
DEVELOPING CLINICAL COMMISSIONING GROUPS IN ESSEX

Accountability and Rules of Engagement
with Practices

July 2011



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INTRODUCTION

The Health and Social Care Bill proposes the most radical changes in the history of the NHS. Previous commissioning initiatives have been largely top down in approach and have met with limited success.

The establishment of commissioning groups is fundamentally different. All practices will have a duty to be members of a commissioning group. Clinical commissioning groups must be developed from the bottom up in an environment that facilitates individual practices taking responsibility for their own clinical behaviour and deciding how best services can be developed to meet the needs of their patients.

These radical new proposals cannot work unless there is engagement with practices across the whole of the county and an ownership of what is being proposed by the vast majority of the GP community in Essex.

All GPs, irrespective of their contractual status, need to have an opportunity to be involved in the new commissioning agenda and at the same time feel empowered to make the necessary improvements to patient care and services envisaged by the new reforms.

THE ROLE OF THE LMCs AND THE PURPOSE OF THE DOCUMENT

At this time of change, the LMCs in Essex have an increasingly significant role as the local representatives of the profession. This role is not in any way diminished by the appointment of local GPs as clinical leaders of emerging commissioning groups.

The LMCs consider that their role in providing advice, information and support to all GPs is crucial. The legislation proposed a number of significant changes, some contractual, that if not handled sensitively and fairly at a local level, could threaten the constructive working relationship between practices and between practices and commissioning groups.

The LMCs will continue to act as an “honest broker” and help ensure any arrangements that are put in place by emerging commissioning groups are developed in a way that is acceptable to local GPs.

Commissioning groups will all be required to produce a formal Constitution that will be publicly available. The Constitution must include a number of areas as a minimum, one of which will be the arrangements “for securing the effective participation of the commissioning group’s members”.¹

This document has been produced with the aim of stimulating discussion on this critical element of the Constitution. It proposes a number of measures and key principles which, in the opinion of the LMCs, should be included as part of the Constitution of all clinical commissioning groups in Essex.

¹ Liberating the NHS: Legislative Framework and Next Steps

The proposals are detailed under the headings of:

- Accountability and Engagement
- Democratic Legitimacy/Voting Procedures
- Conflict of Interest
- Performance Management and the "Quality Premium"
- Dispute Resolution Procedures

and are solely aimed at ensuring that fair and transparent rules of engagement with practices are agreed, particularly in the area of performance management and the local "Quality Premium". The suggested processes for dealing with conflicts of interest and dispute resolution should properly protect practices and reassure patients that their treatment and care will not in any way be jeopardised by the establishment of commissioning groups.

This document is an important element of the LMCs' continued dialogue with constituent practices, GPs and commissioning groups. North and South Essex LMCs finalised these proposals at their meetings in June. The intention is that discussions will now begin in earnest with emerging commissioning groups with a view to securing their agreement to the inclusion of these measures in their formal constitutions.

ACCOUNTABILITY AND RULES OF ENGAGEMENT

If the alignment of clinical and financial responsibilities is to have the desired effect of improving healthcare outcomes and increasing patient choice, then constructive working relationships between commissioning groups and individual practices are crucial.

Commissioning groups must be led from the bottom up. Individual practices have a key role in ensuring that commissioning decisions reflect their views of patients' needs and their own referral intentions.

Whilst the ultimate responsibility rests with commissioning groups, each group will be required to develop their own arrangements to hold constituent practices to account.

There is a clear expectation that the structures put in place to support commissioning groups should not replicate current PCT arrangements. North and South Essex LMCs are strongly of the opinion that this change in culture shall be evidenced by a number of two-way accountability measures. The LMCs take the view that, as a minimum, the following measures should form an integral part of the Constitutions of all commissioning groups.

COMMISSIONING GROUPS' ACCOUNTABILITY TO PRACTICES

Regular Meetings

All practices should receive one visit per year from the commissioning group to address practice level issues. In addition to the AGM there should be at least two other commissioning group wide meetings for all practice members that do not have the public in attendance.

Annual General Meeting (AGM)

The commissioning group will hold an AGM that will be open to all constituent GPs and members of the public.

Survey of Practices

The commissioning group will undertake an annual survey of practices to obtain feedback on levels of satisfaction and perceived engagement with the commissioning process. The LMCs and EQUIP will jointly produce a Questionnaire for use by commissioning groups. The results will be analysed by the LMCs and EQUIP and feedback provided to commissioning groups.

Power of Recall

The GP leadership of the commissioning group will be appointed following a selection/election process agreed with the LMCs. See Page 9 for further details. It is possible however that the leadership of the commissioning group may become out of touch with the views and needs of the members of the group. To guard against this eventuality, a Power of Recall will be built into the constitution that allows the leadership

to be recalled following an Extraordinary General Meeting called by at least 75% of the commissioning group's member GPs, provided that the response rate is at least 50% of eligible GPs.

PRACTICES' ACCOUNTABILITY TO THE COMMISSIONING GROUP

Practices' responsibilities to the commissioning group will form part of the annual Service Level Agreement (SLA) between the two parties. (See Page 19) Responsibilities could include as a minimum:-

- Nominating commissioning and prescribing leads to a) represent the practice at commissioning group/locality meetings and b) represent the needs of the practice's patient population within the commissioning group.
- Actively engaging with the commissioning group to help improve services within the area.
- Sharing appropriate referral, prescribing and emergency admissions data.
- Following the clinical pathways and referral protocols agreed by the commissioning group (except in individual cases where there are justified clinical reasons for not doing this).
- Managing the practice's prescribing budget.
- Participating in and delivering, as far as possible, the clinical and cost effective strategies agreed by the commissioning group.
- Establishing a practice reference group as a means of obtaining the views and experiences of patients and carers.
- Working constructively with the locality sub-committee/commissioning group.
- Responding in a timely manner to information requests from the commissioning group.

DEMOCRATIC LEGITIMACY/VOTING PROCEDURES

Commissioning groups will require widespread support from local GPs if they are to engage clinicians and successfully work with them to take ownership of the commissioning agenda.

The crucial difference between clinically led commissioning groups and previous GP commissioning initiatives is the imperative for all GPs and practices to be signed up to what is a corporate agenda, but one in which an element of practices' resources are likely to be linked to the overall performance of the commissioning group.

Leadership within practices will be increasingly important. Practices will need to ensure that they have a productive role in contributing and adhering to the commissioning group's objectives.

Clinical leadership will underpin the success of commissioning groups but it will be different from that which exists under current arrangements. Clinicians who take on the role of leading their peers will need to engage their colleagues in thinking and behaving differently. It is therefore crucial that leaders have an understanding of the perspective, concerns and aspirations of GPs which, when translated into operational policy, will help ensure that it facilitates engagement and, where necessary, changes GP behaviour.

Strategic leadership at a locality level, together with leadership at an individual practice level, both need to be properly resourced. The resources will enable GPs to have protected time with local backfill or in the case of sessional GPs, compensation for loss of earnings. Resources will form part of the commissioning group's Management Allowance once they are formally established, however, in the meantime this will be provided by PCTs as set out in the NHS Operating Framework 2011. Details of funding allocated at practice level should form part of the SLA agreed between individual practices and the commissioning group (*see Page 19*).

It is important to ensure that whoever is appointed to a leadership role within the commissioning group has both the right competencies required to fill the role and the support of GPs. A mandate from the profession locally is a prerequisite for any prospective leader.

Any appointment process must be conducted fairly and impartially. The LMCs in Essex, as impartial bodies, are best placed to lead and advise on the appointment process and have significant experience of successfully running democratic elections.

It is essential that the whole process is inclusive and that no GP, irrespective of their contractual status, has any grounds to claim that they have been unfairly excluded. The proposal for discussion is that the constitution of all commissioning groups will require any elections/voting procedures to be based on the following key principles agreed by North and South Essex LMCs:-

Who is Eligible to Stand for Selection/Election?

- Any GP working in the area in question will be eligible to stand for election irrespective of whether they are partners, salaried or freelance locum GPs. There is an expectation that peripatetic locums would only vote in their “home” commissioning group. The LMC would be the final arbiter in cases of dispute.

Publicity and Seeking Applications/Nominations

- The nomination process will be publicised as widely as possible.
- The LMC will write directly to all GPs working in the area using information from the respective Medical Performers List and EQUIP.
- The nomination process will run for a period of between two and four weeks.

Defining the Electorate

- Each GP working in the area, whether partner, salaried or locum, will be entitled to vote.

Issuing Ballot Papers

- The LMC holds good data on constituents working in the area which will be of help in issuing ballot papers.
- The data will be taken from the relevant Medical Performers List and information held by EQUIP.
- Practices will be encouraged to let the LMC know of any doctor working in the practice who does not receive a ballot paper.
- A period of between two and four weeks will be allowed for the return of completed ballot papers.

Counting the Result

- The voting system used will be first past the post, eg. in cases where six GPs are to be elected, each eligible GP will be entitled to cast up to six votes.

CONFLICTS OF INTERESTS

BACKGROUND

There is widespread support for the proposal that as part of the new commissioning arrangements, systems need to be in place to ensure fairness and transparency of decision making. This is considered to be particularly important in the case of decisions made to commission services from GP practices and/or GP controlled provider companies.

The DH has signalled its intentions not to prescribe the exact approach that commissioning groups should take in managing conflicts of interest. The BMA has made reference to the importance of the existing GMC Guidance on probity in situations where clinicians have a financial or commercial interest in commissioning decisions.

Every commissioning group must put in place effective and transparent clinical and corporate governance structures to underpin the commissioning process. The supplementary guidance to the GMC guidelines "Good Medical Practice" 2006 states:-

"If you have a financial interest in an institution and are working under an NHS or employers' policy, you should satisfy yourself, or seek assurances from your employing or contracting body, that systems are in place to ensure transparency and to avoid, or minimise the effects of, conflicts of interest. You must follow the procedures governing the scheme".

Conflicts of interest for GPs under the arrangements as currently proposed are likely to fall into three distinct areas as follows:-

- Clinical commissioning leaders having a significant interest in a provider company.
- GPs referring patients to a provider company that they have an interest in and/or making decisions regarding the care of their patients that influences the "quality premium" they receive.
- Senior LMC officers also being Board members of commissioning groups.

North and South Essex LMCs have agreed the following important principles that, in their view, should form an integral part of any processes put in place by a commissioning group to manage conflict of interest and ensure fairness in investment decisions.

CLINICAL COMMISSIONING LEADERS AND PROVIDER COMPANIES

Directors of Provider Organisations

GPs who are Directors of provider organisations are not permitted to also be Board members of a commissioning group. This would constitute a prejudicial interest.

Register of Interest

All members of the Board of the commissioning group and any Locality Sub-Committees have to provide a record of their interest for inclusion on a publicly available register.

The commissioning group's Accountable Officer must be informed within 28 days of a member taking office of any interests requiring registration, or within 28 days of any change to a member's registered interests.

Personal Interest

Members must declare if they have a personal interest, and the nature of that interest, before the matter is discussed or as soon as it becomes apparent. Even if an interest is detailed in the Register of Interest, it must be declared in meetings where matters relating to that interest are discussed.

Members who declare a personal interest will be able to remain in the meeting and speak on the issue unless the personal interest is deemed by the Accountable Officer to be a prejudicial interest.

REFERRAL OF PATIENTS TO A PROVIDER COMPANY/CARE OF PATIENTS THAT INFLUENCES THE "QUALITY PREMIUM"

GPs must continue to treat and care for patients in a way that keeps the interests of patients at the heart of all decision making. GPs must continue to refer patients to the service that they, in their professional opinion, believe is the most appropriate for the patient's condition. Paragraphs 74 and 75 of the GMC's "Good Medical Practice" states:-

"74 You must act in your patients' best interest when making referrals and when providing or arranging treatment or care. You must not ask for or accept any inducement, gift or hospitality which may affect or be seen to affect the way you prescribe for, treat or refer patients. You must not offer such inducements to colleagues".

"75 If you have a financial or commercial interest in organisations providing healthcare or in pharmaceutical or other biomedical companies, these interests must not affect the way you prescribe for, treat or refer patients".

When referral happens to be to an institution in which the GP has a vested financial interest, Paragraph 76 of the GMC's "Good Medical Practice" states:-

"76 If you have a financial or commercial interest in an organisation to which you plan to refer a patient for treatment or investigation, you must tell the patient about your interest. When treating NHS patients you must also tell the healthcare purchaser".

Paragraphs 4 and 7 of the supplementary guidance to the GMC's "Good Medical Practice" are also applicable and state:-

"4 Some doctors or members of their immediate family own or have financial interests in care homes, nursing homes or other institutions providing care or treatment. Where this is the case, you should avoid conflicts of interest which may arise, or where this is not possible, ensure that such conflicts do not adversely affect your clinical judgement. You may wish to note on the patient's record when an unavoidable conflict of interest arises".

"7 In all cases you must make sure that your patients and anyone funding their treatment is made aware of your financial interest".

LMC OFFICERS – BOARD MEMBERSHIP OF COMMISSIONING GROUPS

A number of LMC officers will have the qualities necessary to play a role within their local commissioning group. Whilst this is a potentially difficult area, in general terms it is accepted as being advantageous to both an emerging commissioning group and local GPs if LMC leaders are involved in the development of the commissioning group through the shadow stage.

Once the transition stage has been completed or after April 2013, it will not however be appropriate for a GP to hold a substantial role within their LMC and be a member of the Board of their commissioning group. In Essex, substantial has been defined as being as a minimum the Secretary and Chair of an LMC.

LMCs will have an important role in holding commissioning groups to account especially in the management of practice commissioning performance. Any conflict of interest at this point would be unacceptable.

PERFORMANCE MANAGEMENT AND THE “QUALITY PREMIUM”

PERFORMANCE MANAGEMENT OF PRACTICES BY COMMISSIONING GROUPS

The legislation will place an explicit duty on all clinical commissioning groups to support the NHS Commissioning Board (NHSCB) in continuously improving the quality of primary medical care services.

The NHSCB will still have an overarching responsibility for commissioning services and holding GP contracts, but commissioning groups will be expected to play a substantial role in helping to monitor, benchmark and improve the quality of GP services.

Effective systems to support clinical governance including clinical audit will be crucial as will the role of commissioning groups in improving patient care across the system, including both the quality and accessibility of care provided by GP practices.

This is one of the most radical elements of the reforms and one that carries the greatest element of risk. If performance management is not sensitively handled, it has the potential to undermine the ability of commissioning groups to deliver the efficiencies and changes required.

The implementation of performance management regimes at a local level requires detailed consideration involving commissioning groups, practices and the LMCs. It is important that performance measures are introduced in a structured and if necessary, a phased way following discussions with the profession locally. North and South Essex LMCs are strongly of the view that any performance management system should be introduced taking account of the following principles:-

- The role of commissioning groups in performance managing practices will be restricted, at least in the first year, to the monitoring of the objectives agreed as part of the local “Quality Premium”.
- The NHSCB holds the contracts for all managed practices and it is their role to performance manage compliance with GMS/PMS contracts.
- Commissioning groups will not have any powers to expel individual practices from the organisation as part of their local performance management arrangements.
- Each commissioning group will be required to consult with the LMC annually on its intended performance management regime in so far as it relates to the “Quality Premium”.
- All GPs and practices will have an obligation to participate in the process.
- The LMC will act as a mediator in all cases where practices refuse to engage in this process.
- The system of performance management will be supportive in nature and based on the principles of peer review and shared learning.
- The performance of practices will be monitored by means of regular meetings and data returns, probably quarterly and probably based at a locality level.

- Regular sharing of information will allow issues to be identified at an early stage and remedial action taken as and when necessary throughout the year.
- Any disagreement over issues arising as part of the performance management process will be dealt with in accordance with the commissioning group's Dispute Resolution Procedure.
- Separately agreed arrangements will need to be put in place by commissioning groups to deal appropriately with any potential poor performance issues identified as part of the performance management process.
- The commissioning group's performance management processes will not detract in any way from the responsibilities of individual GPs to report any concerns about the conduct of colleagues as outlined in the GMC's "Good Medical Practice".
- The objectives that will be performance managed will be agreed by both parties and documented as part of the annual Service Level Agreement agreed between the individual practices and the commissioning group.

LOCAL QUALITY PREMIUM

The legislation will introduce basic powers allowing the introduction of a "Quality Premium". The initial proposal is that commissioning groups should receive a "Quality Premium" based on the outcomes achieved for patients together with the commissioning group's financial performance.

There will be further discussions between the BMA and stakeholders aimed at ensuring that any new arrangements "create the right incentives for collaborative work between practices to improve quality and outcomes and enable GPs to make the right clinical judgements for individual patients".²

It remains unclear how this is likely to be achieved in practice and how prescriptive any further guidance will be. Given the intention of the reforms in encouraging increased local decision making, it appears likely that the topslice from practices' baselines to fund the "Quality Premium" will be agreed nationally, but that the operation of the scheme and the criteria used to determine practices' eligibility to payment will be left to local agreement.

This being the case, the view of North and South Essex LMCs is that a number of underlying principles need to be agreed at an early stage with practices and commissioning groups to ensure that local implementation is fair and reasonable. The proposals being put forward by the LMCs are as follows:-

- The "Quality Premium" available to an individual practice is topsliced from its own financial baseline using a calculation agreed between the NHS Employers and the GPC.

² Liberating the NHS: Legislative Framework and Next Steps

- The annual scheme agreed by each commissioning group must allow each practice to earn back the full amount of the topslice subject to the successful achievement of agreed objectives.
- The scheme will not allow any individual practice to earn back more than the original topslice from the baseline.
- The commissioning group must formally consult with the LMC each year on its plans and proposals for the operation of the local "Quality Premium".
- Objectives need to be agreed annually between the commissioning group and individual practices and documented as part of the Service Level Agreement between the two parties.
- Agreed objectives must be realistic and achievable and entirely within the control of the practice.
- It would be inappropriate for objectives to be set that were likely to be subject to influence by external factors outside the remit of the Practice.
- All objectives must be ethically sound, must not jeopardise the role of GPs as patients' advocates and must not place at risk the ability of GPs to comply fully with the requirements of the GMC's "Good Medical Practice".
- Objectives that require practices to follow clinical pathways and/or referral protocols agreed by the commissioning group must allow a right of veto to practices in individual cases where there are justified clinical reasons for taking an alternative course of action.
- Targets should be monitored throughout the year at a frequency agreed with the constituent practice and documented in the SLA.
- The monitoring of objectives should, whenever possible, be undertaken using a system of peer review as has been agreed for the recently introduced QOF Quality and Productivity Indicators.
- Wherever practical, payment mechanisms should include a system of thresholds that in themselves reward varying degrees of workload and achievement.
- Individual practices should have a right of appeal against a decision of the commissioning group not to allow all or part of the "Quality Premium".
- All appeals/disputes should be resolved in accordance with the commissioning group's Local Dispute Resolution Procedure.
- Any surplus "Quality Premium" monies that are not awarded to individual practices are not to be allocated to other practices in the commissioning group as additional income.
- Any surplus from the "Quality Premium" is to be separately identified in the commissioning group's accounts and ringfenced for investment in primary care as part of the commissioning group's Commissioning Plan in the following financial year.

DISPUTE RESOLUTION PROCEDURE

BACKGROUND

It is almost inevitable that on occasions practices will disagree with decisions made by their commissioning group or in some cases, actions taken by other practices that impact on them. Disputes may arise over a number of issues that could include referral management, prescribing practices, achievement of objectives set by the commissioning group and eligibility for the "Quality Premium".

It is important that all practices have the ability to appeal against any such decisions and have the right to request that any dispute is resolved by means of an agreed Dispute Resolution Procedure that forms part of the commissioning group's constitution.

Current NHS Regulations place an expectation upon PCTs and contractors to make every effort to communicate and co-operate with each other before considering referring the dispute for determination in accordance with the formal local dispute resolution process.

It is proposed that the arrangements in place to deal with disputes arising from the new commissioning responsibilities follow closely existing procedures already in place in a number of PCTs which involve a three staged process.

Stage 1: The Informal Process

Informal resolution helps develop and sustain a partnership approach between practices and between practices and commissioning groups.

Each party should involve the LMC at this stage in either an advisory or mediation role.

It is a requirement that the Informal Process must have been exhausted before either party is able to escalate the dispute to Stage 2: The Local Dispute Resolution Panel.

Stage 2: The Formal Local Process

In cases where either party remains dissatisfied with the outcome of Stage 1, then they have the right to request Formal Local Dispute Resolution in writing, including grounds for the request to the Accountable Officer of the commissioning group.

Other than in cases, which in the opinion of the Accountable Officer and following consultation with the LMC, are considered to be frivolous or vexatious, a Local Dispute Resolution Panel (LDRP) will be convened to hear the dispute and make a determination.

Members of the LDRP

The Panel will consist of:-

- A clinical member of the Board of another commissioning group.
- A GP conciliator (from a Panel to be established by the LMCs).
- An LMC representative (from a different part of Essex).
- Panel Secretary (non voting).

The Panel will agree its own Chairman.

The Hearing

The hearing will be held within 20 working days of the request being lodged. At least 7 working days notice of the hearing date will be given to all participants.

Documentation

All relevant documentation will be provided to all parties and panel members at least 5 working days before the hearing.

Procedure at the LDRP Hearing

The discussion of the Panel will remain confidential. The Panel Secretary will keep a record of the hearing.

The Appellant will be asked to present their case. Members of the Panel will be given the opportunity to ask any questions relevant to the case.

The Respondent will be asked to present their response. Members of the Panel will be given the opportunity to ask any questions relevant to the case.

The Appellant and the Respondent will then withdraw.

Following the presentation of the facts the Panel will deliberate and reach a decision on the case based on a majority of the voting panel members.

The Panel Chair will notify both parties of the decision including any recommendations in writing within 7 days after the hearing.

If either party disputes the decision of the LDRP and the decision relates directly to provisions in its GMS/PMS contract, then it may refer the matter to the Family Health Services Appeal Unit (FHSU) of the NHS Litigation Authority in line with relevant NHS Regulations, for dispute resolution under the "NHS Dispute Resolution Procedure".

Stage 3: Appeal to The Secretary of State through the FHSU – NHS Dispute Resolution Procedure

Written requests must be directed to the FHSU, 1 Trevelyan Square, Boar Lane, Leeds, LS1 6AE within three years beginning on the date on which the matter giving rise to the dispute happened or should reasonably have come to the attention of the party wishing to refer the dispute.

Disputes should be address directly to the FHSU and must include:-

- The names and addresses of the parties to the dispute.
- A copy of the contract.
- A brief statement describing the nature and circumstances of the dispute.

INTER PRACTICE DISPUTES

It is envisaged that the Stage 2 Formal Process will be used in the main to deal with disputes between individual practices and commissioning groups.

In cases where the dispute is between practices and it is an issue that warrants formal dispute resolution, then the same process and timescales will apply.

The only proposed change is that the LMC representative on the LDRP will be a representative from an LMC outside of Essex. It is extremely unlikely that any disputes between practices will be appropriate for referral to the Secretary of State for determination as detailed in Stage 3.

RESPONSES TO THE DISCUSSION DOCUMENT

This document was produced with the aim of stimulating discussion and debate on the way in which commissioning groups and practices should engage with each other as part of the new commissioning arrangements.

As part of the consultation process with constituent practices and transitional commissioning group leaders, a number of responses were received. Most of the comments received were supportive of the proposed direction of travel. In a number of cases the initial proposals were amended to reflect the feedback received.

Whilst there were differing views on the operational detail of some of the proposals, this in most cases reflected the varying stages of development of individual commissioning groups. There was, however, clear and widespread support for the need to have in place transparent and fair rules of engagement that were acceptable to practices.

GOVERNMENT LISTENING EXERCISE – THE NHS FUTURE FORUM

The listening exercise has now been completed and the Government has published a list of the key changes that it intends to make as a result of the NHS Future Forum's report.

A number of these changes are likely to have a significant effect on the way in which clinical commissioning groups operate at a strategic level. Interestingly however, the report's recommendations make no reference to the relationship between practices and commissioning groups and how it is intended they will work together to take forward the new commissioning agenda. It is therefore increasingly likely that these crucial terms of engagement will be left to local determination.

SERVICE LEVEL AGREEMENT (SLA) BETWEEN INDIVIDUAL PRACTICES AND THE COMMISSIONING GROUPS

The new commissioning arrangements herald a major change in the relationship between practices and between practices and the soon to be established commissioning groups.

The new system of engagement, that will involve elements of performance management, is an area of high risk and one that has the potential to lead to an increasing number of disputes.

It is therefore important that a mechanism is put in place to help prevent misunderstandings and offer a degree of reassurance to both parties about their respective obligations and expectations.

The SLA will be the vehicle by which the agreements reached between commissioning groups and constituent practices will be formally documented. The SLA will be important in providing objectivity to a difficult process and will be the formal mechanism by which eligibility to the local "Quality Premium" will be determined.

Suggested headings for the Agreement include:-

- Parties to the Agreement
- Aims and Objectives of the Commissioning groups
- Responsibilities of the Practice
- Responsibilities of the Commissioning groups
- Annual Objectives/Targets agreed with the Practice
- Monitoring Arrangements, Frequency of Meetings, Data Returns
- Total Quality Premium available to the Practice
- Indicative Budgets of the Practices
- Financial Resources Available to Support the Practice's Involvement in Commissioning
- Dispute Resolution
- Review of Agreement
- Signatures to the Agreement

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