available or the existence or contents of them have been notified to the CCG by NHS England from time to time;
Survival Clauses	means clauses 10 *(Information Sharing and Information Governance),* 13 *(Financial Provisions and Liability),* 14 *(Claims and Litigation)* 17 *(Termination),* 18 *(Staffing),* 19 *(Disputes)* and 20 *(Freedom of Information)*, together

	with such other provisions as are required to interpret these clauses (including the Schedules to this Agreement); and
Transfer Regulations	means the Transfer of Undertakings (Protection of Employment) Regulations 2006, as amended.

Schedule 2
Delegated Functions

Part 1: Delegated Functions: Specific Obligations

1. Introduction

1.1. This Part 1 of Schedule 2 *(Delegated Functions)* sets out further provision regarding the carrying out of each of the Delegated Functions.

2. Primary Medical Services Contract Management

2.1. The CCG must:

2.1.1. manage the Primary Medical Services Contracts on behalf of NHS England and perform all of NHS England's obligations under each of the Primary Medical Services Contracts in accordance with the terms of the Primary Medical Services Contracts as if it were named in the contract in place of NHS England;

2.1.2. actively manage the performance of the counter-party to the Primary Medical Services Contracts in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services including by taking timely action to enforce contractual breaches and serve notice;

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

2.1.4. comply with all current and future relevant national Guidance regarding PMS reviews and the management of practices receiving Minimum Practice Income Guarantee (MPIG) (including without limitation the *Framework for Personal Medical Services (PMS) Contracts Review* guidance published by NHS England in September 2014 (http://www.england.nhs.uk/wp-content/uploads/2014/09/pms-review-guidance-sept14.pdf));

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

2.1.6. keep a record of all of the Primary Medical Services Contracts that the CCG manages on behalf of NHS England setting out the following details in relation to each Primary Medical Services Contract:

2.1.6.1. name of counter-party;

2.1.6.2. location of provision of services; and

2.1.6.3. amounts payable under the contract (if a contract sum is payable) or amount payable in respect of each patient (if there is no contract sum).

2.2. For the avoidance of doubt, all Primary Medical Services Contracts will be in the name of NHS England.

2.3. The CCG must comply with any Guidance in relation to the issuing and signing of Primary Medical Services Contracts in the name of NHS England.

2.4. Without prejudice to clause 13 *(Financial Provisions and Liability)* or paragraph 2.1 above, the CCG must actively manage each of the relevant Primary Medical Services Contracts including by:

2.4.1. managing the relevant Primary Medical Services Contract, including in respect of quality standards, incentives and the QOF, observance of service specifications, and monitoring of activity and finance;

2.4.2. assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety);

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

2.4.4. agreeing information and reporting requirements and managing information breaches (which will include use of the NHS Digital IG Toolkit SIRI system);

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

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

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

Enhanced Services

2.5. The CCG must manage the design and commissioning of Enhanced Services, including re-commissioning these services annually where appropriate.

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

2.7. When commissioning newly designed Enhanced Services, the CCG must:

2.7.1. consider the needs of the local population in the Area;

2.7.2. support Data Controllers in providing 'fair processing' information as required by the DPA;

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

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

2.7.5. consult with Local Medical Committees, each relevant Health and Wellbeing Board and other stakeholders in accordance with the duty of public involvement and consultation under section 14Z2 of the NHS Act;

2.7.6. obtain the appropriate read codes, to be maintained by NHS Digital;

2.7.7. liaise with system providers and representative bodies to ensure that the system in relation to the Enhanced Services will be functional and secure; and

2.7.8. support GPs in entering into data processing agreements with data processors in the terms required by the DPA.

Design of Local Incentive Schemes

2.8. The CCG may design and offer Local Incentive Schemes for GP practices, sensitive to the needs of their particular communities, in addition to or as an alternative to the national framework (including as an alternative to QOF or directed Enhanced Services), provided that such schemes are voluntary and the CCG continues to offer the national schemes.

2.9. There is no formal approvals process that the CCG must follow to develop a Local Incentive Scheme, although any proposed new Local Incentive Scheme:

2.9.1. is subject to consultation with the Local Medical Committee;
2.9.2. must be able to demonstrate improved outcomes, reduced inequalities and value for money; and
2.9.3. must reflect the changes agreed as part of the national PMS reviews.

2.10. The ongoing assurance of any new Local Incentive Schemes will form part of the CCG's assurance process under the CCG Assurance Framework.

2.11. Any new Local Incentive Scheme must be implemented without prejudice to the right of GP practices operating under a GMS Contract to obtain their entitlements which are negotiated and set nationally.

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

Making Decisions on Discretionary Payments

2.13. The CCG must manage and make decisions in relation to the discretionary payments to be made to GP practices in a consistent, open and transparent way.

2.14. The CCG must exercise its discretion to determine the level of payment to GP practices of discretionary payments, in accordance with the Statement of Financial Entitlements Directions.

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

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

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

3. Planning the Provider Landscape

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

3.1.1. establishing new GP practices in the Area;
3.1.2. managing GP practices providing inadequate standards of patient care;
3.1.3. the procurement of new Primary Medical Services Contracts (in accordance with any procurement protocol issued by NHS England from time to time);
3.1.4. closure of practices and branch surgeries;
3.1.5. dispersing the lists of GP practices;
3.1.6. agreeing variations to the boundaries of GP practices; and
3.1.7. coordinating and carrying out the process of list cleansing in relation to GP practices, according to any policy or Guidance issued by NHS England from time to time.

3.2. In relation to any new Primary Medical Services Contract to be entered into, the CCG must, without prejudice to any obligation in Schedule 2, Part 2, paragraph 3 *(Procurement and New Contracts)* and Schedule 2, Part 1, paragraph 2.3:

3.2.1. consider and use the form of Primary Medical Services Contract that will ensure compliance with NHS England's

obligations under Law including the Public Contracts Regulations 2015/102 and the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013/500 taking into account the persons to whom such Primary Medical Services Contracts may be awarded;

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

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

4. Approving GP Practice Mergers and Closures

4.1. The CCG is responsible for approving GP practice mergers and GP practice closures in the Area.

4.2. The CCG must undertake all necessary consultation when taking any decision in relation to GP practice mergers or GP practice closures in the Area, including those set out under section 14Z2 of the NHS Act (duty for public involvement and consultation). The consultation undertaken must be appropriate and proportionate in the circumstances and should include consulting with the Local Medical Committee.

4.3. Prior to making any decision in accordance with this paragraph 4 *(Approving GP Practice Mergers and Closures)*, the CCG must be able to clearly demonstrate the grounds for such a decision and must have fully considered any impact on the GP practice's registered population and that of surrounding practices. The CCG must be able to clearly demonstrate that it has considered other options and has entered into dialogue with the GP contractor as to how any closure or merger will be managed.

4.4. In making any decisions pursuant to paragraph 4 *(Approving GP Practice Mergers and Closures)*, the CCG shall also take account of its obligations as set out in Schedule 2, part 2, paragraph 3 *(Procurement and New Contracts)*, where applicable.

5. Information Sharing with NHS England in relation to the Delegated Functions

5.1. This paragraph 5 *(Information Sharing with NHS England)* is without prejudice to clause 9.4 or any other provision in this Agreement. The CCG must provide NHS England with:

5.1.1. such information relating to individual GP practices in the Area as NHS England may reasonably request, to ensure that NHS England is able to continue to gather national data regarding the performances of GP practices;

5.1.2. such data/data sets as required by NHS England to ensure population of the primary medical services dashboard;

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

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

5.2. The CCG must use the NHS England approved primary medical services dashboard, as updated from time to time, for the collection and dissemination of information relating to GP practices.

5.3. The CCG must (where appropriate) use the NHS England approved GP exception reporting service (as notified to the CCGs by NHS England from time to time).

5.4. The CCG must provide any other information, and in any such form, as NHS England considers necessary and relevant.

5.5. NHS England reserves the right to set national standing rules (which may be considered Guidance for the purpose of this Agreement), as needed, to be reviewed annually. NHS England will work with CCGs to agree rules for, without limitation, areas such as the collection of data for national data sets and IT intra-operability. Such national standing rules set from time to time shall be deemed to be part of this Agreement.

6. Making Decisions in relation to Management of Poorly Performing GP Practices

6.1. The CCG must make decisions in relation to the management of poorly performing GP practices and including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the performers list).

6.2. In accordance with paragraph 6.1 above, the CCG must:

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

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

6.2.3. respond to CQC assessments of GP practices where improvement is required;

6.2.4. where a GP practice is placed into special measures, lead a quality summit to ensure the development and monitoring of an appropriate improvement plan (including a communications plan and actions to manage primary care resilience in the locality); and

6.2.5. take appropriate contractual action in response to CQC findings.

7. Premises Costs Directions Functions

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

7.2. In particular, but without limiting the generality of paragraph 7.1, the CCG shall make decisions concerning:

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

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

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

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

7.5. The CCG must work cooperatively with other CCGs to manage premises and strategic estates planning.

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

Schedule 2
Part 2 – Delegated Functions: General Obligations

1. Introduction

1.1. This Part 2 of Schedule 2 *(Delegated Functions)* sets out general provisions regarding the carrying out of the Delegated Functions.

2. Planning and reviews

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

2.2. The role of the CCG includes:

2.2.1. carrying out primary medical health needs assessments (to be developed by the CCG) to help determine the needs of the local population in the Area;
2.2.2. recommending and implementing changes to meet any unmet primary medical services needs; and
2.2.3. undertaking regular reviews of the primary medical health needs of the local population in the Area.

3. Procurement and New Contracts

3.1. The CCG will make procurement decisions relevant to the exercise of the Delegated Functions and in accordance with the detailed arrangements regarding procurement set out in the procurement protocol issued and updated by NHS England from time to time.

3.2. In discharging its responsibilities set out in clause 6 *(Performance of the Delegated Functions)* of this Agreement and paragraph 1 of this Schedule 2 *(Delegated Functions)*, the CCG must comply at all times with Law including its obligations set out in the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013/500 and any other relevant statutory provisions. The CCG must have regard to any relevant guidance, particularly Monitor's guidance *Substantive guidance on the Procurement, Patient Choice and Competition Regulations*

(https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/283505/SubstantiveGuidanceDec2013_0.pdf).

3.3. Where the CCG wishes to develop and offer a locally designed contract, it must ensure that it has consulted with its Local Medical Committee in relation to the proposal and that it can demonstrate that the scheme will:

3.3.1. improve outcomes;
3.3.2. reduce inequalities; and
3.3.3. provide value for money.

4. Integrated working

4.1. The CCG must take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Professional Networks, local authorities, Healthwatch, acute and community providers, the Local Medical Committee, Public Health England and other stakeholders.

4.2. The CCG must work with NHS England and other CCGs to co-ordinate a common approach to the commissioning of primary medical services generally.

4.3. The CCG and NHS England will work together to coordinate the exercise of their respective performance management functions.

5. Resourcing

5.1. NHS England may, at its discretion provide support or staff to the CCG. NHS England may, when exercising such discretion, take into account, any relevant factors (including without limitation the size of the CCG, the number of Primary Medical Services Contracts held and the need for the Local NHS England Team to continue to deliver the Reserved Functions).

Schedule 3
Reserved Functions

1. Introduction

1.1. This Schedule 3 *(Reserved Functions)* sets out further provision regarding the carrying out of the Reserved Functions.

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

2. Management of the national performers list

2.1. NHS England will continue to perform its primary medical care functions under the National Health Service (Performers Lists) (England) Regulations 2013.

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

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

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

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

2.3. NHS England may hold local Performance Advisory Group (**"PAG"**) meetings to consider all complaints or concerns that are reported to NHS England in relation to a named performer and NHS England will determine whether an initial investigation is to be carried out.

2.4. NHS England may notify the CCG of all relevant PAG meetings at least seven (7) days in advance of such meetings. NHS England may require a representative of the CCG to attend such meetings to discuss any performer concerns and/or quality issues that may impact on individual performer cases.

2.5. The CCG must develop a mechanism to ensure that all complaints regarding any named performer are escalated to the Local NHS England Team for review. The CCG will comply with any Guidance issued by NHS England in relation to the escalation of complaints about a named performer.

3. Management of the revalidation and appraisal process

3.1. NHS England will continue to perform its functions under the Medical Profession (Responsible Officers) Regulations 2010 (as amended by the Medical Profession (Responsible Officers) (Amendment) Regulations 2013).

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

3.2.1. the funding of GP appraisers;
3.2.2. quality assurance of the GP appraisal process; and
3.2.3. the responsible officer network.

3.3. Funding to support the GP appraisal is incorporated within the global sum payment to GP practices.

3.4. The CCG must not remove or restrict the payments made to GP practices in respect of GP appraisal.

4. Administration of payments and related performers list management activities

4.1. NHS England reserves its functions in relation to the administration of payments to individual performers and related performers list management activities under the National Health Service (Performers Lists) (England) Regulations 2013 and other relevant legislation.

4.2. NHS England may continue to pay GPs who are suspended from the national performers list under the Secretary of State's Determination: Payments to Medical Practitioners Suspended from the Medical Performers List (1 April 2013).

4.3. For the avoidance of doubt, the CCG is responsible for any ad hoc or discretionary payments to GP practices (including those under section 96 of the NHS Act) in accordance with clause 6.2.1.4 and Schedule 2 *(Delegated Functions)* Part 1 paragraphs 2.13 and 2.14 of this Agreement, including where such payments may be considered a consequence of actions taken under the National Health Service (Performers Lists) (England) Regulations 2013.

5. Section 7A Functions

5.1. In accordance with clauses 13.17 to 13.20, NHS England retains the Section 7A Functions and will be responsible for taking decisions in relation to the Section 7A Functions.

5.2. In accordance with clauses 13.17 to 13.20, the CCG will provide certain management and/or administrative services to NHS England in relation to the Section 7A Functions.

6. Capital Expenditure Functions

6.1. In accordance with clauses 13.13 to 13.16, NHS England retains the Capital Expenditure Functions and will be responsible for taking decisions in relation to the Capital Expenditure Functions.

7. Functions in relation to complaints management

7.1. NHS England retains its functions in relation to complaints management and will be responsible for taking decisions in relation to the management of complaints. Such complaints include (but are not limited to):

7.1.1. complaints about GP practices and individual named performers;
7.1.2. controlled drugs; and
7.1.3. whistleblowing in relation to a GP practice or individual performer.

7.2. The CCG must immediately notify the Local NHS England Team of all complaints received by or notified to the CCG and must send to the Local NHS England Team copies of any relevant correspondence.

7.3. The CCG must co-operate fully with NHS England in relation to any complaint and any response to such complaint.

7.4. In accordance with clauses 13.21 to 13.23, NHS England may ask the CCG to provide certain management and/or administrative services to NHS England (from a date to be notified by NHS England to the CCG) in relation to the handling and consideration of complaints.

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

8.1. NHS England will carry out such other ancillary activities that are necessary in order for NHS England to exercise the Reserved Functions.

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

8.3. The CCG must assist NHS England's controlled drug accountable officer (**"CDAO"**) to carry out its functions under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

8.4. The CCG must nominate a relevant senior individual within the CCG (the **"CCG CD Lead"**) to liaise with and assist NHS England to carry out its functions under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

8.5. The CCG CD Lead must, in relation to the Delegated Functions:

8.5.1. on request provide NHS England's CDAO with all reasonable assistance in any investigation involving primary medical care services;

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

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

8.5.4. analyse the controlled drug prescribing data available; and

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

Schedule 4
Further Information Sharing Provisions

1. Introduction

1.1. The purpose of this Schedule 4 *(Further Information Sharing Provisions)* and the associated Personal Data Agreement is to set out the scope for the secure and confidential sharing of information between the Parties on a **Need To Know** basis between individual Personnel in order to enable the Parties to exercise their primary medical care commissioning functions in accordance with the law. This Schedule and the associated Personal Data Agreement is designed to:

1.1.1. inform about the reasons why Relevant Information may need to be shared and how this will be managed and controlled by the organisations involved;

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

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

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

1.1.5. apply to the sharing of Relevant Information relating to GPs where necessary;

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

1.1.7. ensure that Data Subjects are, where appropriate, informed of the reasons why Personal Data about them may need to be shared and how this sharing will be managed;

1.1.8. apply to the activities of the Parties' Personnel; and

1.1.9. describe how complaints relating to Personal Data sharing between the Parties will be investigated and resolved, and how the information sharing will be monitored and reviewed.

2. Purpose

2.1. The Specified Purpose(s) of the data sharing initiative is to facilitate the exercise of the CCG's Delegated Functions and NHS England's Reserved Functions:

2.1.1. the management of the primary medical service performers' list in accordance with section 91 of the NHS Act;
2.1.2. management of GP revalidation and appraisal;
2.1.3. administration of payments and related performers list management activities;
2.1.4. planning and delivering the provision of appropriate care services;
2.1.5. improving the health of the local population;
2.1.6. performance management of GP providers;
2.1.7. investigating and responding to incidents and complaints; and
2.1.8. reducing risk to individuals, service providers and the public as a whole.

2.2. Specific and detailed purposes are set out in the Personal Data Agreement appended to this Schedule.

3. Benefits of information sharing

3.1. The benefits of sharing information are the achievement of the Specified Purposes set out above, with benefits for service users and other stakeholders in terms of the improved local delivery of primary healthcare services.

4. Legal basis for Sharing

4.1. Each Party shall comply with all relevant Information Law requirements and good practice in relation to the processing of Relevant Information shared further to this Agreement.

4.2. The Parties shall identify the lawful basis for sharing Relevant Information for each purpose and data flow, and document these in the attached Personal Data Agreement.

5. Relevant Information to be shared

5.1. The Relevant Information to be shared is set out in the attached Personal Data Agreement.

6. Restrictions on use of the Shared Information

6.1. Each Party shall only process the Relevant Information as is necessary to achieve the Specified Purpose, and, in particular, shall not use or process Relevant Information for any other purpose unless agreed in writing by the Data Controller that released the information to the other. There shall be no other use or onward transmission of the Relevant Information to any third party without a lawful basis first being determined, and the originating Data Controller being notified.

6.2. Access to, and processing of, the Relevant Information provided by a Party must be the minimum necessary to achieve the Specified Purpose. Information and Sensitive Personal Data will be handled at all times on a restricted basis, in compliance with Information Law requirements, and Personnel should only have access to Personal Data on a justifiable **Need to Know** basis for the purpose of performing their duties in connection with the services they are there to deliver. The **Need to Know** requirement means that the Data Controllers' Personnel will only have access to Personal Data or Sensitive Personal Data if it is lawful for such Personnel to have access to such data for the Specified Purpose and the function they are required to fulfil at that particular time, in relation to the Specified Purpose, cannot be achieved without access to the Personal Data or Sensitive Personal Data specified.

6.3. Having this Agreement in place does not give licence for unrestricted access to data that the other Data Controller may hold. It lays the parameters for the safe and secure sharing and processing of information for a justifiable **Need to Know** purpose.

6.4. Neither Party shall subcontract any processing of the Relevant Information without the prior written consent of the other Party. Where a Party subcontracts its obligations, it shall do so only by way of a written agreement with the sub-contractor which imposes the same

obligations as are imposed on the Data Controllers under this Agreement.

6.5. Neither Party shall cause or allow Data to be transferred to any territory outside the European Economic Area without the prior written permission of the responsible Data Controller.

6.6. Any particular restrictions on use of certain Relevant Information are included in the attached Personal Data Agreement.

7. Ensuring fairness to the Data Subject

7.1. In addition to having a lawful basis for sharing information, the DPA generally requires that the sharing must be fair. In order to achieve fairness to the Data Subjects, the Parties will put in place the following arrangements:

7.1.1. amendment of internal guidance to improve awareness and understanding among Personnel;
7.1.2. amendment of privacy notices and policies; and
7.1.3. consideration given to further activities to promote public understanding where appropriate.

7.2. Each Party shall procure that its notification to the Information Commissioner's Office reflects the flows of information under this Agreement.

7.3. Further provision in relation to specific data flows is included in the attached Personal Data Agreement.

8. Governance: Personnel

8.1. Each Party must take reasonable steps to ensure the suitability, reliability, training and competence, of any Personnel who have access to the Personal Data (and Sensitive Personal Data) including reasonable background checks and evidence of completeness should be available on request by each Party.

8.2. The Parties agree to treat all Relevant Information as confidential and imparted in confidence and must safeguard it accordingly. Where the Personnel are not healthcare professionals (for the purposes of the DPA) the employing Parties must procure that its Personnel operate under a duty of confidentiality which is equivalent to that which would arise if that person were a health professional.

8.3. Each Party shall ensure that all Personnel required to access the Personal Data (including Sensitive Personal Data) are informed of the confidential nature of the Personal Data and each Party shall include appropriate confidentiality clauses in employment/service contracts of all Personnel that have any access whatsoever to the Relevant Information, including details of sanctions against any employee acting in a deliberate or reckless manner that may breach the confidentiality or the non-disclosure provisions of Information Law requirements, or causes damage to or loss of the Relevant Information.

8.4. Each Party shall provide evidence (further to any reasonable request) that all Personnel that have any access to the Relevant Information whatsoever are adequately and appropriately trained to comply with their responsibilities under Information Law and this Agreement.

8.5. Each Party shall ensure that:

8.5.1. only those employees involved in delivery of the Agreement use or have access to the Relevant Information; and

8.5.2. that such access is granted on a strict **Need to Know** basis and shall implement appropriate access controls to ensure this requirement is satisfied and audited. Evidence of audit should be made freely available on request by the originating Data Controller. These access controls are set out in the attached Personal Data Agreement; and

8.5.3. specific limitations on the Personnel who may have access to the Information are set out in the attached Personal Data Agreement.

9. Governance: Protection of Personal Data

9.1. At all times, the Parties shall have regard to the requirements of Information Law and the rights of Data Subjects.

9.2. Wherever possible (in descending order of preference), only anonymised information, or strongly or weakly pseudonymised information will be shared and processed by Parties, without the need to share easily identifiable Personal Data. The Parties shall cooperate in exploring alternative strategies to avoid the use of Personal Data in order to achieve the Specified Purpose. However, it is accepted that some Relevant Information shared further to this Agreement may be Personal Data/Sensitive Personal Data.

9.3. Processing of any Personal Data or Sensitive Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a **Need to Know** basis. If either Party:

9.3.1. becomes aware of any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted or unusable; or

9.3.2. becomes aware of any security breach,

in respect of the Relevant Information it shall promptly notify the other Party. The Parties shall fully cooperate with one another to remedy the issue as soon as reasonably practicable.

9.4. In processing any Relevant Information further to this Agreement, each Party shall:

9.4.1. process the Personal Data (including Sensitive Personal Data) only in accordance with the terms of this Agreement and otherwise only in accordance with written instructions from the originating Data Controller in respect of its Relevant Information;

9.4.2. process the Personal Data (including Sensitive Personal Data) only to the extent as is necessary for the provision of the Specified Purpose or as is required by law or any regulatory body;

9.4.3. process the Personal Data (including Sensitive Personal Data) only in accordance with Information Law requirements and shall not perform its obligations under this Agreement in

such a way as to cause any other Data Controller to breach any of their applicable obligations under Information Law; and

9.4.4. process the Personal Data in accordance with the eight data protection principles (the **"Data Protection Principles"**) in Schedule 1 to the DPA.

9.5. Each Party shall act generally in accordance with the Seventh Data Protection Principle, and in particular shall implement and maintain appropriate technical and organisational measures to protect the Personal Data (and Sensitive Personal Data) against unauthorised or unlawful processing and against accidental loss, destruction, damage, alteration or disclosure. These measures shall be appropriate to the harm which might result from any unauthorised or unlawful processing, accidental loss, destruction or damage to the Personal Data (and Sensitive Personal Data) and having regard to the nature of the Personal Data (and Sensitive Personal Data) which is to be protected. In particular, each Data Controller shall:

9.5.1. ensure that only Personnel authorised under this Agreement have access to the Personal Data (and Sensitive Personal Data);

9.5.2. ensure that the Relevant Information is kept secure and in an encrypted form, and shall use all reasonable security practices and systems applicable to the use of the Relevant Information to prevent and to take prompt and proper remedial action against, unauthorised access, copying, modification, storage, reproduction, display or distribution, of the Relevant Information;

9.5.3. obtain prior written consent from the originating Data Controller in order to transfer the Relevant Information to any third party;

9.5.4. permit the other Data Controllers or the Data Controllers' representatives (subject to reasonable and appropriate confidentiality undertakings), to inspect and audit the data processing activities carried out further to this Agreement (and/or those of its agents, successors or assigns) and comply with all reasonable requests or directions to enable the Data Controllers to verify and/or procure that the other

Data Controller is in full compliance with its obligations under this Agreement; and

9.5.5. if requested, provide a written description of the technical and organisational methods and security measures employed in processing Personal Data.

9.5.6. Specific requirements as to information security are set out in the Schedule.

9.5.7. Each Party shall use best endeavours to achieve and adhere to the requirements of the NHS Information Governance Toolkit, particularly in relation to Confidentiality and Data Protection Assurance, Information Security Assurance and Clinical Information Assurance.

9.5.8. The Parties' Single Points of Contact (**"SPoC"**) set out in paragraph 14 *(Governance: Single Points of Contact)* below will be the persons who, in the first instance, will have oversight of third party security measures.

10. Governance: Transmission of Information between the Parties

10.1. This paragraph supplements paragraph 9 *(Governance: Protection of Personal Data)* of this Schedule.

10.2. Transfer of Personal Data between the Parties shall be done through secure mechanisms including use of the N3 network, encryption, and approved secure (NHS.net / gcsx) email.

10.3. Faxes shall only be used to transmit Personal Data in an emergency.

10.4. Wherever possible, Personal Data should be transmitted in pseudonymised form, with only reference to the NHS number in 'clear' transmissions. Where there are significant consequences for the care of the patient, then additional data items, such as the postcode, date of birth and/or other identifiers should also be transmitted, in accordance with good information governance and clinical safety practice, so as to ensure that the correct patient record / data is identified.

10.5. Any other special measures relating to security of transfer are specified in the attached Personal Data Agreement.

10.6. Each Party shall keep an audit log of Relevant Information transmitted and received in the course of this Agreement.

10.7. The Parties' Single Point of Contact notified pursuant to paragraph 14 *(Governance: Single Points of Contact)* will be the persons who, in the first instance, will have oversight of the transmission of information between the Parties.

11. Governance: Quality of Information

11.1. The Parties will take steps to ensure the quality of the Relevant Information and to comply with the fourth Data Protection Principle.

11.2. Special measures relating to ensuring quality are set out in the attached Personal Data Agreement.

12. Governance: Retention and Disposal of Shared Information

12.1. The non-originating Party shall securely destroy or return the Relevant Information once the need to use it has passed or, if later, upon the termination of this Agreement, howsoever determined. Where Relevant Information is held electronically the Relevant Information will be deleted and formal notice of the deletion sent to the Party that shared the Relevant Information. Once paper information is no longer required, paper records will be securely destroyed or securely returned to the Party they came from.

12.2. Each Party shall provide an explanation of the processes used to securely destroy or return the information, or verify such destruction or return, if requested by the other Party and shall comply with any request of the Data Controllers to dispose of data in accordance with specified standards or criteria.

12.3. If either Party is required by any law, regulation, or government or regulatory body to retain any documents or materials that it would otherwise be required to return or destroy under this paragraph 12 *(Governance: Retention and Disposal of Shared Information)*, it shall

notify the other Party in writing of that retention, giving details of the documents or materials that it must retain.

12.4. Retention of any data shall comply with the Fifth Data Protection Principle and with all good practice including the Records Management NHS Code of Practice, as updated or amended from time to time.

12.5. Any special retention periods are set out in attached Personal Data Agreement.

12.6. Each Party shall ensure that Relevant Information held in paper form is held in secure files, and, when it is no-longer needed, destroyed using a cross cut shredder or subcontracted to a confidential waste company that complies with European Standard EN15713.

12.7. Each Party shall ensure that, when no longer required, electronic storage media used to hold or process Personal Data are destroyed or overwritten to current policy requirements.

12.8. Electronic records will be considered for deletion once the relevant retention period has ended.

12.9. In the event of any bad or unusable sectors of electronic storage media that cannot be overwritten, the Party shall ensure complete and irretrievable destruction of the media itself in accordance with policy requirements.

13. Governance: Complaints and Access to Personal Data

13.1. Each Party shall assist the other in responding to any request made under Information Law made by persons who wish to access copies of information held about them ("**Subject Access Requests**").

13.2. Complaints about information sharing shall be routed through each Party's own complaints procedure but reported to the Single Points of Contact set out in paragraph 14 *(Governance: Single Points of Contact)* below.

13.3. The Parties shall use all reasonable endeavours to work together to resolve any dispute or complaint arising under this Agreement or any data processing carried out further to it.

13.4. Basic details of the Agreement shall be included in the appropriate log under each Party's Publication Scheme.

14. Governance: Single Points of Contact

14.1. The Parties each shall appoint a single point of contact to whom all queries relating to the particular information sharing should be directed in the first instance. Details of the single points of contact shall be set out in the attached Personal Data Agreement.

15. Monitoring and review

15.1. The Parties shall monitor and review on an ongoing basis the sharing of Relevant Information to ensure compliance with Information Law and best practice. Specific monitoring requirements are set out in the attached Personal Data Agreement.

Template Personal Data Agreement

Data flow : [Description]

Description of information flow and single points of contact for parties involved

Originating Data Controller	[Insert:]			
Contact details for single point of contact for Originating Data Controller	**Name of point of contact**	**Title**	**Contact (email)**	**Contact (phone)**
Recipient Data Controller	[Insert:]			
Contact details for single point of contact of Recipient Data Controller	**Name of point of contact**	**Title**	**Contact (email)**	**Contact (phone)**

Description of information to be shared

Comprehensive description of Relevant Information to be shared	[Insert:]
Anonymised / not information about individual persons	**Yes / No**
Strongly pseudonyimsed	**Yes / No**
Weakly pseudonymised	**Yes / No**
Person - identifiable data	**Yes / No**
Justification for	[Insert or N/A:]

the level of identifiability required	

Legal basis for disclosure and use

DPA Schedule 2 condition/s	[Insert or N/A:]	
DPA Schedule 3 condition/s	[Insert or N/A:]	
Confidentiality	**Explicit consent**	Yes / No [If yes, how documented?:]
	Implied Consent	Yes / No [If yes, how have you implied consent?:]
	Statutory required/permitted disclosure	[Insert statutory basis:]
	Public interest disclosure	[Insert how the public interest favours use/disclosure of the information:]
	Other legal basis	[Insert:]
s. 13Z3 / 14Z23 NHS Act 2006 justification	**S. 13Z3 condition(s) to permit disclosure**	[Insert:]
	S. 14Z23 condition(s) to permit disclosure	[Insert:]
Other specific legal		

considerations	

Restrictions on use of information

[Insert:]

Governance arrangements

Specific measures to ensure fairness to the Data Subject, including privacy impact assessments undertaken	[Insert:]
Access controls on use of information	[Insert:]
Specific limitations on Personnel who may access information	[Insert:]
Other specific security requirements (transmission)	[Insert:]
Other specific security requirements (general)	[Insert:]
Specific requirements as to ensuring quality of information	[Insert:]
Specific requirements for retention and destruction of information	[Insert:]
Specific monitoring and review arrangements	[Insert:]

Schedule 5
Financial Provisions and Decision Making Limits

Financial Limits and Approvals

1. The CCG shall ensure that any decisions in respect of the Delegated Functions and which exceed the financial limits set out below are only taken:

    1.1. by the following persons and/or individuals set out in column 2 of Table 1 below; and
    1.2. following the approval of NHS England (if any) as set out in column 3 of the Table 1 below.

2. NHS England may, from time to time, update Table 1 by sending a notice to the CCG of amendments to Table 1.

Table 1 – Financial Limits		
Decision	**Person/Individual**	**NHS England Approval**
General		
Taking any step or action in relation to the settlement of a Claim, where the value of the settlement exceeds £100,000	CCG Accountable Officer or Chief Finance Officer or Chair	NHS England Head of Legal Services and Local NHS England Team Director or Director of Finance
Any matter in relation to the Delegated Functions which is novel, contentious or repercussive	CCG Accountable Officer or Chief Finance Officer or Chair	Local NHS England Team Director or Director of Finance or NHS England Region Director or Director of Finance or NHS England Chief Executive or Chief Financial Officer
Revenue Contracts		
The entering into of any Primary Medical Services Contract which has or is capable of having a term which exceeds five (5) years	CCG Accountable Officer or Chief Finance Officer or Chair	Local NHS England Team Director or Director of Finance

Capital

Note: As at the date of this Agreement, the CCG will not have delegated or directed responsibility for decisions in relation to Capital expenditure (and these decisions are retained by NHS England) but the CCG may be required to carry out certain administrative services in relation to Capital expenditure under clause 13 *(Financial Provisions and Liability).*

Schedule 6

Template Variation Agreement

Variation Reference:	[insert reference]
Proposed by:	[insert party] [Note – only NHS England may propose National Variations]
Date of Proposal:	[insert date]
Date of Variation Agreement:	[insert date]

Capitalised words and phrases in this Variation Agreement have the meanings given to them in the Agreement referred to above.

1. The Parties have agreed the [National] Variation summarised below:

2. The [National] Variation is reflected in the attached Schedule and the Parties agree that the Agreement is varied accordingly.

3. The Variation takes effect on [insert date].

IN WITNESS OF WHICH the Parties have signed this Variation Agreement on the date(s) shown below

Signed by	**NHS England** **[Insert name of Authorised Signatory] [for and on behalf of] [ ]**
Signed by	**[Insert name] Clinical Commissioning Group** **[Insert name of Authorised Signatory][for and on behalf of] [ ]**

Schedule to Variation Agreement

[Insert details of variation]

Schedule 7
Local Terms

[Note – Local terms may only be agreed between the CCG and NHS England on an exceptional basis and must not derogate from the terms and conditions of this Agreement. Please note that Local Terms may include:

- details of any pooled funds of NHS England and the CCG;
- resourcing arrangements between NHS England and the CCG; and
- details of any particular services that the Assigned Staff will provide to the CCG under Schedule 8.

If there are no Local Terms, state "There are no Local Terms" in this Schedule 7.]

Schedule 8
Assignment of NHS England Staff to the CCG

1. Introduction

1.1. The purpose of this Schedule 8 *(Assignment of NHS England Staff to the CCG)* is to give clarity to the CCG and NHS England, in circumstances where NHS England staff are assigned to the CCG under Model 1 of the Staffing Models.

1.2. In accordance with clause 18 of this Agreement, the Parties have agreed that the CCG may only engage staff to undertake the Delegated Functions under one of the three Staffing Models referred to in that clause.

1.3. The Parties agree and acknowledge that until such time as the CCG's preferred Staffing Model takes effect, the engagement of staff to undertake the Delegated Functions shall be in accordance with the terms of this Schedule 8 *(Assignment of NHS England Staff to the CCG)* (the **"Arrangements"**).

2. Duration

2.1. The Arrangements shall commence on the date of this Agreement and shall continue until the date on which the Parties agree which of the Staffing Models (set out at clauses 18.1.1 to 18.1.3) will be adopted by the CCG and the date on which such Staffing Model shall take effect.

3. Services

3.1. NHS England agrees to make available the Assigned Staff to the CCG to perform administrative and management support services together with such other services specified in Schedule 7 *(Local Terms)* (the **"Services"**) so as to facilitate the CCG in undertaking the Delegated Functions pursuant to the terms of this Agreement.

3.2. NHS England shall take all reasonable steps to ensure that the Assigned Staff shall:

3.2.1. faithfully and diligently perform duties and exercise such powers as may from time to time be reasonably assigned to or vested in them; and

3.2.2. perform all duties assigned to them pursuant to this Schedule 8 *(Assignment of NHS England Staff to the CCG)*.

3.3. The CCG shall notify NHS England if the CCG becomes aware of any act or omission by any Assigned Staff which may have a material adverse impact on the provision of the Services or constitute a material breach of the terms and conditions of employment of the Assigned Staff.

3.4. NHS England shall be released from its obligations to make the Assigned Staff available for the purposes of this Schedule 8 *(Assignment of NHS England Staff to the CCG)* whilst the Assigned Staff are absent:

3.4.1. by reason of industrial action taken in contemplation of a trade dispute;

3.4.2. as a result of the suspension or exclusion of employment or secondment of any Assigned Staff by NHS England;

3.4.3. in accordance with the Assigned Staff's respective terms and conditions of employment and policies, including, but not limited to, by reason of training, holidays, sickness, injury, trade union duties, paternity leave or maternity or where absence is permitted by Law;

3.4.4. if making the Assigned Staff available would breach or contravene any Law;

3.4.5. as a result of the cessation of employment of any individual Assigned Staff; and/or

3.4.6. at such other times as may be agreed between NHS England and the CCG.

4. Employment of the Assigned Staff

4.1. NHS England shall employ the Assigned Staff and shall be responsible for the employment of the Assigned Staff at all times on whatever terms and conditions as NHS England and the Assigned Staff may agree from time to time.

4.2. NHS England shall pay the Assigned Staff their salaries and benefits and make any deductions for income tax liability and national insurance or similar contributions it is required to make from the Assigned Staff's salaries and other payments.

4.3. The Assigned Staff shall carry out the Services from NHS England's places of work and may be required to attend the offices of the CCG from time to time in the course of carrying out the Services. Nothing in this Schedule 8 *(Assignment of NHS England Staff to the CCG)* shall be construed or have effect as constituting any relationship of employer and employee between the CCG and the Assigned Staff.

4.4. NHS England shall not, and shall procure that the Assigned Staff shall not, hold themselves out as employees of the CCG.

5. Management

5.1. NHS England shall have day-to-day control of the activities of the Assigned Staff and deal with any management issues concerning the Assigned Staff including, without limitation, performance appraisal, discipline and leave requests.

5.2. The CCG agrees to provide all such assistance and co-operation that NHS England may reasonably request from time to time to resolve grievances raised by Assigned Staff and to deal with any disciplinary allegations made against Assigned Staff arising out of or in connection with the provision of the Services which shall include, without limitation, supplying NHS England with all information and the provision of access to all documentation and personnel as NHS England requires for the purposes of considering and dealing with such issues and participating promptly in any action which may be necessary.

6. Conduct of Claims

6.1. If the CCG becomes aware of any matter that may give rise to a claim by or against a member of Assigned Staff, notice of that fact shall be given as soon as possible to NHS England. NHS England and the CCG shall co-operate in relation to the investigation and resolution of any such claims or potential claims.

6.2. No admission of liability shall be made by or on behalf of the CCG and any such claim shall not be compromised, disposed of or settled without the consent of NHS England.

7. Confidential Information and Property

7.1. For the avoidance of doubt, this paragraph 8 *(Confidential Information and Property)* is without prejudice to any other provision of this Agreement in relation to confidential information.

7.2. It is acknowledged that to enable the Assigned Staff to provide the Services, the Parties may share information of a highly confidential nature being information or material which is the property of NHS England or the CCG or which NHS England or the CCG are obliged to hold confidential including, without limitation, all official secrets, information relating to the working of any project carried on or used by the relevant Party, research projects, strategy documents, tenders, financial information, reports, ideas and know-how, employee confidential information and patient confidential information and any proprietary party information (any and all of the foregoing being "**Confidential Information**").

7.3. The Parties agree to adopt all such procedures as the other party may reasonably require and to keep confidential all Confidential Information and that the Parties shall not (save as required by law) disclose the Confidential Information in whole or in part to anyone and agree not to disclose the Confidential Information other than in connection with the provision of the Services.

7.4. The obligations under this Agreement apply to all and any Confidential Information whether the Confidential Information was in or comes into the possession of the relevant person prior to or following this Agreement and such obligations shall continue at all times following the termination of the Arrangements but shall cease to apply to information which may come into the public domain otherwise than through unauthorised disclosure by NHS England or the CCG, as the case may be.

8. Intellectual Property

8.1. All Intellectual Property (meaning any invention, idea, improvement, discovery, development, innovation, patent, writing, concept design made, process information discovered, copyright work, trademark, trade name and/or domain name) made, written, designed, discovered or originated by the Assigned Staff shall be the property of NHS England to the fullest extent permitted by law and NHS England shall be the absolute beneficial owner of the copyright in any such Intellectual Property.

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NHS
Wolverhampton
Clinical Commissioning Group

PRIMARY CARE JOINT COMMISSIONING COMMITTEE
March 2017

Title of Report:	General Practice Forward View Implementation Plan 2017-19
Report of:	Sarah Southall, Head of Primary Care
Contact:	As above
Primary Care Joint Commissioning Committee Action Required:	☐ **Decision** ☒ **Assurance**
Purpose of Report:	The General Practice Forward View was published in April 2016 & sets out a series of pledges and aspirational changes to achieve a sustainable primary care for the future. Further Guidance issued by NHS England (September 2016) identifies primary care as a 'must do' area for local operational plans 2017-19. In December 2016 the CCG submitted an outline delivery plan to NHS England for consideration. The final version of Wolverhampton's GPFV implementation plan is attached for reference. The document is being shared with a range of other forums during the month of March as follows:- • Primary Care Operational Management Group • Senior Management Team • Primary Care Strategy Committee • Governing Body The plan sets out how the GPFV will be bought to life locally within Wolverhampton, with commentary to support each chapter; investment, workforce, workload, practice infra-structure & care redesign. The plan concludes with an outline programme of work that will be capture each of the 93 projects NHS England are launching. Some projects have already begun, many are yet to commence & will be incorporated into further iterations of the plan. The committee should note that regular assurance reports on this programme of work will be overseen by the Primary Care Strategy Committee from April 2017 and shared periodically with the forums stated above as well.

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Public or Private:	The contents of the report could be shared with the public.
Relevance to CCG Priority:	• Helping people to recover from episodes of ill health or following injury • Ensuring people have a positive experience of care • Treating and caring for people in safe environment & protecting them from avoidable harm
Relevance to Board Assurance Framework (BAF):	Domain 1 – Well Led Organisation
Attachments:	General Practice Forward View Implementation Plan 2017-19

SLS/GPFV-IP1719/Mar17

NHS
Wolverhampton
Clinical Commissioning Group

General Practice Forward View Implementation Plan 2017-19

Your Health & Care Matter

Introduction

Our vision is to achieve universally accessible high quality out of hospital services that promote health & wellbeing for our local community. We seek to ensure that treatment is available in the right place, at the right time and to improve the quality of life for those living with long term conditions and reduce health inequalities.

In Wolverhampton we are supporting the development of new models of care delivery through emerging models that include a small Primary and Acute Care Model and three Multi-Speciality Care Providers. This is helping us to shape primary and community services for the future.

Our Sustainability & Transformation Plan is driven by improving access, care co-ordination leading to better continuity of patient care provided by a range of professionals across the city that requires transformation of primary care services;

- **Better health:** through reducing long term condition prevalence, reducing the number of deaths in hospital and social isolation but increasing the number of people feeling supported with long term conditions.
- **Better Care:** through improved access & co-ordination of care, patient experience of GP, community & other place based services such as maternity & end of life services. Clinical outcomes will be improved by multi-disciplinary team working for deliver of our care pathways that will lead to standardising access to care. Patient experience improves through co-production & patient activation; delivering more efficient care and preventative services will reduce the necessity for ongoing provision as time progresses. Safety and quality of service will be safeguarded through standardised access & pathways; improved community and reduction in variation.
- **Sustainability:** resource sustainability will be realised through a changing culture & improved staff retention, reductions in emergency bed days, admissions to hospital and use of acute beds, nursing and social care placements.

Our Primary Care Strategy (January 2016) is built on firm foundations as detailed in the General Practice Forward View and sets out how we will transform primary care in Wolverhampton. We have adopted a programme management office approach to ensuring the delivery of our primary care strategy and through close working with NHS England we are pro-actively prepared for and responsive to a range of projects being lead nationally that have an impact on primary care in Wolverhampton.

Operational Plan 2017-19

Our plans for Primary Care are set out in detail in the strategy approved by the Governing Body in January 2016 and the focus through 2017/18 and 2018/19 will be implementing the extensive programme of work that is now well underway. The implementation plans underpinning delivery of the strategy recognise and respond to the many influences of NHSE's General Practice Five Year Forward View to deliver improved access to primary medical services through practices working at scale to meet the needs of their patients.

We will continue to support practices to come together as groups to meet the needs of their patients on a shared basis. There are currently four collaborative groups made up of ca. 40 practices who are working together to provide care at scale for their local population based on National Association of Primary Care 'Primary Care Homes' and Medical Chambers models. We anticipate that, as they develop proposals for new ways of delivering care, this will rationalise into two formal MCP organisations, based on appropriate patient populations that will enable the delivery of sustainable services. We anticipate that these emerging MCPs will directly provide Community based services with a close and direct link to proactive and close population health support and health management. Their approach to providing care, with additional health care professionals on hand to respond to patient presentations is intended to prevent patients losing independence and/or deteriorating without the appropriate intervention from skilled health and social care professionals. Practices will be open longer, offering flexibility in appointment times into the evening and on Saturdays and where necessary a level of cover on Sundays that will be closely aligned with the out of hours service that is also strengthened to accommodate periods of increased demand. This will be a transformational change for Wolverhampton and we will utilise the financial support available to support practice groups – our emerging MCPs, to tackle the ten high impact actions advocated by NHSE and detailed in the Primary Care strategy. We will develop a menu of support for practices/groups to develop their skills and capability to work differently from 2017. Some examples of the types of support we are committed to:-

- Releasing time for care by accessing national resource and expertise to help practices adopt proven innovations quickly, safely and sustainably;
- Building capability for improvement through providing training and coaching for clinicians and managers to develop skills in leading change;
- Using funding to support the development of administrative staff to play a greater role in active signposting and managing more incoming correspondence;
- Actively enabling the use of technology for patient consultations, further strengthened by national funding that the CCG will direct towards helping GPs spend more time with those that need their attention most;
- Encouraging allegiances with community pharmacies, supporting practices to actively support patients accessing pharmacies for minor ailments and better medicines use by patients with long term conditions.
- Continuing to signpost practices towards national programmes such as the Practice Resilience Programme that will enable them to address issues and share learning.

A key milestone will be reached in April 2017, when the CCG embarks on a new approach to commissioning primary care in Wolverhampton, assuming fully delegated responsibility from NHSE. The CCG will purchase health care based on local population need, with particular emphasis placed on improving outcomes for patients with the most complex care needs by ensuring they receive support to meet their health needs as close to home as possible.

Primary Care Strategy

Delivery of the strategy spans a five year period that commenced in 2016 and is anticipated to conclude by 2021. The vision is reliant upon the transference of a range of services that have traditionally taken place in a hospital setting in order for us to reduce demand on secondary care and treat patients in the community. The strategy is underpinned by a programme of work that spans a number of enabling groups.

Each task & finish group was established in 2016 and they have embarked upon bringing the strategy to life with a defined and measurable programme of work to implement the strategy. Seven Task & Finish Groups specifically responsible for developing primary care: Practices as Provides; Localities/Practice Groups as Commissioners; Primary Care Contracting; Workforce; Clinical Pharmacist Role; Estates, Information Management & Technology.

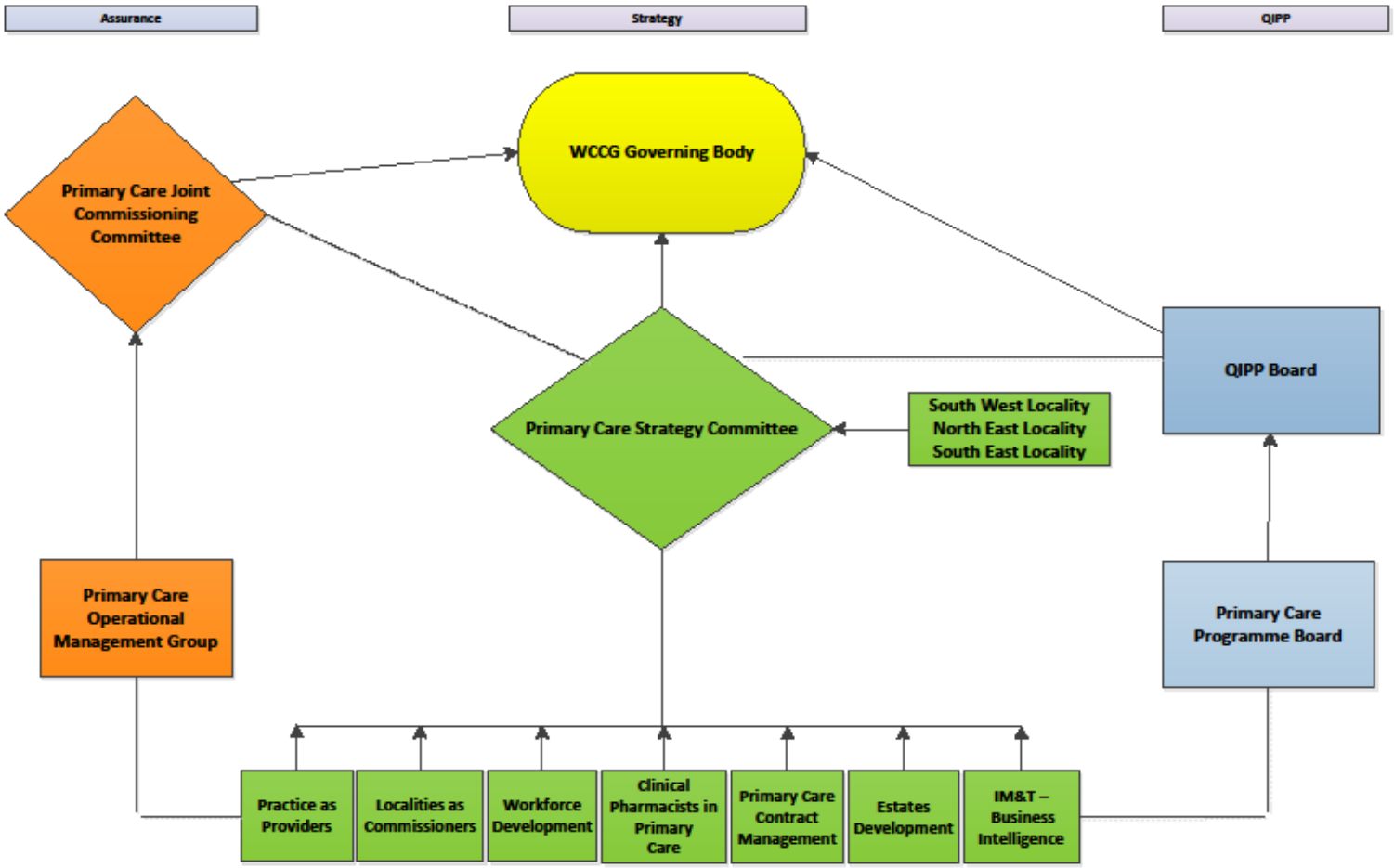
Governance arrangements have been established via the formation of a Primary Care Strategy Committee, a sub committee of the Governing Body. The following slides outline the governance arrangements. It is recognised that there are a number of development activities that will need to take place over the coming years. These are reflected in our organisational development plan & corresponding maturity model (see following slides).

Our governance framework includes the integration of GPFV projects at committee level. Additionally, GPFV is a standing item this dovetails with the developments of the emerging new models of care (MCPs). This is also illustrated in subsequent pages.

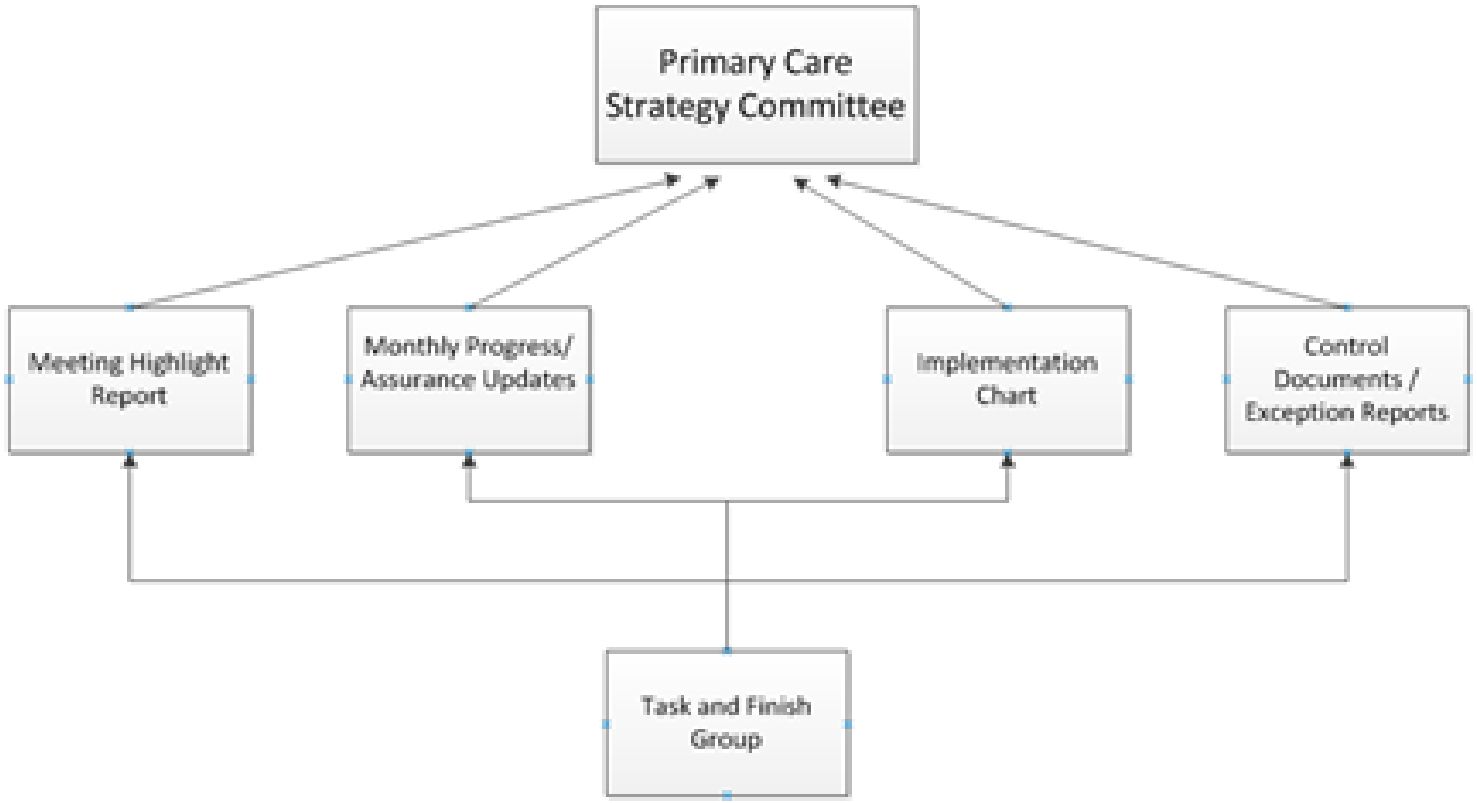
Practices are actively aligning themselves with their preferred model., This not only advocates working at scale but is very closely linked to care redesign. We anticipate that these new ways of working will aid us to identify the sustainable primary care organisation(s) we require for the future. Our demand management plan, introduced during 2016 comprises of a number of projects designed to manage the demand placed on secondary care and improve clinical effectiveness across each sector of the health economy.

Our strategy has been co-designed with member practices. As a membership organisation we are committed to collaborative working. Joint implementation of a very different way of working over the coming years continues to be undertaken in partnership with our group leaders. Our programme of work and accompanying documents demonstrate how this transformation will take place. We will also be launching in 2017/18 a series of locally defined quality indicators that build upon the National Quality Outcomes Framework as we strive for continuous improvement.

Primary Care Strategy Governance



PROGRAMME DELIVERY AND ASSURANCE



Transformational Support

Transformation funding made available from the CCGs allocation will be used to incentivise practices to improve access and champion each of the Ten High Impact Actions over a 2 year period (see investment). This is in addition to existing funding that has enabled practices to work at scale via dedicated Project Management Support provided by the CCG.

We are committed to continued development of sustainable practice groups. Our maturity model provides a roadmap for how we will achieve this - supporting the development of management structures, focusing on service delivery, contractual preparedness and a range of characteristics and financial models. Pivotal to the development of the MCP organisation(s) is collaborative working with the CCG.

Expected outcomes captured within our wider plans for primary care are end to end pathways provided on a citywide footprint. Priority areas are end of life, district nursing, musculo-skeletal service etc. This will be underpinned by MCP contracts that will replace existing standard contracts including DES's/LES's.

Transformational phasing is detailed in our organisational development model (see following slide) this coincides with our Primary Care Strategy implementation and includes GPFV influences as well, to ensure an inclusive approach.

Online GP consultation is a key priority for Wolverhampton. Practices are already working at scale to provide GP and nursing appointments on a shared basis across their group(s) via access to the electronic patient record. Further work is underway:

- Information sharing agreements completed to enable working at scale via clinical systems & interoperability where different clinical systems are in use, due to go live late February 2017
- From April 2017 online consultations will go live at group level, enabling practices to work at scale using a range of consultation types (telephone i.e. voice, text or video call, email as well as face to face) & improve access to appointments i.e. reducing waiting times and providing more evening & weekend appointments.
- Incentives attached to this project as part of the 2 year scheme (see investment) has been made available on a recurring basis & included within the baseline budget for Primary Care beyond 2019

All of the above activities will be overseen by our Primary Care Strategy Committee.

Furthermore, there are 9 PMS practices that remain in the city. We will ensure they are duly supported during the transition to alternative contract types (by 2022). As part of the collaborative contract review visits, attention will be given to the practices' business planning to ensure reductions in revenue are reflected. This will provide an opportunity to ensure these reductions in income does not result in a reduction the level of patient facing services already in place. Practices will be encouraged to hold discussions within the respective emerging MCPs to explore opportunities for collaboration & working at scale & will also benefit from participation in the Practice Resilience Programme to ensure a pro-active approach to manage change.

Links Across the STP - Your Health & Care Matter

Place based working across the Black Country STP has, since summer of 2016, focused on how each local Health Economy plans to integrate pathways to achieve the following objectives:-

- Improve the health and wellbeing of local people
- Improve the quality of local health and care services
- Deliver financial stability and efficiencies throughout the local health care system

Priorities from across the Black Country were reflected in the STP Plan ~~that was~~ developed in collaboration ~~among~~ with health & social care partners.

In Wolverhampton we have a small Primary and Acute Care Model and three emerging Multi-Speciality Care Providers. This is helping us to shape primary and community services for the future.

Our priority is to provide care that is easier to access, in the right place, at the right time and affords continuity throughout the patient journey. It follows our focus is to improve access, care continuity & care co-ordination among professionals.

Our Better Health & Care Plan was shared publicly at the end of 2016 & delivery of the plan across the STP is now underway:-

- Regular peer meetings among Primary Care professionals
- Collaborative approach to the provision of admin & reception training
- Black Country GPFV Event planned for 29 March 2017
- Commitment to transform mental health and learning disability services
- Improving maternity and infant health
- Creating a place where people want to work
- Providing the highest quality buildings to deliver health and care
- Improve patient outcomes & increase patient satisfaction
- Get patients and people who use services to the right place at the right time
- Support people to self-care to maximise independence reduce dependence on health & social care services
- Best Practice/Information Sharing workshops are due to commence in April 2017 for all health & social care stakeholders to showcase & develop service provision across the Black Country
- Local Workforce Advisory Board also meeting to ensure consistent approach to workforce challenges & development

GPFV Readiness Overview

There are many strands to the implementation of the GPFV that require support and input from a range of teams/personnel. Early in 2016 our Executive Team reviewed each of the chapters within the GPFV recognising the extent of work required. Each of strands defined within the chapters have been revisited with the Senior Management Team and scored to confirm their current and anticipated status i.e. already underway (score 1 or 2) and our organisational readiness is confirmed (score 3). This will lead to implementation of MCP contracts anticipated in 2018/19 (score 4).

The scores will be subject to regular monitoring and review to ensure timescales are indeed being achieved, these will be agreed with respective leads & managed as part of the Primary Care programme Management Office approach.

	GP Forward View Implementation	
	Key: Please indicate for each initiative (task) below whether (in the DCO view) that CCG is:	
	1) Already implementing	
	2) Ready to begin to implement this year (16/17)	
	3) Will be ready to implement next (i.e. 17/18)	
	4) Aims to implement later (18/19 or 19/20)	
GPFV chapter Ref	Task	Wolverhampton CCG
	Chapter 1 - Investment in General Practice	
5.2	CCG investment of £3 per head population in developing/supporting primary care provision: The CCG investment is designed to be used to: - stimulate development of at scale providers for extended access delivery: - stimulate implementation of the 10 HIC in order to free up GP time to care; - secure sustainability of general practice to improve in hours access	3
1.5	Will have achieved equitable funding of Practices across GMS/PMS and APMS	3
1.7	Development of single LA/CCG investment arrangements into General Practice through Better Care Fund	3

GPFV Readiness Overview

Chapter 2. - Workforce		
2.1	Plans to increase training in General Practice	1
2.4	CCG supporting Practices to recruit	1
2.5	CCG seeking to recruit GPs from overseas	NA
2.7	CCG has initiatives in place to support GPs retention to return to work or delay leaving General Practice, such as developing portfolio posts, bursary for working in hard to recruit area or other local initiatives e.g. investment in leadership development, coaching and mentoring skills for experienced doctors	3
2.12	Investment in practice nurse measures, including return to work, improve training capacity, increase number of nursing pre-registration placements in primary care, improve retention	1
2.13	Extension of clinical pharmacy working in General Practice	1
2.21	General practice nurses access to mentorship training	1
2.26	CCG supporting practices to implement QNI Voluntary Education and Practice Standards for Practice Nurses	3
2.22	Working with GP Federation to create locum bank (or benefit for more commitment for locums to support General Practice within that CCG area)	3
2.23	Support for GP federations to better manage GP Locum rates	3
2.25	Support Practices to train/use Physicians Associates within General Practice	1
2.27	Practices in CCG have access to and support from Multi-disciplinary training hubs	1 & 2
Chapter 2 - Workforce initiatives to help manage workload pressures in General Practice		
2.14	Propose use of Community Pharmacy to reduce workload pressures in General Practice	1
2.15	Use of Mental health therapists working directly in support of General Practice	3
2.16	Training of care navigators/medical assistants/reception and clerical staff	2
2.17	Propose to pilot new medical assistant roles to support General Practice	3
2.18	Development of direct patient access to physiotherapists to reduce workload in General Practice	2
2.19	Investment in development of practice managers	3
2.24	DCO to have commissioned support (Occupational Health service) for GPs facing burn out	2

GPFV Readiness Overview

Chapter 3. - Workload		
3.1	CCG accessing new national development programme	1
3.2	CCG supporting programme of self-care for patients	2
3.4	CCG plans to reform and integrate OOHs/111 service	2
3.5	CCG engaged and active participant in new DCO Practice resilience programme	1
3.8	CCG introduced GP access to hospital consultant hotline for advice and support	2
3.9	CCG to support GP Practices to implement New GPIT software to automate tasks	2
3.13	CCG proposes to amend national QOF, and AUA (or other National) Enhanced Services to ease GP workload	3
3.17	CCG developing IT strategy to accelerate moves to paper-free NHS	1
3.18	CCG supporting/encouraging greater GP Practice use of Electronic prescriptions	1
3.20	CCG support for GP Practices to use new (planned) Audit tool to help practices identify how they can reduce demand	1
3.21	CCG support to practices to adopt Automated appointment measuring interface	3
3.23	Promote social prescribing	2
Chapter 4: - Practice Infrastructure		
4.1	CCG submitted schemes and active participant in Estates and Technology transformation programme	1
4.4	CCG has an active NHS LIFT / public/private partnership to develop NHS Premises in local area	1
4.5	CCG/LDP proposals to support patients / practices to take up online patient consultation systems	3
4.6	CCGs are commissioning new core GP IT services	1
4.7	GP Federation / New Model of Care Organisations established across whole CCG which is supporting working / sharing across practices and IT interoperability	2
4.8	CCG has strategy in place to put WIFI services in all GP practices	1
4.9	CCG digital strategy supports delivery of Apps/digital self care	3
4.12	Roll out of pharmacy summary care record across CCG area	1
Chapter 5: Care Redesign		
5.1	Deliver the access commitment, including integration of extended access with out of hours and urgent care, enhanced urgent care services, learning from the GP Access Fund and Vanguard sites to support mainstreaming improvements	2
5.3	CCG propose use of New MCP contract to support 'bigger at scale' primary care provision	4
5.5	CCG funding and supporting protected learning time for practices	1

Chapter 1 : Investment in General Practice

The CCGs increased allocation to primary care in 2017/18 will be 4.9% this will be used to fund local initiatives including:-

- Quality Premium : Incident Investigation Training, Complaints Management Training, Peer Review, Risk Stratification
- Social Prescribing : Develop & improve the inclusion of health services in the city's Directory of Services, commission social prescribing advisors
- New Models of Care : Continued investment in workforce ie Project Management Support, Innovation Bids for working at scale
- Newly Commissioned Pathways : End of Life, District Nursing, MSK, Community Echocardiography, Counselling, Diabetes etc
- DES/LES & QoF Plus : Review of national indicators, development of locally defined quality indicators
- PMS Premium : Enhanced Health in Care Homes, General Practice Peer Review, Reduction in Avoidable Admissions – Asthma , Enhanced Review – COPD

The CCG will fund practice(s)/group(s) via a locally developed 2 year incentive scheme that seeks to build on existing investment to support our emerging MCPs to work at scale and will not **only improve access** but make primary care in Wolverhampton **sustainable for the future**. This will be achieved through a collaborative approach to providing improved access among practices, who will be encouraged to work at scale (within their groups) to offer a range of additional appointments for patients during the evening & weekend. Support staff in addition to GPs are planned: Clinical Pharmacists, Nurses, Counselling & Social Prescribers. The incentive scheme will be underpinned by the principles of the 10 high impact actions in 2017/18 & whilst improving access funds will not be available until 2018/19 we are keen to maintain momentum with work already underway in the city to improve access. Therefore, in 2017/18 we will strive to provide an additional 20 minutes consultation time per 1,000 population rising to 45 per 1,000 population in 2018/19 so that our practices achieve the 2019 milestone.

The **10 High Impact Actions** will be used as the basis for the local incentive coupled with improving access & new appointment systems patients will be actively encouraged to sign up for online services during a series of engagement roadshows planned through 2017 to maximise work in the following areas through working with our partners across health, social care and the private sector:-

- Active Signposting
- New Consultation Types
- Reduce DNAs
- Productive Workflows
- Personal Productivity
- Partnership Working
- Social Prescribing
- Support Self Care
- Develop QI Expertise

Financial Assumptions (based on 262,000 population)	2017/18	2018/19
CCG Recurrent Transformation Support £1.50 per head	£500,000	£500,000
NHS England Improving Access Funding	£0	£967,635
Scheme Value Year 1	£500,000	
Scheme Value Year 2		£1,467,635
Scheme Value Overall	**£1,967,635**	

Success will be overseen by our Primary Care Strategy Committee to ensure our practice groups/MCPs are developing as anticipated as MCPS in our maturity model & patients are not only satisfied with improvements we are making with access but also working with us to strive for continuous improvements that are reasonably achievable.

Investment in General Practice continued

Care Navigation Training

Training for administrative and reception staff will commence in March 2017, our plan has been co-produced with member practices, the Local Medical Committee (LMC) and co-ordinated by the CCG to ensure funds allocated to the CCG are spent in line with NHS England's specification to undertake active signposting and document management. Details of our 3 year plan are detailed below:-

Funding Allocations	programme Content	Allocation
2016/17 : Training for administrative & reception staff (Year 1)	• Review & update of Directory of Service ensuring one central citywide Director of Service is developed & owned by practice staff. • Introductory Training for practice admin staff defining the role of the administrator, care navigation & document management. • Monitoring & effectiveness of new skills acquired from this training will be undertaken in conjunction with our Practice Managers Forum & New Models of Care Leads	£23,000
2017/18 : Care Navigators & Medical Assistants (Year 2)	• Continuation of care navigation & promote every contact counts (MECC) with practice personnel & medical assistants • Relaunch of Directory of Services with stakeholders across the city including Social Prescribing & Promotion of Self Care & Signposting Patients to other sources of support including Pharmacies • Online training for all care navigators & medical assistants, including Practice Managers to demonstrate understanding of new skills & utilisation of the DOS • Provision of peer support & mentoring support for practice groups/MCPs • Patient awareness campaigns including diabetes, smoking cessation, sexual health & other local priorities through collaboration with Public Health and local pharmacies • Commence document management system project to improve administrative activities through a consistent approach to coding & managing patient correspondence	£46,385
2018/19 : Care Navigators & Medical Assistants (Year 3)	• Continuation of awareness & online training provisions, including MECC • Implementation of document management system to enable consistent coding & management of patient correspondence • Monitoring to determine benefits realisation, learning & improvements will continue to take place via our Practice Manager's Forum	£46,220

Oversight of Care Navigation Training plan will take place at the Primary Care Strategy Committee to ensure that each component is duly delivered. Discussions with fellow CCGs from across the Black Country STP continue to take place to explore how we may collaborate providers (announced mid December 2016) continue to take place. A fully worked up plan will be attached in the February 2017 iteration of this plan.

Investment in General Practice continued

Vulnerable Practice Programme

One Wolverhampton practice is already taking part in this programme (commencing January 2017).
The CCG recognises that the contract and content form the basis of a confidential agreement between the practice & provider. The practice has confirmed that it will be willing to share an overview of the findings from the programme to share their learning and outcomes plus any tips and techniques that may be relevant to other practices in the city.

The impact from this programme will be realised once the practice has implemented its new skills & actions to tackle individual difficulties. Ultimately the practice will transition from a CQC rating of "requires improvement" to "good" or "outstanding".

Practice Resilience programme

There are two practices due to commence this programme. Funding has been approved by NHS England.
Both practices will undergo an initial diagnostic interview based on the detail within their respective applications that will focus on resilience:-

- Practice 1 Workforce Planning & Sustainability
- Practice 2 Estate integration & rationalisation

Both practices are from different practice groups/MCPs, they have agreed to share the headline learning and any tips and techniques identified during their participation in the scheme *that can* be shared with other practices/groups in the city.

We will work with our practice groups/MCPs to determine future need as the groups mature with particular emphasis on organisational readiness, responding to demand, demand management appropriate to and reflective of prevalence in the registered population, importance of profile i.e. personal, organisational & collaborative, engaging effectively with stakeholders etc.
PMS practices may also benefit from participation in the Practice Resilience programme to ensure a pro-active approach to managing the foreseen change.

Bids will be submitted for 2017-18 & 2018-19 encompassing each new model of care in place in Wolverhampton. These will enable practices working at scale to strive for the highest standards for their employees and the care they deliver to their patients. They will demonstrate clinical effectiveness and achieve good or better ratings with the regulator as well as be recognised for their leadership & pro-active & reactive management of primary and community care.

Time for Care programme

Expressions of interest have been good from across the city, responses have been compiled and a bid for this programme to address each of the areas of interest is in train. This programme will further support the successful achievement of our 2 year scheme for improving access & working with patients to identify and co-produce solutions for improvement. There will be a number of focused programmes required for Wolverhampton practices. We anticipate approval from NHS England and the training programme(s) commencing ~~in~~ summer 2017.

Investment in General Practice continued

Online GP Consultation

Patient online services: Wolverhampton CCG is working with its practices to achieve 10% sign up for patient online as a minimum for each practice, although many are exceeding the 10% minimum standard. This will rise to 20% from 2017/18. A series of roadshows commenced in December 2016 and have continued to encourage as many patients as possible to sign up. This includes practices where uptake is almost at target and also cohorts of patients who are less likely to sign up. Locally this is encouraging Practice staff to: be competitive to sign up patients: add information to Practice websites; use technology where appropriate e.g. Jayex TV/scroll; deploy 'Pull up' posters around the patch.

Wolverhampton CCG will be working with NHS England GPFV Transformation Team and practices to implement online consultations. The funding for the project is detailed below:

17/18 - £69k
18/19 - £92k

The programme of work to compliment this investment has already begun, online consultations will be live from April 2017, staff training will be taking place in March and patients are already being encouraged to sign up for online services via dedicated roadshows & continued support from practice staff.

Summary Care Record (SCR): SCR has potential to be used by GPs in new models of care where patients are not registered to them. Wolverhampton CCG was awarded £716k for technology projects as part of the ETTF bid. The projects that the funding will support are:

Wolverhampton Shared Care Record - £320k
Wolverhampton Shared Care Record Infrastructure - £80k
All in One Patient Solution - £271K
EMIS Remote Consultation - £45k

Electronic Prescription Services (EPS) R2 and Phase 4: Wolverhampton GPs continue to use EPS very well, and will hopefully take to Phase 4 as easily as they have with EPS R2, thus participating to overall savings for the NHS.

Estate & Technology Transformation Fund

5 successful ETTF bids totally £1.7m
3 cohort 1 schemes have been signed off and to be delivered by NHSPS by March 2017
Remaining schemes in cohort 2 are scheduled for completion by 2019

Investment in General Practice continued

PMS Premium

We are committed to preserving the funds attached to the PMS Premium to enable the continuation of the following projects:-

- General Practice Peer Review
- Reduction in Avoidable Admissions – Asthma
- Enhanced Review – COPD
- Primary In Reach Team – Enhanced Health in Care Homes

These schemes also compliment our Demand Management Plan as we move through 2017-19 improving outcomes for patients and reductions in avoidable spend in the secondary care setting.

Public Health Services

Section 7A funding for public health services is intended to increase in 2017/18. We will continue to work collaboratively with Public Health, as a fellow commissioner, to ensure we are aligned and consistently commissioning primary care services. Recognition is given to the importance of collaborative commissioning both within the Primary Care Quality Outcomes Framework and Section 7A commissioning intentions for 2017/18 including:-

- Immunisation Programmes
- Screening Programmes – cancer & non-cancer
- Quality Improvement to the Child Health Information Services (CHIS)
- Public Health Services for people in prison & other places of detention (including Children & Young People's Secure Estate)
- Sexual Assault Referral Centres

Service specifications & national standards will be overseen as part of our collaborative contract review visit programme. However, should any difficulties or concerns be identified in year, our collaborative working communication and problem solving tool will be used for each eventuality to mitigate the risk of recurrence or continued non-adherance.

Mental Health Therapists

Fully funded practice based mental health therapists will be embedded within our Community Neighbourhood Teams during 2017-18 to support practice groups/MCPs with improved Primary Mental Health Care.

The Mental Health Strategy is currently under review to ensure Primary Mental Health Care is duly recognised & a Mental Health Project Worker is due to commence in post March 2017 to ensure effective shared care agreements are in place & clinically effective for both patients and clinicians (GPs & Consultant Psychiatrists).

In the meantime, there will be increased provision of mental health counselling for patients, accessible at group level on a shared basis, to prevent patients deteriorating in the community and requiring input from specialist mental health services.

Chapter 2 : Workforce

Governance

The Workforce Task & Finish Group cited in our governance structure & attached programme of work has a range of activities detailed within programme of work comprising:-

- Workforce Scoping & Planning
- "Wolverhampton - A Place to Work"
- Career Development for clinical & non clinical staff
- Pilot mapping skills for new primary care service provision models
- Piloting new roles/new ways of working
- Developing a leadership culture within primary care
- Improving & implementing standards of practice
- Increase training capacity in primary care
- Recruitment & retention
- Develop a primary care workforce development strategy

Local initiatives that have been developed in detail include:-

- A Recruitment Fair due to be held in March 2017 as part of our work to improve recruitment & retention in general practice & explore the feasibility of introducing a bank of suitable personnel to improve sustainability & planning across practice groups/MCPs.
- Practice nurse support provided by our Quality Team has enabled: improved links with Wolverhampton University; increase in the number of nurse training placements; provision of mandatory & clinical skills training; a programme of mentorship training for nurses has also been secured following a high level of interest.
- CEPN Project Manager recently appointed on a shared basis with Walsall CCG to focus on recruitment & retention and increasing student placements.

Working at Scale/New Models of Care

Our workforce task and finish group is working hand in glove with the new models of care/practice groups/MCPs in the city and also those practices not yet aligned. Each model of care is outlined in a previous slide confirming size and type of the models we are supporting. The programme of work seeks to ensure that each model is driven to adopt a series of workforce changes that will strengthen each profession in primary care.

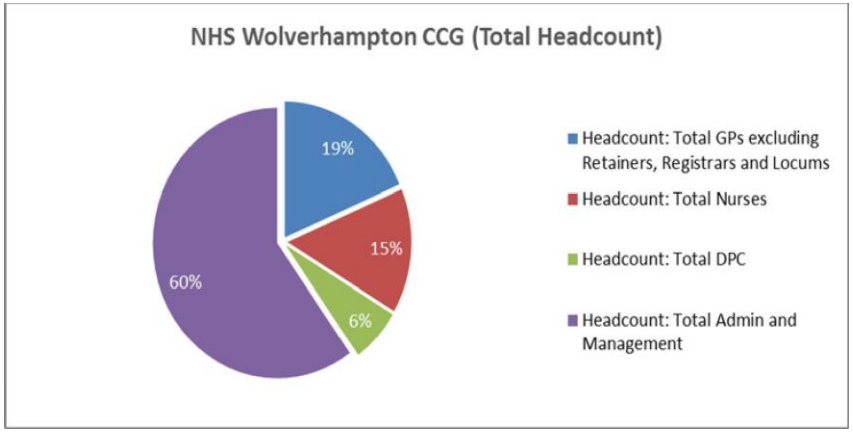
Workforce Risk(s)

Within our Workforce Task and Finish Group their programme of work spans a variety of strands of work pertaining to the development of our workforce, there are however recognised risks including:-

- The age profile of primary care professionals in Wolverhampton, particularly those aged over 54 is 21-31% for GPs, Nurse
- The largest cohort of our workforce are admin/non-clinical personnel which make up 60% of the workforce, 3% more full time equivalents than neighbouring CCGs. A review of back office functions will determine whether this figure is indeed based on need and sustainable for the future.
- Improved access to primary care will become a burden to individual practices if they do not work at scale
- Care navigation is in it's infancy in Wolverhampton, in 2017-19 greater impact in line with the 10 high impact actions will mitigate this risk further
- Continue to work with Wolverhampton University to secure General Practice placements for Physicians Associates (current cohort 20 trainees) across each of our new models of care (emerging MCPs and PACs)
- Loss of student placement sites in Wolverhampton will result in placement with out of area practices
- Risks pertaining to the role of clinical pharmacist were initially unattractive employment options for clinical pharmacists however this risk has been mitigated by a further round of bids to NHS England for 3 years support with funding. Also due to varying funding models and approaches to recruiting Clinical Pharmacists robust clinical networks are being established in the city
- There are 260,037 patients, Wolverhampton has 196 more patients per GP and 62 patients fewer per nurse compared to national benchmarks this is closely linked to the importance of exploration & development of other roles if we are to achieve a sustainable primary care for the future

The following slides provide more detailed information regarding our workforce detailing our headcount, full time equivalents, age profile and workforce compared with patient numbers.

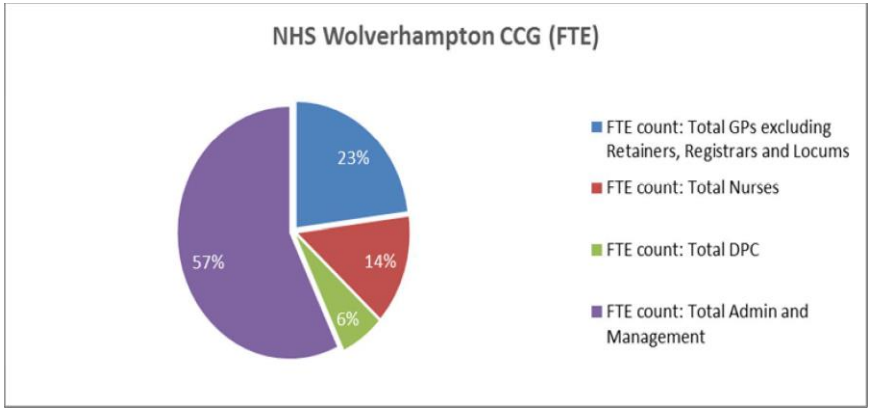
Headcount



Staff Group	Headcount
GPs (excluding Retainers, Registrars and Locums)	**139**
Nurses	**111**
of which Advanced, Specialist and Extended Nurse Roles	*29*
of which District Nurses	*0*
Total Direct Patient Care (DPC)	**49**
of which Therapists (DPC)	*0*
of which Pharmacists (DPC)	*2*
of which Physician Associates (DPC)	*0*
Admin/Non-Clinical	**447**

- In NHS Wolverhampton CCG, there are 139 GPs (excluding Retainers, Registrars and Locums), which make up 19% of the practice workforce
- The largest workforce group is admin/non-clinical, which make up 60% of the workforce, with a headcount of 447
- There are 4% more admin/non-clinical staff in NHS Wolverhampton CCG and 2% fewer GPs when compared with the national percentages (see appendix 5 for national analysis).

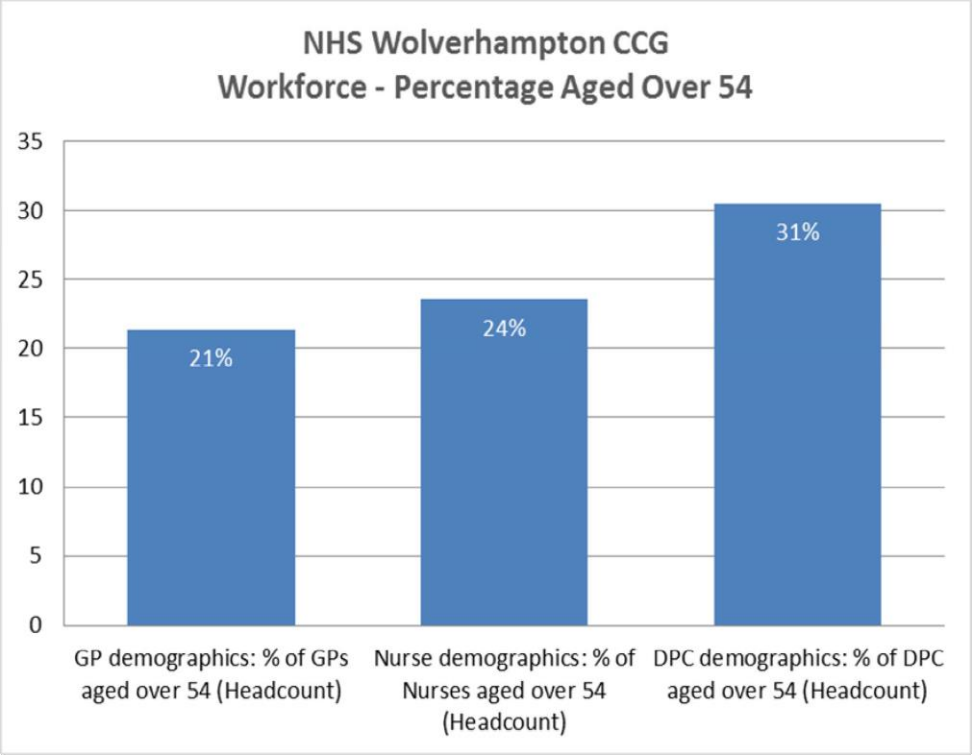
Full Time Equivalents (FTE)



Staff Group	FTE
GPs (excluding Retainers, Registrars and Locums)	**125**
Nurses	**75**
of which Advanced, Specialist and Extended Nurse Roles	*22*
of which District Nurses	*0*
Total DPC	**34**
of which Therapists (DPC)	*0*
of which Pharmacists (DPC)	*1*
of which Physician Associates (DPC)	*0*
Admin/Non-Clinical	**311**

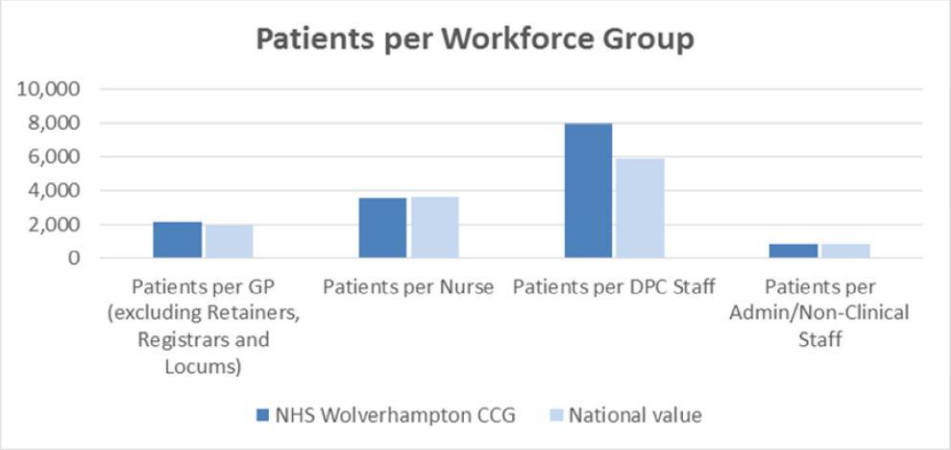
- In NHS Wolverhampton CCG, there are 125 FTE GPs (excluding Retainers, Registrars and Locums), which make up 23% of the practice workforce
- The largest workforce group is admin/non-clinical, which make up 57% of the workforce, with 311 FTEs
- There are 3% more admin/non-clinical FTEs in NHS Wolverhampton CCG when compared with the national percentage and 2% fewer GP FTEs (see appendix 5 for national analysis)
- In secondary care, the proportion of clinical staff to non-clinical staff is significantly higher than in general practice, with only 25% of staff being non-clinical (see appendix 5)

Age Profile of Workforce



- Over one fifth of GPs and nurses in NHS Wolverhampton CCG are aged over 54
- Almost one third of the DPC workforce are aged over 54

Workforce Compared with Patient Numbers



Staff Group	Numbers
FTE: Total GPs (excluding Retainers, Registrars and Locums)	125
FTE: Total Nurses	75
FTE: Total DPC	34
FTE: Total Admin/Non-Clinical	311
Total Patients	269,037
Patients per GP (excluding Retainers, Registrars and Locums) FTE	2,147.8
Patients per Nurse FTE	3,572.4
Patients per DPC FTE	7,971.5
Patients per Admin/Non-Clinical FTE	864.4
GP FTEs (excluding Retainers, Registrars and Locums) per 1,000 Patients	0.47
Nurse FTEs per 1,000 Patients	0.28
DPC FTEs per 1,000 Patients	0.13
Admin/Non-Clinical FTEs per 1,000 Patients	1.16

- There are 269,037 patients in NHS Wolverhampton CCG
- In relation to the workforce, this totals:
  - 2,148 patients per GP
  - 3,572 patients per Nurse
  - 7,972 patients per DCP
- When compared with the national analysis (see appendix 5), in NHS Wolverhampton, there are:
  - 196 more patients per GP
  - 62 fewer patients per Nurse
  - 2,065 more patients per DPC

Chapter 3 : Workload

Clinical Pharmacist(s) Working Practices

Investment has already begun from a variety of practices across the city - some are involved in the national pilot(s). Bids are currently being prepared by the emerging MCPs , with support from the CCG to enable them to not only introduce the role but also begin to experience the benefits of care redesign.

The role of clinical pharmacist has been promoted with GP colleagues it is recognised as an asset to the practice team. Our medicines optimisation team have oversight of the training and development of Clinical Pharmacists.

Development Programmes

A number of practices are participating in development programmes available via NHSE including:-

- Vulnerable Practice programme (1 Practice)
- Practice Resilience programme (2 Practices)
- Time for Care programme (1 group already commenced, 2 further groups anticipated in 2017/18)

Practice Manager Development

Practices attended a regional workshop held in December. Those unable to attend received a copy of the presentation & the topic will be discussed at our local Practice Manager Monthly Meeting. The launch of the Practice Manager Development Programme has been embraced locally, implementation is due to commence shortly. Attendance will be monitored via the General Practice Transformation Board & locally via our Primary Care Strategy Committee.

Selfcare for Patients

As one of the 10 High Impact Actions our local incentive scheme will maximise the opportunities to encourage self-care in all contacts. Practices will promote messages consistent with Choose Well, promoting healthy lifestyle messages (Making Every Contact Count) and proactive self- management of long term conditions through patient-held management plans or training courses & expert patient programmes. We are also exploring the introduction “The Sound Doctor”, a video and online resource to assist patients with condition specific self care.

Practice groups/MCPs are also working with Pharmacy Champions as part of the Healthy Living Pharmacy initiative to promote self care for patients will be delivering a series of campaigns together both in practices and pharmacies across the city.

Access to Consultant Hotline

In line with the national CQUIN for acute hospitals, there is a commitment to further improve advice & support for GPs from secondary care consultants. Consultant Connect is a conduit to enable joint working between primary and secondary care. The Consultant Connect model is a fully supported service and software platform that allows GPs to access immediate telephone advice and guidance from local hospital specialists during a patient consultation to discuss the presenting symptoms. In CCGs where the system has been implemented this has significantly reduced the number of referrals to secondary care. We anticipate implementation of Consultant Connect, in addition to existing support available via Advice & Guidance in 2017.

Ten High Impact Actions – Service & Care Delivery Improvement Map

High Impact Action	Benefits for practice	Benefits for patients	Short Term plan 6 months	Medium Term Plan 12-18 month	Longer Term Plan 24 months +	Measures of success and triggers for practices to receive payment
1 Active signposting Patients towards the most appropriate source of help to include Web and app-based portals which provide self-help resources	Frees GP time. Makes more appropriate use of each team member's skills. Reduces internal referrals.	Improves appointment availability. Reduces low-value consultations and onward referrals. Shorter wait to get to see the most appropriate person.	Reception staff training Social Prescribing Link Workers in post. Agree definitions of low value consultations Monitor the numbers of patients supported by Social Prescribing Link Workers Monitor the impact of SP on number patients supported by the service Enhanced Directory of Services available locally (WIN)	DOS embedded across health & social care sectors Online Care Navigation Training Medical Assistant(s) Role embedded		Number of patients supported by social prescribing Reduction in attendances at practice by patients supported by social prescribing Numbers of patients accessing online directory Reduction in the number of low value consultations
2 New consultation types, such as phone and email.	Shorter appointments (eg phone consultation average 50% shorter, 66% dealt with entirely on phone). More opportunities to support self care with e-consultations, text message follow-ups and group consultations.	Greater convenience, often no longer requiring time off work/caring duties. Improves availability of appointments. More opportunities to build knowledge, skills and confidence for self care.	Phone Consultation Set baseline of phone consultations by practice. Agree trajectory of increasing the % of all consultations undertaken by phone over 6 month, 12-18 month and 24+ months. Complete public awareness campaign on the benefits of telephone consultation and the clinical presentations where this would be appropriate.	E-Consultation improved uptake & availability to patients Simple Telehealth Group Consultations		Number of contacts using new consultation types Increase in number of consultations completed by phone Numbers of patients taking part in group consultations
3 Reduce DNAs	Free GP time. Easier to avoid queues developing, through more accurate matching of capacity with demand.	Improves appointment availability.	Set baseline of DNA rates by practice. Review of practice DNA policies. Agree trajectory of improving attendance rates over 6 month, 12-18 month and 24+ months. Text Messaging to confirm appointments Patients completing appointment cards Appointment Reminders by text Practices reporting attendances (e.g. number of appointments booked and attended)	Telephone follow up Primary Mental Health Strategy implementation		Reduction in practice DNA rates from baseline levels
4 Develop the team	Frees GP time. Makes more appropriate use of each team member's skills. Reduces internal referrals. Improved job satisfaction for administrative staff undertaking enhanced roles.	Improves appointment availability. Reduces low-value consultations and onward referrals. Shorter wait to get to see the most appropriate person.	Workforce training and development programme ie Time for Care, Practice Resilience & Practice Manager Programme	Physician Associates Mental health Support Workers Nursing Associates Admin & Reception Staff/Medical Assistants Practice Managers Practice Pharmacists Minor Illness Nurses		Number of contacts delivered by non medical practice staff Activities undertaken by Medical Assistants
5 Productive work flows Introduce new ways of working which enable staff to work smarter, not just harder.	Frees time for staff throughout the practice. Reduces errors and rework. Improves appointment availability and patient experience.	Improves appointment availability and customer service.	Better work flow for prescriptions, letters and queries	As above Consider ways to release GPs from administrative tasks		Number of additional appointments generated as a result Positive patient experience ie GP Survey/FFT etc
6 Personal productivity Support staff to work in an optimal fashion by reducing waste in routine processes	Frees clinicians to do more in each consultation, with fewer distractions and frustrations. Improves staff wellbeing and job satisfaction.	Improved quality of consultations, with more achieved. Reduced absence of staff.	Computer confidence & greater use of IT (patients/practice staff) Continued support for both individual & team resilience Less administrative work undertaken by clinicians Longer appointment slots for complex patients	Sustained improvement in use of clinicians time		
7 Partnership working Practices working at scale offers benefits in terms of improved organisational resilience and efficiency,	Frees GP time, makes best use of the specific expertise of staff in the practice. Creates economies of scale and opportunities for new services and organisational models.	Access to expanded range of services wrapped around the patient in the community. Reduces delays introduced by referrals to different providers.	Implementation of the Consultant Connect platform or the further development of the Advice and Guidance. Training and development required for both these systems.	Practices working at scale Direct Access to Therapists Work collaboratively with specialists Healthy Living Pharmacies		Number of additional appointments generated through collaborative working Number of direct access referrals to therapists Reduction in the number of referrals to secondary care Number of appointments for patients registered at another practice
8 Use social prescribing Refer or signpost patients to services which increase wellbeing and independence.	Frees GP time, makes best use of their specific medical expertise.	Improved quality of life. Improved ability to live an independent life.	Social Prescribing (12 month pilot intially with commitment to extend) Monitor the numbers of patients supported by Social Prescribing Link Workers Monitor the impact of SP on number of attendances at the practice by patients supported by the service	Reduction in patients who are socially isolated Improved physical/ mental wellbeing & independence GP time freed up for patients with complex needs		Number of patients supported by social prescribing Patient feedback positive experiences of care GP Survey & Complaints/Compliments Improved patient outcomes including reduced presentations within urgent care system
9. Self Care	Frees GP time, makes best use of their specific medical expertise.	Improved ability to live an independent life.	Number of staff in practice completing MECC training Numbers of patients with Long Term Conditions taking part in a LTC review – with a defined self care component Reduce dependance on community neighbourhood teams	Continued reduction in dependency on practice / community neighbourhood team		Number of patients taking part in a comprehensive long term conditions review Number of referrals to Stop Smoking Services Number of referrals to Drug and Alcohol services
10 Build QI expertise	Improved ability to achieve rapid, safe and sustainable improvements to any aspect of care. Increased staff morale and sense of control.	Assurance of continuous improvement in patient safety, efficiency and quality of care.	Timely care provided closer to home Continued co-production of improved service provision through working with PPGs & engaging with population Cohesive team working & commitment to continuously improve care & service quality	Reduction in negative care & service experiences Multi-disciplinary Team Work fully embedded at Practice/Group & Community Neighbourhood Team level		Practice undertaking 1 comprehensive QI project per year. Practice Group & Community Neighbourhood Team Service Quality Dashboard Performance

Workload continued

GP IT Automated Tasks

The IM & T team within the CCG actively review new opportunities to support GPs automation against set criteria to ensure they are viable, time saving and cost efficient.

Wolverhampton CCG are already working on a number of projects these include working in collaboration with GPs to support the development of automated tasks. The Integrated referral forms project was carried out with GPs to ensure that forms are easily accessible via the GP's clinical system. These forms auto populate to ensure that the GPs save time and forms are in the correct format.

The development of the Wolverhampton Shared Care Record project has an end of life module. This supports the auto population of the care plan with demographics and allows the easy transfer data from the clinical system into the plan. This plan will then be accessible across the whole of the Wolverhampton Health economy and can be updated by clinical staff throughout the health economy

Chapter 4 : Practice Infra-structure

Chapter 4 of the GPFV focusses on practice infra-structure. Our Estates and IT Task and Finish Groups have established work programmes detailing projects in place for each of the following areas:-

Project	Start	Completion	Funding Allocation(s)
ETTF Technical ETTF bids was awarded to Wolverhampton CCG to develop three areas • The Wolverhampton Shared Care Plan incorporating Primary care data, secondary care data (Acute, Community & Mental health) and Social care data. • EMIS Remote Consultation -The provision of access to GP clinical systems to view, book appointments and record consultation information on clinical systems within federated GP groups. • ALL in One Patient Solution - The provision of an advanced auto arrival solution that supports the delivery of Health information and the recording of friends and family through a questionnaire module.	01/11/16	31/03/17	£716k
Online Consultation & Interoperability Wolverhampton CCG will be working with NHS England GPFV Transformation Team and practices to implement online consultations.	01/04/2017	31/03/2020	Funding allocation based on National formula
WIFI in Practices Wolverhampton CCG is one of NHS Digital's Wi-Fi early adopters and will complete the roll out of Wi-Fi in GP Practices by 31st March 2017	01/09/16	31/03/17	£168K to include up front costs and two years running costs
Apps to Support Self Care The Wolverhampton Shared Care Record will provide a patient portal to the whole Wolverhampton Health Economy. This will support patients to view their own record and will develop to support the use of wearable's and monitoring devices.	01/04/17	31/03/19	

Chapter 5 : Care Redesign

During 2016 our new models of care have gained momentum in their development that has lead to their capacity and capability being strengthened. Each model of care is committed to tackling the challenges faced in primary care.

Practices took part in a range of Extended Access Schemes that commenced on 24 December:-

- 6 practices provided additional capacity during the Xmas & new year bank holiday(s)
- 7 practices providing additional capacity in hours
- 17 practices participating in group level cover within Primary Care Home (1&2) providing additional capacity for their patients on each Saturday morning from 24 December through until 4 March 2017 funded by the CCG, NHSE & A&E Delivery Board. Cover is provided from 3 sites across the city.

Schemes were designed to alleviate pressure on the urgent care system, initially during the Christmas and new year period, & some extended through until the end of February. We have worked closely with our urgent care lead to assess and manage demand, this has enabled stronger working relationships between 111 and our Urgent Care Centre and practices working together during what is anticipated to be a particularly challenge period. Improved access from 2017 onwards will be achieved by practices working together to provide further appointments during the evening & weekend providing not only GP appointments but also nursing and clinical pharmacists.

Enhanced Health in Care Homes Framework

In order to optimise the health of our population we will continue to build on measures already in place to improve health outcomes for patients in care home settings. Enhanced primary care support will continue based on work of the Primary In Reach Team (PITs) to ensure all homes have consistent GP & primary care cover.

Risk stratification will be undertaken at practice level in conjunction with their designated community matron to identify patients at high risk of admission in order to pro-actively review their care needs and develop a patient centred care plan designed to meet their individual needs. Working in this way enables a number of professionals to work together to develop a multi-disciplinary approach to managing the patients needs with holistic care yet encouraging the patient to own their plan and play a role in self management with support when needed. This approach seeks to reduce unplanned admissions to hospital and provides the patient with a named accountable individual who is responsible for their care co-ordination.

Sustained reduction in admissions to hospital, consistent care for residents in care homes are key outcomes that will demonstrate success. High quality end of life care and reduced length of stay as well as continued clinical quality improvement measures overseen by our Quality Nurse Team are examples of how we measure success Also attached are a series of supporting documents that further demonstrate how we will maximise care redesign including our Primary Care Strategy, Strategy Programme of Work, Operating Plan 2017-19 and STP Plan on a Page.

As we move away from locality level meetings & clinical networks and align with MCP/practice group working we are able to ensure that practices remain engaged in continued development of working at scale & implementation of CCG plans as they mature to be an MCP. Practices have long standing arrangements in place for back fill to enable participation in protected learning, this will continue in future years.

Primary Care - New Models of Care

NHS
Wolverhampton
Clinical Commissioning Group

Aim

Wolverhampton's Primary Care Strategy is underpinned primarily by delivery through a Multi Speciality Community Provider (MCP) contracting model, delivered by care hubs supported by integrated teams.

The introduction of care hubs enable the new care model to deliver improved access, improved care co-ordination and continuity of care in the community whereby care can be provided closer to home and in the community setting as far as reasonably practical.

Scope

- Primary Care Strategy implementation focussing on practice groupings, commissioning at scale provision, estate & IT developments, and clinical & non clinical workforce to cultivate group functionality with new roles to strengthen functionality.
- Community Neighbourhood Teams, wrapped around groups of practices including community matrons, specialist nurses (including paediatrics), social workers, mental health services and the voluntary sector who will oversee patient care.
- Patients will benefit from enhanced care navigation enabling greater choice and shared decision making, advice and support
- Practices working at scale and in close collaboration with out of hours services to enable 24 hour cover in the right place at the right time
- MCPs commissioning services from providers based on population need
- Sustainability of service review based on population need demographics

Partners

- Wolverhampton Care Collaborative, Wolverhampton Total Health and Unity Wolverhampton (MCPs)
- Royal Wolverhampton Trust
- Black Country Partnership Foundation Trust
- Healthwatch Wolverhampton
- Private & independent sector providers
- City of Wolverhampton Council
- NHS England

Status

- Year 1 of 4 year implementation plan
- Primary Care Home (ministerial visit to PCH site November 2017; Wolverhampton Total Health & Wolverhampton Care Collaborative)
- 2017/18 Shadow year (Alliance Agreements)
- 2018/19 MCP Contracts awarded (Partial Integration MCP)
- 2019/20 MCP Contracts awarded (Fully Integrated MCP)
- 2020/21 Business as usual (performance & contract monitoring)

STP Footprint

Black Country

V6.4 January 2017

New Models of Care (Wolverhampton)

NHS Wolverhampton Clinical Commissioning Group

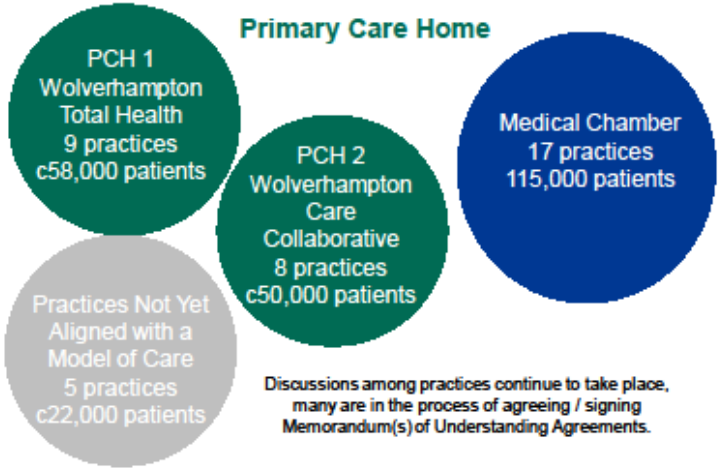
Multi-speciality Care Provider is a new deal for GP's as part of the 5 Year Forward View. This would take the shape of being a collaboration of a group practices i.e. federations, networks or single organisation(s). This is not only an opportunity to standardise back office functions and avoid replication but also a way of expanding leadership to include many healthcare professionals. Across the grouping there will be a collaborative approach to service provision whilst there will be a greater convenience for patients shifting the majority of outpatient consultations & ambulatory care out of hospital settings.

Primary & Acute Care Systems (PACs/VI) is a collaboration between NHS Trusts and GP Practices to meet the needs of registered list(s) of patients. This is an opportunities for trust's to kick-start primary care expansion but reinforce out of hospital care which could evolve into taking accountability for all health needs of a registered list of patients. Part of Vertical Integration is a greater level of back office support which is intended to improve the business element of General Practice.

Vertical Integration (VI)

Primary Care Home is a joint NAPC and NHS confederation programme. Primary Care Home Model is based on care hubs/neighbourhood approach. Supported by the new models programme featuring provision of care to a defined, registered population between 30-50,000 people, function with an integrated workforce with a strong focus on partnerships spanning primary/secondary/social care, a combined focus on the personalisation of care with improvements in population health outcomes, alignment of clinical & financial drivers with appropriate shared risks and rewards.

Primary Care Home



Discussions among practices continue to take place, many are in the process of agreeing / signing Memorandum(s) of Understanding Agreements.

Group Governance Arrangements

CCG Practice Group Governance Arrangements

PRIMARY CARE NEW MODELS OF CARE & MEMBERSHIP GOVERNANCE
Demonstrating clinical effectiveness through implementing the CCG's Primary Care Strategy, responding to the General Practice Five Year Forward View (GP5YFV) & making primary medical services fit for the future.

Priorities:-
Clinicians involved in & influencing care pathways & decision making
Peer Review focusing on Right Care Pathways & reducing variation, improving quality of care
Demand Management including patient choice, referral management and improved outcomes for patients
Risk Stratification (using Aristotle & other clinical data to ensure patient need is met through patient centered and co-ordinated care

Delivery Toolkit:-

Peer Review
Direct access for GPs to Consultant advice

NICE Quality Standards/ TAGs

Aristotle & EMIS

Quality Assurance (safety, experience & effectiveness)

Indicators of Success:-
Increased liaison with secondary care consultants, reduced referrals
Patient care provided closer to home as services transfer into community settings
Improved access ie online, telephone, text consultations, extended opening, 7 day services
Quality Outcomes Framework (National & Local) Monitoring

GENERAL PRACTICE GROUP MEETINGS (Quarterly)
Lead by Nominated Group Leaders:-
Primary Care Home 1
- 9 Practices
- c60,000 patients

Primary Care Home 2
- 8 Practices
- c53,000 patients

Medical Chambers
- 17 Practices
- c115,000 patients

Vertical Integration
- 4 Practices
- c25,000 patients
- Potentially further practices

Remaining Practices
- 5 Practices
- c21,000 patients

Priorities for discussion:-
- Principles of Good Governance
- Monitor Performance (demand, finance & contracts, risk assurance)
- Assisting in consistent commissioning of health services
- Demonstrating local ownership of the group's vision & values
- Demonstrating the furtherance of group working & provision of care closer to home

GROUP LEADER MEETINGS (Monthly)
Lead by the CCG Chairman:-
Primary Care Home : 1) Dr G Pickavance & 2) Dr P Mundlur
Medical Chambers : C Dr K Ahmed
Vertical Integration : Dr J Parkes
Director of Strategy & Transformation
CCG Head of Primary Care

Priorities for discussion:-
- Good Governance including GPs Vision, Values & Issues
- New Models of Care : Care Closer to Home, Information Sharing, Consistent Commissioning, Performance
- Practice development & educational requirements (ie Team W)

CCG MEMBERS MEETINGS (Quarterly)
Lead by the CCG Chairman:-
Attendance from Practices, Primary Care Groups & CCG personnel

Priorities for discussion:-
- Practice Developments
- Primary Care Updates
- Opportunity for all practices to come together & exchange information/ receive updates

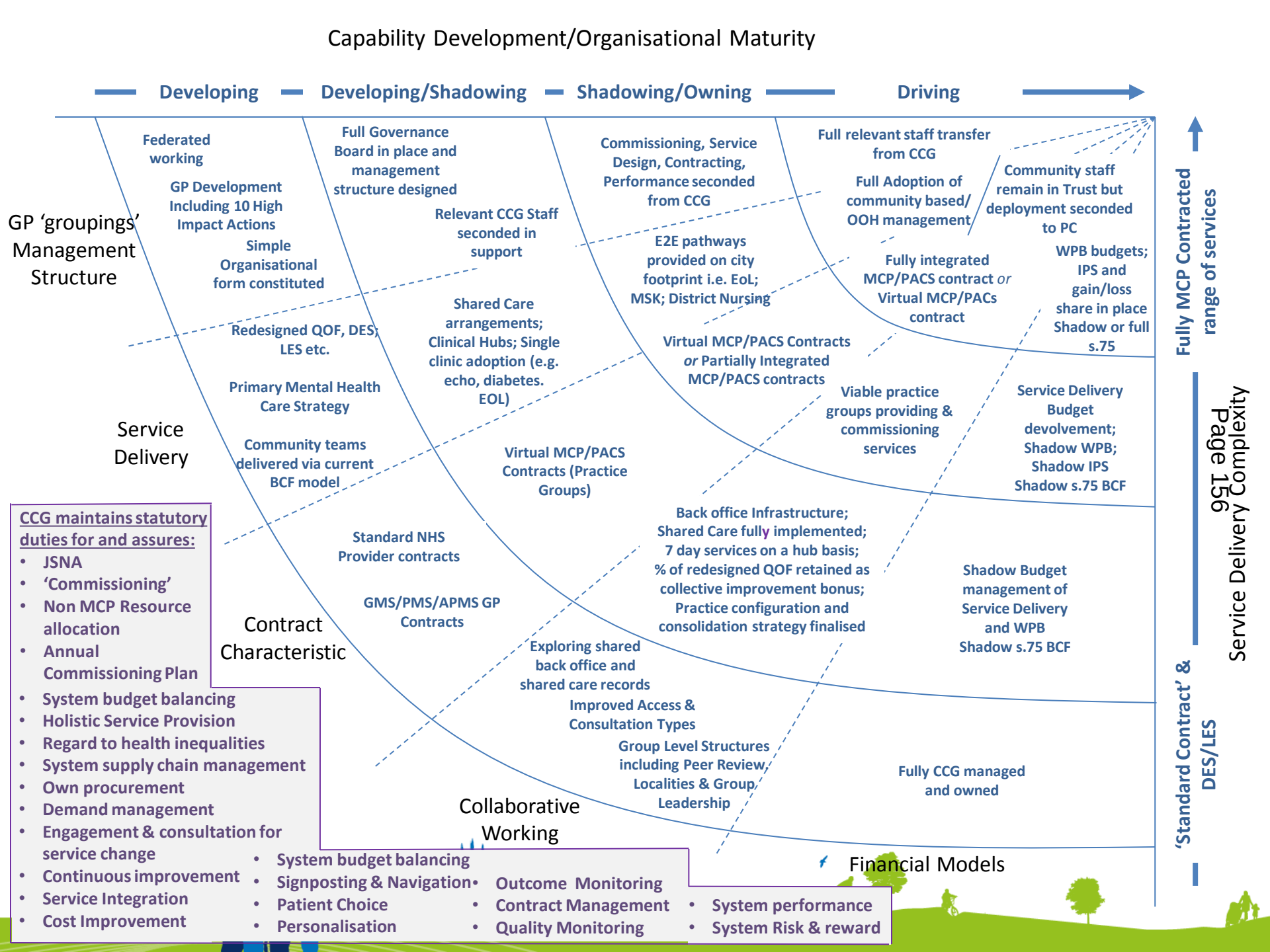
Other forums with an interest in Primary Care:-
- Clinical Reference Group
- Primary Care Commissioning Committee
- Primary Care Strategy Committee (delivery board)
- Governing Body

SLS/V2.0 Feb17

New Models of Care - Implementation Timeline

Organisational Development Plan

Objective	2016/17	2017/18	2018/19	2019/20	2020/21
Primary Care Strategy Implementation	*Back office function review *Practice groups forming *MOUs signed & commenced new ways of working *Ten high impact actions scoped	*Launch 10 high impact action projects (IT etc) *Introduce new roles (Workforce ie Clinical Pharmacist, Mental Health Therapist, Nurse Associate, Physicians Associate & additional GPs) *Strengthen CNTs via our Better Care Programme (Specialist Nurses & Paediatrics) *Improved access (7DS) *Care Navigation; Active Patient Management; Social Prescribing all in place	*Sustain benefits from 10 high impact actions *Co-location of practices & services *Practice mergers - fewer/larger practices *Estate Strategy finalised *Estate Transformation Phase 1	*7 day primary & community services lead by practice groups via MCP contracting route *Estate Transformation Phase 2	*Business as usual for fully implemented model(s) of care including Contract Management, Risk Management, Finance & Performance & Clinical Effectiveness *Estate Transformation Phase 3
New Models of Care (MCP Framework) Primary Care Home 1&2	*Wolverhampton Care Collaborative & Wolverhampton Total Health (companies limited by share) *Priorities identified & responsive plans Launched	*Shadow Year NHS Contract practice/group *Strengthen infra-structure i.e. Business Management etc. *Development of risk adjusted capitated budgets	*MCP Partial Integration of primary & community services *Risk adjusted capitated budgets (shadow year) *Some services continue to be commissioned by CCG	*MCP Full Integration primary & community services (potential inclusion of out of hours strand of urgent care) *Full capability of acting as a lead integrator or as part of a lead integrator model and commissioning & sub-contracting service providers *Risk adjusted capitated budgets (fully integrated)	*Business as usual contracts monitored as all other providers *Provider Contract Review Meetings *Provider Clinical Quality Review Meetings
Medical Chambers	*Unity Wolverhampton (federation) *Alliance working without formalities of limited company *Priorities identified & responsive plans Launched	*Formation of limited company & associated Governance *Strengthen infra-structure ie Business Management etc.			
RWT PACs/VI	*Practices sub contract GMS to RWT *Practice staff employed by RWT	*Development of risk adjusted capitated budgets *See Checkpoint(s) below	*Risk adjusted capitated budgets (shadow year) * See Checkpoint(s) below	*Risk adjusted capitated budgets (fully integrated) *See Checkpoint(s) below	*Business as usual
Commissioned Services – Working at Scale MCPs Providing & Sub Contracting Services	*Enhanced Primary Care Schemes for delivery 2017/18 fully worked up (by Q4) *Consult on service specifications Q4 *Ten High Impact Actions launched *Peer Review of RightCare Pathways *Development of Local Quality Outcomes Framework/Incentive Scheme *Identify areas for priority investment based on population need	*Small scale service provision (EPCS) *Embed ten high impact actions (7DS , reduced DNAs etc) *Phase 1 services/pathways specified & commissioned from MCP; Frail Elderly, Diabetes, EOL, *Phase 2 services/pathways Community services planned *'RightCare' Pathways including LTC Management being addressed by MCPs *Commence transfer or services to community setting i.e. diagnostics (community ECG Reporting & Echo Clinics)	*MCPs & CCG both commissioning different aspects of community services *Including those carried forward from 2017/18 & new services defined in Commissioning Intentions *Roll out of Phase 2 Community Services commissioned from MCPs *Plan service requirements in preparation for full Community Service MCP delivery	*MCPs commissioning/ sub-contracting services i.e. EOL/Community Services, Out of Hours *Full MCP Community services procurement	*Business as usual of at scale delivery of MCP commissioned primary & community Services
Development Support Primary Care Home 1&2	*Project Manager & Gap Analysis (Q2) aligned with PCS Committee *Branding & patient engagement (Q4) *Scope extent of variation among practices & begin standardised approach (Q4)	*CCG based commissioning Support roles including contracting, redesign/ transformation, BI & finance aligned to each group to address business management requirements (secondment/ new posts) *Develop clinical leadership *Continue to reduce variation & improve care quality *Ownership & management of demand ie referrals management & reduce variation	*Continued ownership & management of Demand on services (all sectors) *Benefits realisation of primary care clinical leadership *Commissioning and provision roles confirmed & staff employed/seconded to MCP(s) *Functional business infra-structure Implemented	*Continued development of organisational form & functions	*Business as usual
Medical Chambers	*Project Manager & Gap Analysis (Q3) aligned with PCS Committee *Branding & patient engagement (Q4) *Scope extent of variation among practices & begin standardised approach (Q4)				
RWT PACs/VI	*Project support (Q1→) *First Wave June 2016 (x3 practices) *Second Wave Feb 2017 (2x practices) *Development of trust integration team	* See Checkpoint(s) below	* See Checkpoint(s) below	* See Checkpoint(s) below	*Business as usual
Measuring Success – Dashboard(s)	*Dashboard development & launch * Care Navigation; Active Patient Management; Social Prescribing *Demand Management *Risk stratification & co-ordinated care	*Quarterly monitoring of clinical outcomes *Clinical effectiveness/use of resources *Patient choice & shared decision making *Pro-active approach to population care needs	*Introduce contract & clinical quality review processes to monitor finance, performance & clinical outcomes & reduce variation *Clinical effectiveness/use of resources	*Continuous improvement in all aspects of successful models of care *Strive for consistent	*Business as usual contracts monitored as all other providers *Provider Contract Review Meetings *Provider Clinical Quality Review Meetings


Capability Development/Organisational Maturity
Developing
Developing/Shadowing
Shadowing/Owning
Driving
GP 'groupings' Management Structure
Federated working
GP Development Including 10 High Impact Actions
Simple Organisational form constituted
Full Governance Board in place and management structure designed
Relevant CCG Staff seconded in support
Commissioning, Service Design, Contracting, Performance seconded from CCG
Full relevant staff transfer from CCG
Full Adoption of community based/ OOH management
Community staff remain in Trust but deployment seconded to PC
E2E pathways provided on city footprint i.e. EoL; MSK; District Nursing
Fully integrated MCP/PACS contract or Virtual MCP/PACs contract
WPB budgets; IPS and gain/loss share in place Shadow or full s.75
Service Delivery
Redesigned QOF, DES; LES etc.
Primary Mental Health Care Strategy
Community teams delivered via current BCF model
Shared Care arrangements; Clinical Hubs; Single clinic adoption (e.g. echo, diabetes. EOL)
Virtual MCP/PACS Contracts (Practice Groups)
Virtual MCP/PACS Contracts or Partially Integrated MCP/PACS contracts
Viable practice groups providing & commissioning services
Service Delivery Budget devolvement; Shadow WPB; Shadow IPS Shadow s.75 BCF
Contract Characteristic
Standard NHS Provider contracts
GMS/PMS/APMS GP Contracts
Back office Infrastructure; Shared Care fully implemented; 7 day services on a hub basis; % of redesigned QOF retained as collective improvement bonus; Practice configuration and consolidation strategy finalised
Shadow Budget management of Service Delivery and WPB Shadow s.75 BCF
Collaborative Working
Exploring shared back office and shared care records
Improved Access & Consultation Types
Group Level Structures including Peer Review, Localities & Group Leadership
Fully CCG managed and owned
Financial Models
CCG maintains statutory duties for and assures:
JSNA
'Commissioning'
Non MCP Resource allocation
Annual Commissioning Plan
System budget balancing
Holistic Service Provision
Regard to health inequalities
System supply chain management
Own procurement
Demand management
Engagement & consultation for service change
Continuous improvement
Service Integration
Cost Improvement
System budget balancing
Signposting & Navigation
Patient Choice
Personalisation
Outcome Monitoring
Contract Management
Quality Monitoring
System performance
System Risk & reward
Fully MCP Contracted range of services
'Standard Contract' & DES/LES
Service Delivery Complexity

General Practice Forward View - Overview of Actions

Chapter	Requirement	Action(s)	Lead	Timescale(s)	Status
1	CCG Incentive Scheme (£1.50 per head 2017/18 & 2018/19	Finalise co-produced 2 year incentive scheme for practices underpinned by continuous improvement in each of the 10 High Impact Actions at practice/group level. Overseen by Primary Care Strategy Committee	Ranjit Khular	2-17-18	Scoping
1	Develop Community Neighbourhood Teams	Strengthen community neighbourhood teams to include paediatrics, mental health, social worker & wound care /specialist nurses & direct access to Physiotherapy	Andrea Smith	2017-18	Started
1	Achieve equitable funding across all contract types	Continue phase out PMS contracts offering planning support to practices involved & equitable funding as far as reasonably possible.	Vic Middlemiss	2017-18	Started
2	Increase Training in General Practice Recruitment & Retention including recruiting Physician's Associates Practice Nurse Development Multi Disciplinary Training Hub Training Care Navigators / Medical Assistants, Admin & Reception Staff Pilot new Medical Assistant Role Mental Health Therapists role Practice Manager Development	Workforce Task & Finish Group programme of Work	Manjeet Garcha	2016	Started
2	Community Pharmacy Workload/Utilisation Clinical Pharmacist Role	Clinical Pharmacist Task & Finish Group programme of Work	David Birch	2016	Started

General Practice - Overview of Actions continued

Chapter	Requirement	Action(s)	Lead	Timescale(s)	Status
3	Accessing new national development programme ie Practice Resilience Programme Time for Care programme	General Practice Transformation Board & CCG Training Tracker in place, monitored via Workforce Task & Finish Group, reported to Primary Care Strategy Committee. Events co-ordinated & overseen by CCG Primary Care Team. Learning from all training provision(s) are shared at high level with all practice groups/MCPs to ensure tips & techniques are available to non attenders.	Sarah Southall	2016	Started
3	Supporting programme of self care for patients & promote Social Prescribing	Practices as Providers Task & Finish Group Work programme	Ranjit Khular	2017-18	Started
3	CCG Plans to reform & integrate out of hours /111 Service	The Integration of OOH and NHS111 is in place. Access to the clinical hub and the wider skill mix is already in place. There will be continual monitoring and further development as the service embeds.	Dee Harris	2016→	Started
3	CCG introduced GP access to Hospital Consultant Hotline	In addition to Advice & Guidance, Consultant Access Service we will anticipate introducing Consultant Connect (4 acute specialities initially, will extend to Mental Health as well) Trust in support of the CQUIN for acute hospitals 2017-18	Ranjit Khular	2017-18	Started
3	CCG Review of National QoF plus DES & LES's to ease GP Workload	Local steering group due to be formed February 2017. Review QoF indicators, confirm suitability & introduce QoF Plus to include locally defined indicators underpinned for financial incentive(s) to improve quality of care and outcomes for patients and ease GP workload.	Ranjit Khular	2017-18	Started

General Practice - Overview of Actions continued

Chapter	Requirement	Action(s)	Lead	Timescale(s)	Status
3	CCG IT Strategy; Accelerate paper free NHS Support Electronic Prescriptions Audit Tool to help reduce demand Automated appointment measuring interface	The Wolverhampton locality have developed a delivery plan as part of the greater Black Country Local Digital Roadmap which outlines the steps and projects to support paper free at point of care, automated appointment measures and EPS	Steven Cook	2016-2020	Started
4	ETTF; Active participation & submission of schemes	Estates Task & Finish Group programme of Work	Mike Hastings	2016	Started
4	Active NHS Lift/Public/Private Partner to develop NHS Premises in local area	Estates Task & Finish Group programme of Work	Mike Hastings	2016	Started
4	Support practices/patients to take up online patient consultation Promote use of Apps/Digital Self Care WIFI (early implementor) availability in General Practice	Wolverhampton CCG are Wi-Fi early adopters and will have implemented Patient/Public and Staff Wi-Fi in all GP practices by 31st March 2017. AS part of the development of the Wolverhampton Shared Care Record a patient portal will be made available that will support patients view there records and record data from wearable devices. Wolverhampton CCG will be working with NHS England GPFV Transformation Team and practices to implement online consultations	Steven Cook	2017-18	Complete March 2017
4	Commission new Core IT Services for Federations/Groups	The CCG was awarded funding to support the integration of practices through a ETTF bid. They are working with EMIS to allow all of the federations view/book and hold consultations with patients within each federation	Steven Cook	2017-18	Started
4	Roll out Pharmacy Summary Care Record	The project was completed by Midlands and Lancashire CSU during 2016.	Steven Cook		

General Practice - Overview of Actions continued

Chapter	Requirement	Action(s)	Lead	Timescale(s)	Status
5	Deliver access commitment, including integration of extended access with Out of Hours & Urgent Care Commission new Core IT Services for Federations/Groups	The CCG in partnership with Royal Wolverhampton Hospital, The Black Country Partnership and Wolverhampton City Council have created a Wolverhampton Shared Care Record that currently contains Primary and Secondary Care data, which is accessible 24hrs a day. The Development of EMIS remote consultation will also support GPs accessing patients records within their federations.	Steven Cook	2017-18	Started
5	Deliver access commitment, including integration of extended access with Out of Hours & Urgent Care Commission new Core IT Services for Federations/Groups				
5	Introduce MCP Contracts to support 'bigger at scale' primary care provision	Primary Care Task & Finish Group Work Programme	Vic Middlemiss	2018-19	Not Started
5	Funding & Supporting Protected Learning Time	Workforce Task & Finish Group programme of Work	Manjeet Gracha	2016	Started

All components of this plan are overseen by the Primary Care Strategy Committee, each project is managed through to completion by the Task & Finish Group indicated.

Each task & finish group provides a highlight report on a monthly basis to the Primary Care Strategy Committee enabling progress to be closely monitored to ensure achievement.

The detail contained within this document should be read in conjunction with our Operational Plan 2017/19 and enclosed Primary Care Strategy Programme of Work.

This submission has been considered by the members of the Black Country STP Operational Group, who consider it to be consistent with the proposals within the current Sustainability and Transformation Plan.