SERVICE LEVEL AGREEMENT (SLA)

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THIS AGREEMENT is made on

BETWEEN

(1) The NWL Primary Care Trusts (PCTs) Commissioning Partnership, hereafter referred to as "the Partnership", located at 15 Marylebone Road, London NW1 5JD

and

(2) The eight North West London PCTs, hereafter referred to as "the PCTs":

- NHS Brent, located at Wembley Centre for Health and Care, 116 Chaplin Road, London HA0 4UZ
- NHS Ealing, located at 1 Armstrong Way, Southall, UB2 4SA
- NHS Hammersmith and Fulham, located at 1 Hammersmith Broadway, London W6 PDL
- NHS Harrow, located at Fourth Floor, The Heights, 59-65 Lowlands Road, Harrow, Middlesex HA1 3AW
- NHS Hillingdon, located at Kirk House, 97-109 High Street, Yiewsley, West Drayton UB7 7HJ
- NHS Hounslow, located at Sovereign Court, 15-21 Staines Road, Hounslow, Middlesex, TW3 3HR
- NHS Kensington and Chelsea, located at Courtfield House, St Charles Hospital, London W10 6DZ
- NHS Westminster, located at 15 Marylebone Road, London NW1 5JD

STATEMENT OF INTENT

This SLA sets the remit for a single acute commissioning, procurement and contracting function, "the Partnership", to strengthen the approach to commissioning services from acute providers in North West London. It reflects the case for change of the Partnership which was agreed by the **Joint Committee of Primary Care Trusts (JCPCT)** on 3 July 2009 and subsequently endorsed by the Boards of:

- NHS Brent on 30 July 2009

- NHS Ealing on 30 July 2009
- NHS Hammersmith and Fulham on 8 July 2009
- NHS Harrow on 7 July 2009
- NHS Hillingdon on 28 July 2009
- NHS Hounslow on 9 July 2009
- NHS Kensington and Chelsea on 21 July 2009
- NHS Westminster on 21 July 2009

In this SLA, the Partnership includes the Acute Commissioning Vehicle (ACV) and the Clinical Directorate (CD).

The Partnership's Clinical Networks are not covered by this SLA. The Strategic Planning Directorate (SPD) is not covered by this SLA and may be included in a subsequent revision.

LEGAL STATUS

This Agreement reflects the voluntary constitution between the Partnership and PCTs and shall not be regarded for any purpose as giving rise to contractual rights or liabilities and shall not be considered a contract enforceable by law.

SEVERABILITY

If any part of this Agreement is declared invalid or otherwise unenforceable, it shall be severed from this Agreement and this shall not affect the validity and/or enforceability of the remaining provisions.

AGREEMENT PERIOD

The Agreement commences on 1 September 2009 and will last until 31 March 2012. The Agreement will be subject to a phased implementation.

This Agreement will be subject to an annual review whereby all parties can determine if it should continue on the basis of non delivery of Benefits. If Benefits have been realised then it will continue in force until the next 12 month review period.

In signing this Service Level Agreement, PCTs acknowledge that Benefits realised will impact on some PCTs more than others, and that improvements in performance will vary between Providers. The Benefits Realisation Plan sets out the anticipated benefits to PCTs as detailed within Schedule 4.

DISSOLUTION AND RISK

The Partnership can be dissolved by the JCPCT. The JCPCT would require a majority agreement by 75% of member PCTs. For such matters where voting is required each member PCT shall have one vote and the JCPCT shall reach decisions by a simple majority of PCTs with at least 1 member present, but with the chairs having a second and deciding vote if necessary. The aim should be for unanimity. The expectation is that six months notice will be given, unless all parties agree to a shorter period.

In the event of the Partnership being dissolved, the PCTs will divide the close-down costs as follows:

- NHS Brent 15.92%
- NHS Ealing 17.54%
- NHS Hammersmith and Fulham 9.75%
- NHS Harrow 10.11%
- NHS Hillingdon 12.38%
- NHS Hounslow 11.99%
- NHS Kensington and Chelsea 9.61%
- NHS Westminster 12.70%

The PCTs commit to looking for suitable alternative positions in their organisations for Partnership staff and paying any redundancy costs in proportion to their annual financial contribution to the Partnership.

In the event that this Agreement is terminated whether by effluxion of time or by notice of termination the Parties agree to co-operate to ensure an orderly wind down and transfer of the obligations and duties as set out in this Agreement with minimum disruption to service users and in accordance with Schedule 5.

AMENDMENTS TO SERVICE LEVEL AGREEMENT

This Agreement can be amended following approval firstly in the Collaborative Commissioning Group (CCG) and secondly in the JCPCT. In both groups, matters requiring decision will be taken on the basis set out in “Dissolution and Management of Risk”.

Minor amendments- judged as such by all members of the Collaborative Commissioning Group- can be agreed by unanimity in the Collaborative Commissioning Group.

1. DEFINITIONS AND INTERPRETATION

1.1 In this Agreement, unless the context otherwise requires, the following terms have the following meanings:

i) "**ACV**" (Acute Commissioning Vehicle) refers to arm of the Partnership that provides Contract & Procurement, Performance & Information and Finance functions and is responsible for the management of acute contracts for the Sector.

ii) **"Acute"** relates to hospital activities, and to those specialities primarily concerned in the surgical, medical and emergency sectors. Specifically excluded are the psychiatric and long stay sectors.

iii) **"Acute Budget Envelope"** refers to the sum of the combined acute contract values

iv) **"Agreement"** and **"SLA"** mean this agreement, together with its Schedules.

v) **"Annual Business Cycle"** refers to the commissioning activities undertaken by the Partnership on a annual basis

vi) **"Benchmarking"** is a process of comparing an organisation's performance to that of other organisations using objective and subjective criteria.

vii) **"Benefits"** refer to the benefits identified and set out in the Partnership's Benefits Realisation Plan.

viii) **"Claims management"** is activity and costs claimed by acute service providers.

ix) **"Clinical leadership"** means putting clinicians at the heart of shaping and running clinical services, so as to deliver excellent outcomes for patients and populations, not as a one-off task or project, but as a core part of clinicians' professional identity.

x) **"Commissioner"** is a senior health official responsible for commissioning health services.

xi) **"Commissioning"** in the NHS is the process of ensuring that the health and care services provided meet the needs of the population effectively. It is a complex process with responsibilities ranging from assessing

population needs, prioritising health outcomes, procuring products and services and managing service providers.

xii) **"Governance"** relates to decisions that define expectations, grant power, or verify performance. It consists either of a separate process or of a specific part of management or leadership processes.

xiii) **"Hosting arrangements"** means the terms and conditions under which NHS Westminster will place Partnership staff on their payroll.

xiv) **"Intelligent customer"** is defined as the capability of the organisation to have a clear understanding and knowledge of the product or service being supplied.

xv) **"MoU"** or **Memorandum of Understanding** is a document describing a bilateral or multilateral agreement between parties. It expresses a convergence of will between the parties, indicating an intended common line of action. It is used most often in cases where parties either do not imply a legal commitment or in situations where the parties cannot create a legally enforceable agreement.

xvi) The **"Networks"** mean the clinical networks, which will inform the Partnership's strategic direction and contribute performance data to aspects of contracting and performance management of the acute providers.

xvii) **"Provider"** means an individual or an organisation that provides health services to patients.

xviii) The **"Sector"** means the area covered by the eight Primary Care Trusts in North West London.

xix) **"Serious Untoward Incident"** is any event, incident or circumstance that could or did lead to unintended or unexpected injury (physical or psychological) disease, suffering, disability, death, loss or damage to a patient or Agency or subcontracted staff.

xx) **"Supply-side"** is the side of an economy which determines how many goods are supplied at any given price.

xxi) **World Class Commissioning** refers to the Department of Health competencies used to measure commissioning capabilities

1.2 A reference to the singular shall indicate the plural and vice versa and a reference to a gender shall include any gender.

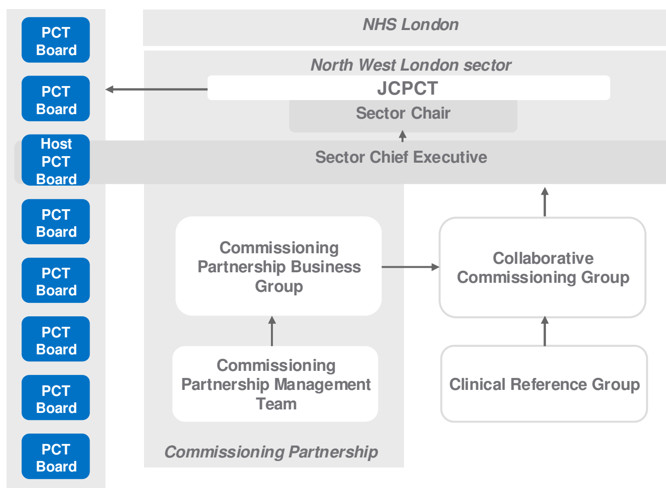
1.3 The headings in this Agreement shall not affect its interpretation.

1.4 References to any statute of statutory provision include a reference to that statute or statutory provision as amended, extended or re-enacted from time to time whether by statute, statutory instrument, directions or by directive or regulation which is, in the case of a directive or regulation, intended to have direction application within the United Kingdom and has been adopted by the Council of the European Communities.

1.5 References to a statutory provision shall include any subordinate legislation made from time to time under that provision.

2. GOVERNANCE STRUCTURES

Diagram 1: Guide to the Governance structures



2.1 The JCPCT will be responsible for oversight of the performance and responsiveness of the Partnership. The JCPCT reports to the Board of each PCT. The key responsibilities of the JCPCT are to:

i) sign-off the strategic objectives and programme for acute services commissioning in order to ensure that the sponsoring PCT's objectives are met.

ii) ensure effective and timely reporting of progress and performance to PCTs.

iii) ensure that the responsibilities of the PCT Chief Executives in relation to the commissioning of services are fully discharged.

2.2 The membership of the JCPCT consists of the Chairs and Chief Executives of the NWL PCTs and clinical leadership via Professional Executive Committee (PEC/ CEC) chairs.

2.3 The **Collaborative Commissioning Group (CCG)** has responsibility to agree the strategic objectives for the Partnership, to review the Partnership's Strategic and Operating Plans, and to make recommendations to the JCPCT. The membership of the CCG is PCT Chief Executives, the Sector Chief Executive and Managing Director of the Partnership, PCT Directors of Commissioning or equivalent. The key responsibilities of the CCG are to:

i) ensure that the Annual Business Cycle is conducted effectively.

ii) ensure consistency between the strategy and implementation of shared commissioning arrangements and those undertaken at borough level and in specialist commissioning to the extent that this is possible.

iii) ensure the delivery of Healthcare for London as it applies to those acute service areas where responsibility is delegated to the Partnership, including working with PCTs to undertake any consultations on service changes.

2.4 The **Commissioning Partnership Business Group (CPBG)** reports to the Collaborative Commissioning Group. The membership of the group will be the Managing Director, Directors of the Partnership and one representative from

each PCT. The PCT representatives should include four Directors of Finance and four Directors of Commissioning, with the Partnership facilitating that agreement. Clinical network directors will join the CPBG on a regular basis for network issues. This group has responsibility to:

i) consider the annual business plan and recommend approval from the JCPCT.
ii) provide oversight of the Partnership's financial and business performance.
iii) contribute to resolving and challenging provider performance issues.
iv) provide oversight on borough and acute commissioning developments.
v) monitor performance/responsiveness of the Partnership and have an 'oversight' of intelligent client functions in the PCTs.

2.5 The **Commissioning Partnership Management Team** will consist of the Sector Chief Executive, the ACV Managing Director and Directors of the Partnership. The Commissioning Partnership Management Team will have responsibility to:

i) direct and manage on a day-to-day basis the operation of the Partnership.
ii) track and monitor Partnership progress and performance against the business plan and operating plan, identifying and mitigating against operational difficulties and reporting these to the JCPCT as appropriate.
iii) manage any exceptions to performance and any disputes which occur in line with the agreed procedure.
iv) provide monthly performance updates to PCTs and the Commissioning Partnership Business Group.

2.6 The **Clinical Reference Group** will work with the Partnership to ensure that the Sector works to the highest possible clinical standards, and will be the conduit through which clinical advice and decisions are communicated to the Collaborative Commissioning Group.

3. SERVICE SPECIFICATION

Overview

3.1 The following table 1 sets out roles and responsibilities for the commissioning function in detail.

- Responsible (R) – the individual(s) who perform(s) an activity. They are responsible for action / implementation. Responsibility can be shared.
- Accountable (A) – the individual who has the decision making authority and power of veto. This individual is held responsible in the event of failure. There can only be one accountable person assigned to an activity / decision.
- Consulted (C) – the individual(s) who are consulted prior to a final decision or action being taken. This is a two-way communication.

In the table, the PCT remains legally accountable for the Partnership's activities as the Partnership is not a legal entity in its own right. However, responsibility for different activities within the Partnership's structures will vary between the Partnership and the PCTs.

Table 1: Commissioning Cycle Functions: Roles and Responsibilities

			Activities	R	A	C
Plan	Assess needs and prioritise (1.1)	1.1.1	Scan horizon to inform JSNA/CSP/OP	CP	PCT	PCT/HfL/SHA/PP
		1.1.2	Prepare JSNA/CSP/OP and OD Plan including acute component within timelines including significant clinical input	PCT	PCT	LA/SHA/PP/PBC
		1.1.3	Consult with patient groups, borough, public health and analyse outputs in forming the JSNA/CSP	PCT	PCT	LA/SHA/PP/PBC
		1.1.4	Prioritise strategies and designate to the Partnership	PCT	PCT	LA/SHA/PP/PBC
		1.1.5	Develop improvement plans for acute services on WCC competencies based on PCT OD plans and other inputs	CP	PCT	SHA
		1.1.6	Collate, analyse and benchmark non-acute information (analytical support)	PCT	PCT	-
		1.1.7	Collate, analyse and benchmark acute information (analytical support)	CP	PCT	CSL
	Care Pathway and Service Redesign (1.2)	1.2.1	Identify opportunities for care pathway redesign (in line with CCI) (with PBCs)	PCT	PCT	PBC/PP
		1.2.2	Ensure strong clinical input into care pathway redesign	PCT	PCT	CN/PBC
		1.2.3	Support the design and testing of the acute side of redesigned care pathways or where the redesign relates predominantly to the acute sector	CP	PCT	CN
		1.2.4	Support modelling of service redesign (information analysis – activity/volume into/out of acute sector)	CP	PCT	-
		1.2.5	Lead discussions and negotiations with acute providers and implement redesigned pathways as requested	CP	PCT	CN
		1.2.6	Work closely with Networks to implement service redesign within the acute sector	CP	PCT	CN
		1.2.7	Conduct 'best value' reviews for redesigned pathways and use learnings to disseminate good practice throughout the sector	CP	PCT	CSL
		1.2.8	Provide analysis to support redesign of services, business case production and production of ITTs	CP	PCT	CSL
	Strategic and Capacity Planning (1.3)	1.3.1	Provide analytical support for strategic and capacity planning for acute services	CP	PCT	-
		1.3.2	Conduct financial assessment against plans	PCT	PCT	-
		1.3.3	Conduct meetings with PBC to support planning	PCT	PCT	PBC
		1.3.4	Adjust plan based on consultation with public health and PBCs	PCT	PCT	PBC/PP
		1.3.5	Lead on identification of acute services/activities to commission/decommission	PCT	PCT	CP
		1.3.6	Operationalise acute components of strategic plans produced by PCT, CCI's and public health	CP	PCT	SPD/CN
		1.3.7	Test assumptions with acute trusts	CP	PCT	-
		1.3.8	Produce annual report – acute provider performance	CP	PCT	SPD/CN
		1.3.9	Formulate acute provider monthly and quarterly performance reports	CP	PCT	SPD/CN

			Activities	R	A	C
Engage	Public/Clinical Engagement (2.1)	2.1.1	Lead public and clinical engagement discussions	PCT	PCT	PBC
		2.1.2	Set the framework for service redesign and testing	PCT	PCT	PBC
		2.1.3	Drive local engagement	PCT	PCT	PBC
		2.1.4	Collate patient feedback across the sector (trend analysis)	CP	PCT	-
		2.1.5	Provide analytical function and evidence of compliance (eg, provide intelligent commentary on HCC rating)	CP	PCT	CSL
		2.1.6	Engage GPs and clinicians in the development of KPIs and CQuINs	PCT	PCT	PBC/CP
	Patient Registration and Engagement (2.2)	2.2.1	Ensure effective patient registration processes in place	PCT	PCT	PBC
		2.2.2	Ensure patients are made aware of choice and local services available through campaigns	PCT	PCT	PP
		2.2.3	Engage patients in improving services and care	PCT	PCT	PP/PBC
	Customer Service and Patient Feedback (2.3)	2.3.1	Lead on collecting and collating patient feedback received through PALS and PCT mechanisms	PCT	PCT	PP
		2.3.2	Receive and review acute provider complaint reports	CP	PCT	SPD/CN
		2.3.3	Collate and analyse acute trust specific complaint figures	CP	PCT	-
		2.3.4	Resolve issues arising as a result of acute delivery of care	CP	PCT	SPD/CN
		2.3.5	Send surveys (GP bi-annually/PCT quarterly)	PCT	PCT	SPD/CN
		2.3.6	Create remedial action plans for follow-up based on acute trust survey data / complaints reports	CP	PCT	SPD/CN
		2.3.7	Review choose and book feedback	CP	PCT	-
		2.3.8	Champion the use of choose and book and promote its use by practices	PCT	PCT	PBC
		2.3.9	Proactively identify quality indicators areas for improvement and challenge the acute commissioning portfolio	CP	PCT	PCT
		2.3.10	Provide acute analytical support (eg, PROMs)	CP	PCT	CSL
		2.3.11	Provide acute benchmarking information	CP	PCT	CSL
		2.3.12	Undertake root cause analysis of acute issues allocated to it and consult with PCTs on findings	CP	PCT	PCT

			Activities	R	A	C
Manage	Performance Management of Contracts (4.1)	4.1.1	Deliver all performance management reporting at sector level and to individual PCTs on acute performance	CP	PCT	-
		4.1.2	Undertake all performance monitoring of PCT WCC acute outcome measures	CP	PCT	CSL
		4.1.3	Review activity vs plan	CP	PCT	CSL
		4.1.4	Review and validate all activity (including non-contract activity)	CP	PCT	PCT
		4.1.5	Review SUS data	CP	PCT	-
		4.1.6	Reconcile SUS data to SLAM information and provide exception reports to the PCTs	CP	PCT	-
		4.1.7	Raise challenges for performance management	CP	PCT	-
		4.1.8	Conduct monthly meetings with acute providers to understand activity and service developments	CP	PCT	-
		4.1.9	Implement local demand management strategy	PCT	PCT	PBC/LA
		4.1.10	Monitor acute provider KPIs	CP	PCT	-
		4.1.11	Deliver non-acute component of CSP and operating plans within timeframe agreed	PCT	PCT	PBC/LA
		4.1.12	Deliver acute component of CSP and operating plans within timetables agreed with the PCTs	CP	PCT	SPD/CN
		4.1.13	Provide information on provider performance against acute contracts	CP	PCT	-
		4.1.14	Provide notice and ensure compliance with exit clauses for non-performing providers – decommission where appropriate	CP	PCT	-
		4.1.15	Outline clear process for remedial action	CP	PCT	-
		4.1.16	Manage acute providers within budget to deliver against all targets	CP	PCT	-
		4.1.17	Use data to benchmark providers	CP	PCT	-
		4.1.18	Assure adherence to national standards including NICE guidance	CP	PCT	-
		4.1.19	Provide performance information to PBC clusters via PCTs	CP	PCT	PBC
		4.1.20	Report all acute commissioning performance (activity against budget/contract)	CP	PCT	
		4.1.21	Share acute performance information with key stakeholders (including LAs)	CP	PCT	SHA/LA/PCT
		4.1.22	Evaluate impact of service redesign in terms of impact on acute care	CP	PCT	SPD/CN
	Coding Review (4.2)	4.2.1	Review clinical coding	PCT	PCT	-
		4.2.2	Identify independent treatment request activities which are not contracted and reflect PCT difference within the contracts	CP	PCT	PCT
		4.2.3	Cascade pan-sector coding reviews	CP	PCT	SPD/CN
		4.2.4	Review PBR exclusions	CP	PCT	SPD/CN
		4.2.5	Monitor against NICE guidance with clinical PCT input	CP	PCT	SPD/CN
	Pharmaceutical Cost Management (4.3)	4.3.1	Define process for responding to requests for high cost drugs	PCT	PCT	-
		4.3.2	Validate high cost drugs which sit outside of SLA	PCT	PCT	-
		4.3.3	Pan-London consistency.	CP	PCT	SPD/CN

Acute Sector

3.2 The Partnership will prepare an acute specific Sector wide strategic, operating and organisational development plan.

3.3 The Partnership will have lead commissioning responsibility for the following acute trusts and any other acute care providers as relevant including but not limited to Independent Sector hospital providers:

i) Ealing Hospital NHS Trust
ii) Hillingdon Hospital NHS Trust
iii) NWL Hospitals NHS Trust
iv) Imperial College Healthcare NHS Trust
v) Chelsea and Westminster NHS Foundation Trust
vi) Royal Brompton and Harefield NHS Trust
vii) West Middlesex University Hospital NHS Trust
viii) The London Ambulance Service[1]

3.4 In addition, the Partnership will coordinate for North West London links with lead commissioners for acute service contracts outside of the Sector. This will include the specification of contents where appropriate.

3.5 The Partnership will be responsible for deploying supply-side interventions, specifically developing and negotiating contracts with every provider, running competitive tender processes in line with procurement regulations and best practice, and decommissioning services where agreed with Sector members. Key roles and responsibilities are:

i) Acting as the primary interface between each PCT and each provider, leading the contract review process.

[1] The London Ambulance Service is not an acute sector provider but is a significant contract. Further information is given in section 3.23.

ii) Monitoring and improving relationships with each provider to strike the balance between competition and co-operation – driving greater commercial rigour in parallel with co-operative improvements in care.

iii) Validating that there is alignment with the strategy and support the PCTs in the assessment of the market to identify gaps and identify local and major alternative providers.

iv) Managing the competitive tender process where the strategic planning team has identified a need for competition in the market.

v) Planning all provider negotiation strategies prior to contracting.

vi) Maintaining appropriate audit trails for procurement transactions. If necessary, responding to queries from the Cooperation and Competition Panel for NHS funded services.

vii) Resolving legal procurement challenges and implementing corrective action.

viii) Providing input to the World Class Commissioning Assurance process, with a specific emphasis on: World Class Commissioning competency 5 “Manage knowledge and assess needs”, 7 “Stimulate the market”; World Class Commissioning competency 9 “Secure procurement skills” and World Class Commissioning competency 10 “Manage the local health system”.

The Partnership will work with the PCTs in the development of its strategies for contract negotiation, involving them in a timely fashion.

3.6 The Partnership shall commission the services in accordance with the law and good healthcare practice, and shall comply with:

i) All current national Department of Health guidance as amended from time to time.

ii) the recommendations arising from any audit, Serious Untoward Incident report or Patient Safety Incident report, including contributing to, as appropriate, the identification, recording and investigation of any such incidents.

iii) the standards and recommendations from time to time issued by any relevant professional body and agreed in writing between the Partnership and the services it commissions.

iv) the standards and recommendations from time to time contained in technology appraisals issued by the National Institute for Health and Clinical Excellence (or any successor).

v) Quality and Performance Standards.

vi) The Partnership shall ensure commissioned services carry out such patient experience surveys as agreed by all parties to this agreement in relation to the Services at reasonable intervals in accordance with the Law, nationally mandated requirements and co-operate with any surveys that the PCT may carry out. Details of arrangements for such surveys shall be made available to the PCT on request. The Partnership shall agree in advance, the nature and form of surveys with the Sector.

vii) For the avoidance of doubt, nothing in this Agreement is intended to prevent this Agreement from setting higher quality standards than those required by any Regulator, and the Parties shall make all reasonable efforts to comply with all NHS best practice guidance.

3.7 The Partnership will improve acute sector performance with a view to realising the Benefits identified in the Benefits Realisation Plan and set out in Schedule 4. The Benefits will be subject to review, and amended to take changing DH (Department of Health) and NHS London guidance into account.

3.8 In terms of improving contracts further, the Partnership will:

i) work with providers to set Patient Reported Outcome Measures (PROMs) thresholds and hold providers to account where performance does not meet the agreed levels.

ii) develop a best practice approach that can be applied to each contract.

iii) introduce a comprehensive performance management system to manage contract non-compliance within the Sector.

iv) manage the performance of all acute providers against national and local targets or contracts.

v) set the CQUINs for providers reflecting local PCT priorities.

3.9 In terms of clinical input to the commissioning process, the Partnership will:

i) ensure that providers are commissioned in line with a strong focus on quality of care and improved clinical outcomes as outlined by Standards for Better Health.

ii) put in place a robust clinical governance framework which will cover all aspects of acute clinical governance including patient safety, clinical effectiveness and assurance of secondary care processes.

3.10 In respect of information about provider performance, the Partnership will, working closely with **Commissioning Support for London (CSL) to:**

i) standardise and monitor the reporting processes to provide PCTs with accurate up to date information on the performance of each of the acute providers against their SLAs.

ii) report directly to each PCT against their schedule of requirements and individual trust performance, concerning individual contract performance.

ii) work with ACVs in other Sectors to share performance information and best practice.

iii) provide oversight of clinical standards of Sector acute providers for PCTs.

iv) apply robust clinical governance scrutiny across hospitals.

v) benchmark non-tariff prices across the Sector, report to PCTs and apply this information in the commissioning process.

3.11 The Partnership will aggregate data for all eight PCTs which will provide a broader benchmarking group.

<u>Stakeholders</u>

3.12 The Partnership will drive an “intelligent customer” relationship with **Commissioning Support for London (CSL)** in relation to CSL products that

support acute commissioning. The Partnership will work with CSL to shape commissioning tools and products.

3.13 In working with CSL, the Partnership will:

i) lead Sector-wide service review, redesign, capacity planning, business case development and travel time analysis.
ii) work with CSL on projects spanning the whole of London and coordinating the change process following consultation.
iii) support redesign work in individual PCTs on an ad hoc basis.
iv) highlight key changes to acute services and develop plans to operationalise these changes, e.g. taking into account NHS London requirements, PCT CSPs and operating plans.
v) support the design of any Sector-wide acute pathways, so that redesign changes are in line with NWL strategy.
vi) report on progress of individual projects and escalate key risks and issues
vii) engage with relevant stakeholders in developing the individual project plans.

Staff and hosting arrangements

3.14 The Partnership will develop clear career pathways for staff, to develop World Class Commissioning competencies in acute commissioning. The Partnership will develop a robust organisational development strategy and programme for skills development. The Partnership will ensure that it is staffed efficiently by competent people to deliver the service.

3.15 NHS Westminster will manage the employment contracts of the Partnership staff, including terms and conditions and Standard Financial Instruments. The Partnership will have a separate Service Level Agreement with NHS Westminster setting out the terms and value of the hosting arrangement.

Financial Management

3.16 The Partnership and PCTs' Executive Teams will agree an Acute Budget Envelope before the financial year begins. PCTs will set challenging but achievable budgets. The Partnership reserves the right to challenge PCTs if it believes that unreasonable budget expectations have been set for contract negotiations.

3.17 In terms of managing budgets:

i) The Partnership will keep the acute commissioning budgets separate and aligned to individual PCTs.
ii) The Partnership will negotiate the terms and costs of each provider SLA. The Partnership will feed back its recommendations to the PCTs' Executives for ultimate sign-off.
iii) If over-performance by a provider is identified then this will be funded by the particular PCT to which that over-performance applies. Similarly, if there is an under-performance by one of the providers then this will result in a contract adjustment for the particular PCT for which the under-performance applies
iv) The Partnership will alert the PCTs if there is an expected over-performance so that risk can be managed as effectively as possible.
v) The Partnership and PCTs will work together to address issues of over-performance, agreeing key actions and milestones. The Partnership will feed back to PCTs on progress in subsequent discussions with the Provider Trusts.
vi) The ultimate financial responsibility for signing off the budget for a provider SLA and an under- or over-performance against that SLA will remain with the individual PCTs. PCTs remain accountable for their financial performance and, as such, for setting reasonable baseline budgets.

3.18 In cases of strategic change, a Provider Trust may request transitional funding. The Partnership will consider the request carefully and make a recommendation to the JCPCT. The decision would require the support of

PCTs representing 75% of the value of the contract concerned. All decisions must take account of the organisational and financial position of member PCTs and the aim should be for decisions to be unanimous. The cost will be funded on a pro-rata basis according to the value of the contract to affected PCTs.

3.19 In terms of financial reporting, the Partnership will provide,

i) projections of forecast year end outturn position on SLAs across the total acute contract portfolio for each PCT – forecasting will be modelled on performance to date against plan, remedial action expected to be undertaken by PCTs e.g. reductions in GP referrals, discussion with providers re known service pressures, local knowledge.
ii) routine analysis for PCTs of activity and cost against the plan and KPIs as agreed as part of the Benefits Realisation Plan - identify any unexpected or unexplained variance to plan by specialty and actions arising. This reporting will take account of seasonal variations and map progress towards targets accordingly.
iii) a level of detailed financial reporting to allow PCTs to inform their budgeting processes and provide an adequate level of detailed reporting to their Boards.

3.20 Furthermore, the Partnership will hold monthly follow up meetings as required with PCTs to discuss any adverse or favourable variance to contract.

3.21 The Partnership will harness and share claims management best practice across the Sector's PCTs to validate provider invoices.

3.22 The Partnership will manage its administrative budget carefully and in line with best practice. Where there is a risk of overspend against the budget the Partnership will take action it considers necessary to bring the budget back into balance. Any recorded under spend will be reimbursed to the PCTs in line with their original contributions.

London Ambulance Service

3.23 The Partnership will take the role of co-ordinating commissioner on behalf of all London PCTs. The sector Chief Executive will act as NHS London's senior responsible officer for Emergency Care and the Partnerships Managing Director will act as the accountable officer for LAS and commissioning staff. The performance of LAS and expected improvements across the capital fall outside of the Benefits Realisation Plan but will form part the Consortium Governance Agreement with London PCTs.

Safeguarding Children and Vulnerable Adults

3.24 The Partnership is responsible for ensuring that the national guidelines on child protection and vulnerable adults are implemented and monitored in its commissioned services and that all relevant staff and subcontracted staff and/or services, working with children, young people, vulnerable adults and their families, have enhanced CRB checks and take all reasonable measures to ensure that the risks of harm to children's, young people's and vulnerable adults' welfare are minimised and; where there are concerns regarding children's, young people's and vulnerable adults' welfare, appropriate, timely action is taken.

Management Information

3.25 Reliable data is essential to the successful functioning of the Partnership. The Partnership and PCTs will work together to ensure that the necessary information is provided. The reports to be provided by the Partnership, which should include analysis, are set out in Schedule 2. A data-sharing agreement is at Schedule 3. These Schedules will be amended from time to time as PCT, NHS London and the Department of Health requirements change.

3.26 The Partnership will work with CSL to maximise the tools and resources to support the delivery and presentation of the reports to the PCT

Information requests

3.27 The Partnership will seek to respond promptly to the information requests from the PCTs and specifically commits to:

i) responding to queries relating to patient safety and specific patient queries immediately

ii) responding to information queries and issues relating to service development within three working days

PCT Responsibilities

3.28 The PCTs will be responsible for the following:

i) Payment to the Partnership in the amount of and in accordance with the procedures detailed in this agreement;

ii) Performance management of the agency and the services it commissions; via delegated responsibility to the JCPCT;

iv) The payments required under contract to the service providers commissioned by the Partnership

v) Proving annual commissioning intentions in a timely manner;

vi) To incorporate the experience and expertise of service users and other experts in the planning and development process;

vii) The provision of data and information to the Partnership that the Partnership will require to fulfil its duties and obligations including all existing contracts, SLAs and MOUs and all other documentation, agreement or practice relating to the Partnership contracts within three working days of a request from the Partnership;

viii) The provision of support and co-operation with the Partnership in all matters regarding the commissioning and performance management of all Partnership contracts;

ix) Provide input into the development of CQUINS with Providers;

x) The provision of expert help as reasonably required from time to time to enable the Partnership to develop and implement strategy and change (e.g. Public Health Advisors);

xi) To provide a single point of contact for the Partnership to facilitate better working;

xii) To provide a written report once a month summarising key issues that have arisen between the Providers and Practice Based Commissioners Maintaining an active dialogue with Practice Based Commissioners and feeding their views into the Partnership.

3.29 PCTs will have a specific role in responding to incidents and complaints:

i) In the event of a Serious Untoward Incident (SUI) or emergency, the Provider Trust would contact the relevant PCT and copy in the Partnership. The Partnership will have oversight of acute SUIs, root-cause analysis and sign-off.

ii) The expectation is that PCTs will continue to manage patient complaints. The Partnership will support the PCTs in responding to the complaints as appropriate.

3.30 Furthermore, Chief Executives of the PCTs will retain relationships with their local Provider Trusts, for example around borough based commissioning and patient care pathway design.

Non-Performance

3.31 No party shall be responsible to the others for any failure or delay in performance of their obligations and duties under this Agreement, which is caused by circumstances or events beyond reasonable control of a party. However, the affected party must promptly on the occurrence of such circumstances or events:

i) Inform the other party in writing of such circumstances or events and of what obligation or duty they have delayed or prevented being performed and;

ii) Take all action within its power to comply with the terms of this Agreement as fully and promptly as possible

iii) Unless the affected party takes such steps, this clause shall not have the effect of absolving it from its obligations under this Agreement. For the avoidance of doubt, any actions or omissions of either party's personnel or any failure of either party's systems, procedures, premises or equipment shall not be deemed to be circumstances or events beyond the reasonable control of the relevant party for the purposes of this clause, unless the cause of failure was beyond reasonable control.

iv) PCTs can raise issues about the performance of the Partnership through the Dispute Resolution process set out in Section 9.

v) Where a PCT has failed to meet its responsibility to the Partnership, the Partnership can escalate this issue to the JCPCT. The JCPCT would make a decision on the basis set out in the Section Dissolution and Managing Risk.

4. OBLIGATIONS AND RESPONSIBILITIES

4.1 The Partnership and PCTs will need to have a successful collaborative working relationship to secure the improvements in commissioning. This working relationship should be built up through active support of the various Governance Groups and through ongoing contacts. PCTs will commit the time and investment necessary to be an "intelligent customer" of the Partnership and will play an active role in collective priority setting.

4.2 The Partnership and PCTs will work together to improve commissioning and acute performance in North West London. The Partnership will act as the agent of PCTs in improving provider performance. PCTs ensure that their staff are fully aware of the Partnership's role to avoid duplication of work. They will commit to the necessary changes to the way they commission to improve World Class Commissioning Assessment rankings.

4.3 The Partnership will in at all times exercise its duty of care towards the Sector and will act in the best interests of the Sector.

4.3 The Partnership will form strong and consistent relationships with acute providers, striking the balance between competition and cooperation using best practice relationship management techniques from across the Sector, on behalf of North West London NHS as a whole.

4.4 To improve capability, the Partnership will bring together current resources and supplement them with additional talent to drive better outcomes for patients and commissioners. The Partnership and PCTs will support each other in embedding commissioning skills and expertise across North West London. This will include rotational and flexible career opportunities.

4.5 PCTs will commit to funding the Partnership. NHS Westminster will manage payroll and office accommodation for the Partnership staff, and will be reimbursed from the Partnership's funds.

4.6 The introduction of the Partnership requires a significant commitment to change practices and this will take time to embed before the real benefits are delivered. Therefore this agreement will need to run for a minimum period of 3 years to allow the potential to be achieved fully.

5 PERFORMANCE MONITORING

5.1 A set of key performance indicators (KPIs) – i.e. a set of quantifiable measures that are used to assess performance – has been established to monitor the performance of the Partnership and is set out in the Benefits Realisation Plan in Schedule 4.

5.2 The Partnership will maintain a performance dashboard and issue a quarterly benefits report which will be reviewed at the Commissioning Partnership Business Group.

5.3 This quarterly benefits report shall consist of at least the following KPIs:

i) Acute indicator scores for the acute trusts contracting with the PCTs. These indicators are published by the Care Quality Commission (CQC) and a complete list can be found in the Benefits Realisation Plan in Schedule 4 of this SLA

ii) Acute related PCT indicator scores. These indicators are published by the CQC. Refer to the Benefits Realisation Plan in Schedule 4 for a suggested list of indicators which can be classified as ‘acute related’.

iii) The Partnership running costs (including ACV, Clinical Directorate and SPD)

iv) The Partnership staff turnover rates

v) The Partnership staff satisfaction rates (annual)

vi) The number of temporary staff employed by the Partnership

vii) Commissioning for Quality and Innovation (CQUIN) measures for NWL providers

viii) Patient Reported Outcome Measures (PROMs) for NWL providers

ix) Results from the acute relevant CQC national patient surveys

x) Results from local patient surveys

xi) Total expenditure on elective non-tariff activity for NWL PCTs. This should be against the agreed levels of activity and financial plan and show OP and non-elective as well as elective.

xii) Expenditure per weighted population on elective non-tariff activity for the NWL PCTs

xiii) Latest activity and financial performance for each provider SLA

xiv) Performance against any volume reducing metrics that are included in the provider SLAs (e.g. consultant to consultant referrals, first to follow-up ratios)

xv) Latest performance of the NWL PCTs against World Class Commissioning (WCC) competency 5 – "Manage knowledge and assess needs"

xvi) Latest performance of the NWL PCTs against WCC competency 7 – "Stimulate the market"

xvii) Latest performance of the NWL PCTs against WCC competency 9 – "Secure procurement skills"

xviii) Latest performance of the NWL PCTs against WCC competency 10 – "Manage the local health system"

The KPIs will be amended from time to time as JCPCT, NHS London and Department of Health requirements change.

5.4 The PCTs are responsible for monitoring the performance of the Partnership under this SLA through the JCPCT and the Commissioning Partnership Business Group, using the above quarterly benefits report performance indicators. In addition, the PCTs will also use indicators such as quality, accuracy and timeliness of the information received to provide feed back to the Partnership and performance manage the SLA.

5.5 The Partnership will seek regular feedback from PCTs. As part of the Annual Review process set out in the Agreement Period, the Partnership will present its achievements and development areas, taking account of feedback and setting out the improvement actions it will take.

6. COSTS AND PAYMENT

6.1 The Partnership's costs are set out in Table 1 below.

Table 2 Partnership cost summary

Cost category	2009/10	2010/11	2011/12	2012/13
Acute commissioning costs	£2.18m	£4.09m	£3.99m	£3.99m
SPD costs	£0.69m	£1.19m	£1.19m	£1.19m
Transition costs	£0.80m	£0.01m	£0.01m	£0.01m
Total	**£3.67m**	**£5.29m**	**£5.19m**	**£5.19m**

(Note: totals correct, rounding may affect addition of parts. This includes costs for the Strategic Planning Directorate.)

6.2 The cost contributions to the Partnership will be allocated to each of the PCTs based on their weighted populations.

Table 3 Cost contributions from each of the PCTs in the Sector to the Partnership- including costs for the Strategic Planning Directorate.

PCT	% Contribution[2]	2009/10 contribution[3] [4]	2010/11 contribution	2011/12 contribution	2012/13 contribution
Brent	15.92%	£0.54m	£0.84m	£0.83m	£0.83m
Ealing	17.54%	£0.60m	£0.93m	£0.91m	£0.91m
Hammersmith & Fulham	9.75%	£0.34m	£0.52m	£0.51m	£0.51m
Harrow	10.11%	£0.35m	£0.53m	£0.52m	£0.52m
Hillingdon	12.38%	£0.43m	£0.66m	£0.64m	£0.64m

[2] Based on weighted population

[3] The contributions in the first and second years of operation include transition costs. Contributions to the Partnership for this period will be revised, on a pro-rata basis, to take into account the date that the PCT transferred staff to the Partnership.

[4] Westminster PCT has agreed to fund £200,000 of the £410,139 Ernst & Young consultancy costs. The remaining costs will be divided along the lines of the proportions set out in Table 3.

PCT	% Contribution[2]	2009/10 contribution[3,4]	2010/11 contribution	2011/12 contribution	2012/13 contribution
Hounslow	11.99%	£0.42m	£0.63m	£0.62m	£0.62m
Kensington & Chelsea	9.61%	£0.34m	£0.51m	£0.50m	£0.50m
Westminster	12.70%	£0.65m	£0.67m	£0.66m	£0.66m
Total contributions	**100%**	**£3.67m**	**£5.29m**	**£5.19m**	**£5.19m**

6.3 In the mobilisation phase, covering the year 2009/10, PCTs' contributions will be calculated on a pro-rata basis depending on when they transferred staff into the Partnership or when the acute commissioning function transferred.

6.4 The Partnership will not overspend against these agreed costs unless agreed in advance by the JCPCT.

7. CONFIDENTIALITY

7.1 Other than as allowed in this Agreement, Confidential Information is owned by the Party that discloses it (the "Disclosing Party") and the Party that receives it (the "Receiving Party") has no right to use it.

7.2 Subject to Sections 7.3 and 7.4, the Receiving Party agrees:

i) to use the Disclosing Party's Confidential Information only in connection with the Receiving Party's performance under this Agreement;

ii) not to disclose the Disclosing Party's Confidential Information to any third party or to use it to the detriment of the Disclosing Party; and

iii) to maintain the confidentiality of the Disclosing Party's Confidential Information and to return it immediately on receipt of written demand from the Disclosing Party.

7.3 The Receiving Party may disclose the Disclosing Party's Confidential Information:

i) in connection with any dispute resolution process set out in Section 9

ii) in connection with any litigation between the Parties;

iii) to comply with the Law;

iv) to a Regulator and or to Monitor as required;

v) to its staff, who shall in respect of such Confidential Information be under a duty no less onerous than the Receiving Party's duty set out in section 7.2 ; and

vi) to NHS Bodies for the purpose of carrying out their duties

7.4 The obligations in clauses 7.2 and 7.3 shall not apply to any Confidential Information which:-

i) is in or comes into the public domain other than by breach of this Agreement;

ii) the Receiving Party can show by its records was in its possession before it received it from the Disclosing Party; or

iii) the Receiving Party can prove that it obtained or was able to obtain from a source other than the Disclosing Party without breaching any obligation of confidence.

7.5 The Disclosing Party does not warrant the accuracy or completeness of the Confidential Information.

7.6 The Receiving Party shall indemnify the Disclosing Party and shall keep the Disclosing Party indemnified against Losses and Indirect Losses suffered or incurred by the Disclosing Party as a result of any breach of this Section.

7.7 The Parties acknowledge that damages would not be an adequate remedy for any breach of the commitments set out in this section by the Receiving Party, and in addition to any right to damages the Disclosing Party shall be entitled to the remedies of injunction, specific performance and other equitable relief for any threatened or actual breach of this Section.

7.8 This Section (Confidential Information of the Parties) shall survive the expiry

or the dissolution of this Agreement for any reason, for a period of 5 years.

8. DATA PROTECTION AND FREEDOM OF INFORMATION

8.1 Both the Partnership and the PCTs acknowledge their respective duties under the Data Protection Act 1998 and the Freedom of Information Act 2000 and hereby confirm that they will fully comply with said Acts and shall give all reasonable assistance to each other where appropriate or necessary to comply with any obligations arising under the said Acts.

8.2 All parties shall ensure that Personal Data is safeguarded at all times in accordance with the Law, which shall include without limitation the obligation on the Partnership to:

i) perform an annual information governance self-assessment against the Primary Care Trust requirements using the NHS information governance toolkit;

ii) have an information guardian able to communicate with the JCPCT board, who will take the lead for information governance and from whom the Provider's board shall receive regular reports on information governance matters including details of all data loss and confidentiality breaches;

iii) (where transferred electronically between a PCT and the Partnership, and between a Provider and the Partnership) only transfer essential data that is (a) necessary for direct patient care; and (b) encrypted to the higher of the international data encryption standards for healthcare and the National Standards (this includes, but is not limited to, data transferred over wireless or wired networks, held on laptops, CDs, memory sticks and tapes);

iv) have policies which are rigorously applied that describe individual personal responsibilities for handling Personal Data;

v) have a policy that allows it to perform its obligations under the NHS Care Records Guarantee;

vi) have agreed protocols for sharing Personal Data with other NHS organisations and (where appropriate) with non-NHS organisations; and

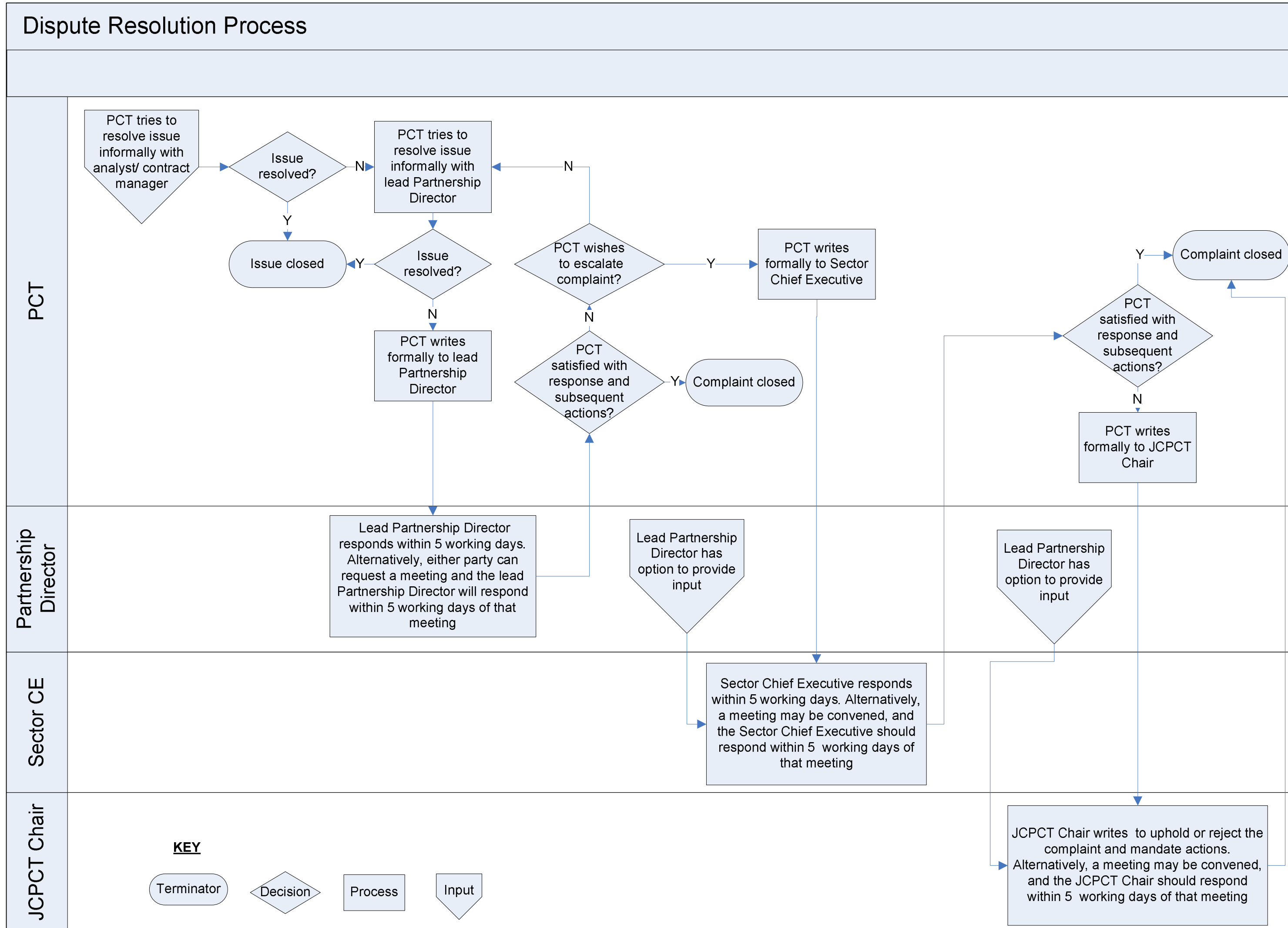
vii) have a system in place and a policy for the recording of any telephone

calls, where appropriate, in relation to the Services, including the retention and disposal of such recordings.

9. DISPUTE RESOLUTION

9.0 The process for dispute resolution is set out in Diagram 2

Diagram 2


Dispute Resolution Process
PCT
Partnership Director
Sector CE
JCPCT Chair
PCT tries to resolve issue informally with analyst/ contract manager
Issue resolved?
N
Y
Issue closed
PCT tries to resolve issue informally with lead Partnership Director
Issue resolved?
Y
N
PCT writes formally to lead Partnership Director
Lead Partnership Director responds within 5 working days. Alternatively, either party can request a meeting and the lead Partnership Director will respond within 5 working days of that meeting
PCT satisfied with response and subsequent actions?
Y
Complaint closed
N
PCT wishes to escalate complaint?
N
Y
PCT writes formally to Sector Chief Executive
Lead Partnership Director has option to provide input
Sector Chief Executive responds within 5 working days. Alternatively, a meeting may be convened, and the Sector Chief Executive should respond within 5 working days of that meeting
PCT satisfied with response and subsequent actions?
Y
Complaint closed
N
PCT writes formally to JCPCT Chair
Lead Partnership Director has option to provide input
JCPCT Chair writes to uphold or reject the complaint and mandate actions. Alternatively, a meeting may be convened, and the JCPCT Chair should respond within 5 working days of that meeting
KEY
Terminator
Decision
Process
Input

Resolving complaints informally

9.1 Day to day liaison between PCTs and the Partnership is managed through the analyst/ contract manager. Informal complaints should initially be made through the analyst/ contract manager and it is hoped that most can be resolved at this stage. The PCT relationship lead within the Partnership will be the lead Partnership Director, (including the Managing Director, the Strategy and Performance Director and the Clinical Director) who will develop relationships with PCTs and resolve concerns informally and at an early stage. Formal dispute is a last resort, which should seldom if ever be necessary. Most disagreements can be solved through discussion and negotiation. PCTs will endeavour to resolve complaints informally where possible.

Stage 1: Formal Complaint to lead Partnership Director

9.2 A PCT may choose to make a formal complaint in writing. In this instance, a representative of the PCT, at least Director grade, will write to the lead Partnership Director, setting out their complaint and with supporting evidence. The lead Partnership Director will respond within five working days. This response will address the complaint and set out the actions that will be taken as a result and the timescales.

9.3 Either the PCT representative or the lead Partnership Director may wish to meet to discuss the complaint, and this meeting should be held as soon as convenient. The lead Partnership Director will write to respond formally within five working days of the meeting.

Stage 2: Escalation to Sector Chief Executive

9.4 In escalating further:

i) If the PCT is dissatisfied with the response, then a PCT representative, of at least Director level, can, within five working days, write formally to

the **Sector Chief Executive** to escalate the issue. This letter should set out the complaint, substantiated where possible by evidence and explain why the Partnership Director's response has not addressed the issue satisfactorily. The letter should be copied to the lead Partnership Director, who has five working days to respond.

ii) If the PCT is not satisfied that the actions promised by the lead Partnership Director have been carried out satisfactorily within the promised timescales, then a PCT representative, of at least Director level, can escalate the issue through writing formally to the Sector Chief Executive, setting out the complaint substantiated by evidence where possible. This letter should be copied to the lead Partnership Director, who has five working days to provide his or her input to the Sector Chief Executive.

9.5 In responding:

i) The Sector Chief Executive shall write to the party making the complaint within five working days of the deadline for the lead Partnership Director's response, copied to the other parties referred to in 9.6. In this letter, the Sector Chief Executive should uphold or reject the complaint, giving reasons. The Sector Chief Executive has the option to request actions with timescales. The lead Partnership Director would then report on progress on these to the Sector Chief Executive.

ii) Alternatively, at the discretion of the Sector Chief Executive, or at the request of either the PCT representative, the lead Partnership Director or the Chair of the Commissioning Partnership Business Group, a meeting may be held to discuss the complaint. The meeting should be held as soon as convenient, and the Sector Chief Executive should write to respond formally to the complaint within five working days of the meeting, copying in the parties mentioned in this paragraph.

Stage 3: Escalation to JCPCT Chair

9.6 In terms of further escalation:

i) If the PCT is dissatisfied with the outcome then they can appeal to the **JCPCT** within five working days of the Sector Chief Executive response. The lead Partnership Director has five working days to respond.

ii) Moreover, if the PCT or the Sector Chief Executive is not satisfied with the progress made in taking forward the actions specified by the Sector Chief Executive, then they can appeal to the JCPCT Chair. This appeal should take the form of a written letter setting out the original complaint, and the reasons for the appeal, supported by evidence. The letter should be copied to the other parties referred to in this paragraph, and the lead Partnership Director who has five working days to provide his or her input to the Sector Chief Executive.

9.7 In responding,

i) The JCPCT Chair shall write to the party making the complaint within five working days of the deadline for the lead Partnership Director's response, copied to the other parties referred to in 9.6. In this letter, the JCPCT Chair should uphold or reject the complaint, giving reasons. The JCPCT Chair has the option to request actions with timescales. The lead Partnership Director would then report on progress on these to the JCPCT Chair.

ii) Alternatively, at the discretion of the JCPCT Chair, or at the request of the complaining party, a meeting may be held to discuss the complaint. The meeting should be held as soon as convenient, and the Sector Chief Executive should write to respond formally to the complaint within five working days of the meeting, copying in the parties mentioned in paragraph 9.6. The JCPCT Chair has the option to request actions with timescales. The lead Partnership Director would then report on progress on these to the JCPCT Chair.

NHS London Intervention

9.8 Intervention is a formal process, signaled by a letter from NHS London's Chief Executive to the PCT or Sector Chief Executive. It is distinct from advice NHS London may provide to, and requests it may make of, PCTs in review meetings and day-to-day interactions. NHS London will endeavour to use these informal approaches to support PCTs and the Partnership to resolve performance issues without the need for formal intervention.

9.9 NHS London will use three stages of escalation and intervention:

i) 'Performance under review'

ii) 'Underperforming'

iii) 'Challenged'

When an organisation is underperforming, it will be given the defined maximum period of time in which to recover. Failure to demonstrate recovery within this timescale will result in escalation.

9.10 Commissioner risk ratings will be used to typically trigger intervention by NHS London. In most cases, escalation and further intervention would only result where a PCT or the Partnership fails to address underperformance within the defined period. Each level of intervention will have a corresponding set of consequences which affect reporting frequency, risk rating and reputation.

9.11 NHS London will use a range of intervention options to resolve performance issues at PCTs and the Partnership, which are in line with its broad-ranging powers and remit. These range from commissioner-led investigation to organisation/ service restructuring. Depending on the particular situation the intervention options may be used individually or in concert.

9.13 Consistent with the principle that NHS London's approach to intervention will be clear in purpose, interventions will relate specifically to the areas where the risk

rating has led to concern. However, NHS London may broaden its scope of action if its initial intervention reveals further areas of concern.

9.14 Performance improvement teams will be created to address poor performance across a number of areas. These teams will be funded by PCTs based on their performance with poor performing organisations contributing the most.

This Agreement has been entered into on the date stated at the beginning of it.

Signed on behalf of the NWL Partnership

____

Dated:

Signed on behalf of NHS Brent

____

Date:

Signed on behalf of NHS Ealing

____

Date:

Signed on behalf of NHS Hammersmith and Fulham

____

Date:

Signed on behalf of NHS Harrow

____

Date:

Signed on behalf of NHS Hillingdon

____

Date:

Signed on behalf of NHS Hounslow

____

Date:

Signed on behalf of NHS Kensington and Chelsea

____

Date:

Signed on behalf of NHS Westminster

____

Date:

SCHEDULE 1

FULL LIST OF CONTRACTS

Table 4

NW London Sector Trusts
Imperial SLA
Chelsea & Westminster SLA
Royal Brompton SLA
NW London Hospitals SLA
Ealing Hospital
West Middlesex Hospital
Hillingdon Hospital

Other London Trusts
London Ambulance Trust SLA (co-ordinating commissioner)
UCL Hospitals SLA
Guy's & St Thomas' SLA
Royal Free SLA
Royal Marsden SLA
Barts & London Hospitals SLA
Great Ormond St SLA
Moorfields SLA

Kings HealthCare SLA
St Georges HealthCare SLA
Whittington SLA
Royal National Ortho SLA
Homerton
Barnet & Chase Farm
North Middlesex

Out of London Trusts
Kingston Hospital
Epsom & St Helier
Heatherwood & Wexham Park
Ashford & St Peter's
Queen Victoria
Royal Surrey
West Herts hospital
East & North Herts

Acute: NCAs
Non Contract Activity

SCHEDULE 2

REPORTING COMMITMENTS

The precise timing of these reports will be agreed between the Partnership and Heads of Information before the sign-off of the final SLA.

Table 5: Partnership reports

Commissioning Cycle	Performance & Information Activities	Report Name	Format & Method of Delivery	Timetable (Frequency)	Start
Plan – Assess Needs	PI.101 - Share acute information/analysis with PCTs to support needs assessment for acute service capacity planning.	PIr.101 - Acute needs report	Web Portal	Annually	Nov-09
	PI.102 Predictive modeling to asses impact on acute services and ultilisation	PIr.102 Predictive modelling report	Web Portal	Quarterly	Dec-09
Engage – Design Services	PI.201 - Support modeling of service redesign focusing on the impact on the acute sector	PIr.201 Service redesign report	Internal. Available to PCTs on request	Project specific	Dec-09
	PI.202 - Analysis to support the work of the SPD	PIr.202Ad hoc reports	Internal. Available to PCTs on request	Project specific	Dec-09
Procure - Effectively Contract	PI.301 - Support development of acute metrics	PIr.301 Acute metric planning report	Web Portal	Annual	Dec-09
	PI.302 - Write schedule 5 of contract	PIr.302 Schedule 5	Internal. Available to PCTs on request	Annual	Dec-09
	PI.303 - Model expected activity ost	PIr.303 Activity and finance models for contracts	Web Portal	Annual	Dec-09
	PI.304 - Model impact of service redesign/change in need for contracts and Sector CSP (with PCT)	PIr.304 Activity and finance models for CSPs	Web Portal	Annual	Dec-09
	PI.305 - Providing market analysis to support negotiations (e.g. reference cost analysis)	PIr.305 Market Analysis report	Web Portal	Annual	Dec-09
Manage – Monitor Performance	PI.401 - Claims management analysis	PIr.401 Aggregated claims management report	Web Portal	Monthly	Oct-09
	PI.402 - Analysis of over/under performance (proactive and reactive)	PIr.402 Summary Over/Under	Web Portal	Monthly	Oct-09

		performance Repot PIr.402 Summary Exception Reports	 Web Portal and notification by e-mail to respective PCT		
	PI.403 - Analysis to support standards assurance	PIr.403 Standards Assurance report	Web Portal	Monthly	Oct-09
	PI.404 - Performance monitoring (Quality & Outcomes)	PIr.404 Quality & Outcomes benchmarking report	Web Portal (Future CSL)	Monthly	Sep-09
	PI.405 – Performance monitoring – Value for Money and Productivity	PIr.405 VfM and Productivity Report benchmarking report	Web Portal	Quarterly	Nov-09
	PI.406 - Market metric monitoring	PIr.406 Market metric report	Web Portal	Monthly	
	PI.407 - Monitoring of patient experience	PIr.407 Patient Experience reports	Web Portal	Quarterly	Nov-09
	PI.408 - Analysis to support evaluation/effectiveness of service redesign on acute services	PIr.408 Project specific analysis and reporting Ad hoc reports	E-mail	Project Specific	Dec-09
	PI.409 - Share performance information with key stakeholders and partners	PIr.409 Ad hoc reports	E-mail	Ad Hoc	Dec-09

SCHEDULE 3

Data sharing agreement between the Partnership and the PCTs

Data required

This data sharing agreement makes provision for the sharing of information between Acute Commissioning Vehicles to support the performance management of acute NHS trusts in London. In addition to monitoring and managing the acute related PCT targets, the vehicles will also need to monitor the acute trust targets which do not form part of PCTs' Periodic Reviews. The table below shows the 26 targets which the vehicles will need to monitor and manage. The definitions of the targets can be found on the Care Quality Commission website. http://www.cqc.org.uk/

Table 6 – Targets for which ACVs are responsible

PCT/Acute	Target	Data Source	Frequency
PCT	Category A calls meeting 19 minute standard	LAS	Weekly
PCT	Category A calls meeting 8 minute standard	LAS	Weekly
PCT	Category B calls meeting 19 minute standard	LAS	Weekly
PCT	Diabetic retinopathy screening	ACV	Monthly
PCT	Pregnant women: 12 week maternity appointment	ACV	Monthly
Both	18 week referral to treatment times	UNIFY2	Monthly
Both	Access to GUM clinics	UNIFY2	Monthly
Both	All cancers: one month diagnosis (decision to treat) to treatment (including new cancer strategy commitment)	CWTDb	Monthly
Both	All cancers: two month urgent referral to treatment (including new cancer strategy commitment)	CWTDb	Monthly
Both	All cancers: two week wait	CWTDb	Monthly
Both	Delayed transfers of care	SitReps	Weekly
Both	Incidence of Clostridium difficile	HPA	Real Time

Both	Inpatients waiting longer than the 26 week standard	HPA	Monthly
Both	Outpatients waiting longer than the 13 week standard	ACV	Monthly
Both	Patients waiting longer than three months (13 weeks) for revascularisation	ACV	Monthly
Both	Stroke care	ACV	Monthly
Both	Total time in A&E	SitReps	Weekly
Both	Data Quality on Ethnic Group	SUS	Monthly
Acute	Access to healthcare for people with a learning disability	ACV	Monthly
Acute	Cancelled operations and those not admitted within 28 days	ACV	Monthly
Acute	Incidence of MRSA Bacteraemia	HPA	Real Time
Acute	Experience of patients	ACV	Annual
Acute	Infant health and inequalities: smoking during pregnancy and breastfeeding initiation	ACV	Monthly
Acute	Maternity Hospital Episodes Statistics: data quality indicator	SUS	Monthly
Acute	NHS Staff satisfaction	ACV	Annual
Acute	Waiting times for Rapid Access Chest Pain Clinic	ACV	Monthly

A large amount of this data should be available directly to the PCT via online systems such as UNIFY2 and Open Exeter. It is the responsibility of the Acute Commissioning Vehicles to ensure that this data can be accessed for all relevant trusts and PCTs. In addition the ACVs will be responsible for monitoring the acute specific targets for all PCTs. Therefore this data does not need to flow between ACVs in order to facilitate the transfer of performance management from NHS London to ACVs (although this would obviously be desirable)

However, there are a small number of targets where data will need to be shared between the ACVs. The information required to monitor these targets is shown below. It is anticipated that this data will be provided at least monthly within 20 working days of the end of the month. The information will be sent securely via NHS mail and each

ACV will need to set up a dedicated NHS email account for the purpose of data transfer.

Table 7 – Basic data requirements

PCT/Acute	Target	Data Element
PCT	Diabetic retinopathy screening	Number of people with diabetes offered screening for the early detection of diabetic retinopathy
		Number of patients excluded from screening
PCT	Pregnant women: 12 week maternity appointment	The number of women who have seen a midwife or maternity healthcare professional for health and social care assessment of needs, risks and choices by 12 weeks and 6 days of pregnancy
Both	Outpatients waiting longer than the 13 week standard	Full waiting list returns are required
Both	Patients waiting longer than three months (13 weeks) for revascularisation	Full waiting list returns are required
Both	Stroke care	Number of patients who spent at least 90% of their time on a stroke unit
		Number of people who were admitted following a stroke
		Number of TIA cases with a higher risk of stroke who are treated within 24 hours
		Number of TIA cases with a higher risk of stroke

This information will need to be provided at a PCT level for all acute trusts within each sector.

SCHEDULE 4

BENEFITS REALISATION PLAN

SCHEDULE 5

WINDING DOWN

1. In the event of the termination of this Agreement for whatever reason the Parties agree to work together in good faith to ensure an orderly wind down of the Agreement and minimum disruption to the provisions of the Services.

2. The Partnership shall provide all reasonable co-operation and assistance and provide to the PCTs all information and documentation as prescribed in this Schedule or as might otherwise be reasonably requested by the PCTs should for whatever reason this Agreement comes to an end or in contemplation of the Agreement coming to an end.

3. The Partnership shall allow third parties acting on behalf of the PCTs and the PCTs themselves its employees officers or agents access at all reasonable times and at reasonable notice so as to not interfere with the delivery of the service to appropriate staff and sites as notified by the Authorised Officer in order to allow for the proper preparation for the transfer of staff (if applicable) and services.

4. The following information and supporting documentation shall be provided in both printed and electronic format and to a reasonable timescale laid down by the Authorised Officers in anticipation of the coming to an end of the Agreement (for what ever reason)

    - Information required for the purpose of the Transfer Regulations;
    - Full details of staff undertaking the provision of the Services;
    - Job description and full details of their duties and responsibilities
    - Salary costs
    - Terms and conditions of service
    - Relevant procedures/policies
    - Qualifications
    - Absenteeism
    - Industrial disputes
    - Outstanding industrial injury claims

- Leave entitlement
- Sickness records
- Pension entitlement
- Other contractual benefits

5. At the expiry of this Agreement (for whatever reason) the Partnership shall at the return at nil cost to each PCTs all equipment (of whatever nature including intellectual assets) used in providing the Services if the said equipment was originally supplied to the Partnership or if the equipment had subsequently been purchased by the Partnership with funds from the PCTs which has not subsequently been reasonably disposed of in the normal course of providing the Service together with all records relating to the Service (it being acknowledged that the Partnership may retain copies of the records for its own purposes)

6. The Parties shall agree a lead-out plan within such reasonable timescale as agreed by the Parties on the anticipation of the coming to an end of the Agreement (for whatever reason). The lead-out plan shall include outlines for project managing the transfer process from the Partnership to the PCTs or if a new provider which will achieve a controlled and timely transfer of the Services (with as little disturbance to the service users as is possible) and any staff from NHS Westminster to the PCTs and or incoming provider/partner if applicable. Such a plan must include and address as a minimum:

   - Resource and time allocated to the project by the Partnership
   - Resource, time allocation and requirements that will be required of the PCTs and incoming provider/partner
   - Staffing
   - The approach taken to staff transferring which will allow the incoming contractor access to these staff
   - Accommodation
   - Joint inspection of the condition of the premises
   - IT equipment (hardware and software), Data and records both current and archived (computer held, paper and other formats). Options for transfer and the transfer process of the data.
   - Work in progress and projects under development

- Records, management information and professional publications

- A contingency for the Partnership to continue to deliver the Services to the PCTs on a temporary basis following the expiry of this Agreement. Such a contingency should describe the process and outline costs.

7. Once notice has been served to terminate this Agreement (for whatever reason) and in any event towards the date of termination of the Agreement the Partnership undertakes not to change personnel or service delivery structure nor dismiss staff other than for bona fide economic or operational reasons related to delivery of the Services, including but not limited to changes to preclude or promote the application of the TUPE regulations. The Partnership should not unrealistically allocate staff without organisation or economic justification nor unreasonably reorganise its workforce into particular undertakings nor increase the remuneration of employees or otherwise improve their terms and conditions of employment without economic justification towards the date of termination of this Agreement with a view to discouraging other potential bidders/partners or otherwise.

8. During a reasonable period prior to termination the Partnership shall allow reasonable access to relevant premises, staff, IT sites and business/service processes in order that the PCTs and or tenderers/prospective partners as appropriate obtain an overview of the Services.

9. Upon the anticipation of the coming to an end of the Agreement the Partnership will with immediate effect work jointly with both the PCTs and the incoming provider/partner (if applicable) in order to achieve a controlled, accurate and timely transfer of staff, the services and the property utilised in providing the Services.