Primary Care Commissioning Committee

Wednesday 19 October 2016, 13:00 – 15:00
The Boardroom, Leafield House, King Lane, Leeds LS17 5BP

In Public

AGENDA

<table>
<thead>
<tr>
<th>Item No.</th>
<th>Item</th>
<th>Presented By</th>
<th>Paper Y/N</th>
<th>Time</th>
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</thead>
<tbody>
<tr>
<td>028/2016 PCCC</td>
<td>Welcome and Apologies</td>
<td>Graham Prestwich</td>
<td>N</td>
<td>13:00</td>
</tr>
<tr>
<td>029/2016 PCCC</td>
<td>Declarations of Interest</td>
<td>Graham Prestwich</td>
<td>N</td>
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<tr>
<td>030/2016 PCCC</td>
<td>Questions from members of the public Patient story</td>
<td>Graham Prestwich</td>
<td>N</td>
<td>13.05</td>
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<tr>
<td>031/2016 PCCC</td>
<td>Approval of PCCC minutes – 22 June 2016</td>
<td>Graham Prestwich</td>
<td>Y</td>
<td>13.15</td>
</tr>
<tr>
<td>032/2016 PCCC</td>
<td>Actions from PCCC – 22 June 2016</td>
<td>Graham Prestwich</td>
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Commissioning and strategy

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<tr>
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<tbody>
<tr>
<td>033/2016 PCCC</td>
<td>GP forward view – planning and delivery</td>
<td>Gina Davy</td>
<td>Y</td>
<td>13.20</td>
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<tr>
<td>034/2016 PCCC</td>
<td>Investment of PMS monies</td>
<td>Lindsey Bell</td>
<td>Y</td>
<td>13.35</td>
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<tr>
<td>035/2016 PCCC</td>
<td>Estates summary report</td>
<td>Gina Davy/Lindsey Bell</td>
<td>Y</td>
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Quality, performance and risk

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<tr>
<th>Item No.</th>
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<tbody>
<tr>
<td>036/2016 PCCC</td>
<td>Primary care quality report</td>
<td>Gina Davy</td>
<td>Y</td>
<td>13.50</td>
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<tr>
<td>037/2016 PCCC</td>
<td>Primary care risk report</td>
<td>Gina Davy</td>
<td>Y</td>
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Finance

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<tr>
<th>Item No.</th>
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<tbody>
<tr>
<td>038/2016 PCCC</td>
<td>Finance update</td>
<td>Jenny Davies</td>
<td>Y</td>
<td>14.15</td>
</tr>
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## Governance

<table>
<thead>
<tr>
<th>Ref</th>
<th>Date</th>
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<th>Presenter</th>
<th>Attend</th>
<th>Time</th>
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</thead>
<tbody>
<tr>
<td>039/2016 PCCC</td>
<td>19 October 2016</td>
<td><strong>PCCC – Terms of reference and scheme of delegation</strong></td>
<td>Stephen Gregg</td>
<td>Y</td>
<td>14.25</td>
</tr>
<tr>
<td>040/2016 PCCC</td>
<td>19 October 2016</td>
<td><strong>Conflicts of interest - update</strong></td>
<td>Stephen Gregg</td>
<td>Y</td>
<td>14.35</td>
</tr>
</tbody>
</table>

## Assurance – Committee summaries

<table>
<thead>
<tr>
<th>Ref</th>
<th>Date</th>
<th>Title</th>
<th>Presenter</th>
<th>Attend</th>
<th>Time</th>
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<tbody>
<tr>
<td>043/2016 PCCC</td>
<td>29th September 2016</td>
<td><strong>Joint Quality and Safety Committee, 29th September 2016</strong></td>
<td>Graham Prestwich</td>
<td>To follow</td>
<td>14.40</td>
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</table>

## Standing items

<table>
<thead>
<tr>
<th>Ref</th>
<th>Date</th>
<th>Title</th>
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<th>Attend</th>
<th>Time</th>
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<tbody>
<tr>
<td>044/2016 PCCC</td>
<td>19 October 2016</td>
<td><strong>Any other business</strong></td>
<td>All</td>
<td>N</td>
<td>14.45</td>
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<tr>
<td>045/2016 PCCC</td>
<td>19 October 2016</td>
<td><strong>Review of the meeting</strong></td>
<td>All</td>
<td>N</td>
<td>14.50</td>
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## Confidential item

<table>
<thead>
<tr>
<th>Ref</th>
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<tbody>
<tr>
<td>046/2016 PCCC</td>
<td>19 October 2016</td>
<td><strong>Public Bodies (Admissions to Meetings) Act 1960</strong></td>
<td>Gina Davy</td>
<td>14.55</td>
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</tbody>
</table>

That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

**Date of next meeting:**
Wednesday 14 December 2016
13:00 – 15:00, Leafield House

**Papers for information only**

- **PCCC work plan 2016/17**
Chair: Graham Prestwich  
Minutes: Joanne France  

<table>
<thead>
<tr>
<th>Members</th>
<th>Initials</th>
<th>Role</th>
<th>Present</th>
<th>Apologies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Graham Prestwich</td>
<td>GPr</td>
<td>Lay Member – PPI</td>
<td>✔</td>
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<tr>
<td>Peter Myers</td>
<td>PMy</td>
<td>Lay Member – Governance</td>
<td>✔</td>
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<tr>
<td>Nigel Gray</td>
<td>NG</td>
<td>Chief Officer</td>
<td>✔</td>
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<tr>
<td>Lucy Jackson</td>
<td>LJ</td>
<td>Consultant in Public Health</td>
<td>✔</td>
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<tr>
<td>Martin Wright</td>
<td>MW</td>
<td>Chief Financial Officer</td>
<td>✔</td>
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<tr>
<td>Gina Davy</td>
<td>GD</td>
<td>Interim Director of Commissioning, NMoC</td>
<td>✔</td>
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<td>Dr Mark Freeman</td>
<td>MF</td>
<td>Secondary Care Consultant</td>
<td>✔</td>
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<tr>
<td>Diane Hampshire</td>
<td>DH</td>
<td>Non-Executive Board Nurse</td>
<td>✔</td>
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<tr>
<th>In Attendance</th>
<th>Initials</th>
<th>Role</th>
<th>Present</th>
<th>Apologies</th>
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<tbody>
<tr>
<td>Anna Ladd</td>
<td>NC</td>
<td>NHS England</td>
<td>✔</td>
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<td>Lesley Sterling-Baxter</td>
<td>LSB</td>
<td>Healthwatch Leeds</td>
<td>✔</td>
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<td>Councillor Neil Buckley</td>
<td>NB</td>
<td>Leeds City Council, Health and Wellbeing Board Member</td>
<td>✔</td>
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<tr>
<td>Stephen Gregg</td>
<td>SG</td>
<td>Head of Governance and Corporate Services</td>
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<tr>
<td>Joanne France</td>
<td>JF</td>
<td>Office Manager / PA (Secretariat)</td>
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<tr>
<td>Stuart Barnes</td>
<td>SB</td>
<td>Communications and Engagement Lead</td>
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<tr>
<td>Heather Edmonds (part)</td>
<td>HE</td>
<td>Head of Medicines Optimisation</td>
<td>✔</td>
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<tr>
<td>Item No.</td>
<td>Agenda Item</td>
<td>Action</td>
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<tr>
<td>014/2016 PCCC</td>
<td>Welcome and Apologies</td>
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<td></td>
<td>The Chair welcomed everyone to the meeting. Members and those in attendance introduced themselves. One member of the public was present. Mark Freeman had advised he would join the meeting late. The Chair was informed that Cllr Buckley is no longer a member of the HWB. SG to contact Health and Wellbeing Board Chair, Cllr Charlwood, regarding future representation.</td>
<td>SG</td>
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<tr>
<td>015/2016 PCCC</td>
<td>Declarations of Interest</td>
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<td></td>
<td>There were no additional declarations. GPr asked all members to ensure their interests are recorded and regularly updated. PMy asked the committee to be mindful that the draft NHSE guidance on conflicts of interest recommended that, ideally, the Chair of the Audit Committee should not also serve as Deputy Chair of the PCCC. It is noted and recorded for future scrutiny that PCCC members do not have any concerns of any perceived or potential conflicts with this dual role and are happy to continue with the arrangement. SG added that the final guidance on conflicts is imminent from NHSE. SG would advise on any required actions by the PCCC should it be acting in contradiction of the guidance.</td>
<td>SG</td>
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<td>016/2016 PCCC</td>
<td>Questions from members of the public – A Patient’s Story</td>
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<td>GPr invited questions. General Practice - what is the mechanism to deal with concerns where a patient has an issue with the way a practice conducts its business? AL confirmed that all patients are able to request a conversation with the practice. What if the practice advises it is too busy to talk to a patient? AL added that in her experience this has never been reported to be the case and that practices are generally open to responding to issues. NG said that the CCG needed to understand the nature of the issue. Clear processes were in place, and internal complaints/complements box are located in most practices. The CCG needed to know if these processes were not working. GD to arrange a further conversation with the patient in attendance. NHSE Contact Centre and internal complaints/complements box are located in most practices.</td>
<td>GD</td>
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<td><strong>A Patient’s Story</strong> - GPr shared a story of a 70 year old lady, who had collapsed at home, resulting in her being admitted to hospital. This was shared as a positive story of the Hospital to Home service supporting a patient’s journey home. Continuity of support was a huge help for the patient along with the personalised care she received. GPr thanked the patient for allowing us to share her story. LJ questioned if this was an Age UK service and if so, the funding will not continue. GPr suggested that if this is the case then its replacement must also strive to provide an equally good service. NG will take this up via the Urgent Care Network.</td>
<td>NG</td>
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<tr>
<td>017/2016 PCCC</td>
<td>Approval of PCCC Minutes – 27 April 2016</td>
<td>Amendments were agreed to GD’s job title and minute 005/2016 was changed to state that under the Delegation Agreement, the CCG had received £26m to provide and support primary care based services.</td>
<td>JF / SG</td>
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<td>Resolved: With the above two amendments, the PCCC approved the minutes of 27 April 2016 as an accurate record.</td>
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<tr>
<td>018/2016 PCCC</td>
<td>Action from PCCC – 27 April 2016</td>
<td>003/2016 Social Media – links to PCCC are shared on Leeds North CCG Facebook and Twitter, with additional updates in the run up to the meeting. Meeting papers are also available on the CCG website seven days prior to the meeting.</td>
<td>NG</td>
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<td>004/2016 ToR – NG will discuss in more detail with the new Director of Nursing and Quality how medicines optimisation issues will be represented at the PCC.</td>
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<td>Items identified as ‘in Progress’: The Chair requested that a brief update is provided to committee to allow actions to be closed.</td>
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<td>PCCC Training Session is planned for 20 July 2016. A follow up session is planned on 4 August for those unable to attend the first date. GD to ensure calendar invitation is circulated.</td>
<td>GD</td>
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<td>Resolved: The PCCC agreed and updated the action log of 27 April 2016.</td>
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<td>019/2016 PCCC</td>
<td>Medicines Optimisation – an overview</td>
<td>HE presented an overview of the role of the medicines optimisation team. The CCG had had responsibility for the £30M prescribing budget since 2013, but now also had some contractual levers. The team took a patient centred approach, but sought to balance this with effective use of resources, focusing on excessive prescribing. HE identified the 4 major areas where half the budget is allocated, together with the main risks and opportunities. MF joined the meeting. HE highlighted a £4m risk relating to e-cigarettes, which might be put on prescription. NICE guidance is not yet available. NG said that there was a need to link this risk to the Healthy Living Strategy.</td>
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The CCG must nominate a senior employee to liaise with NHSE on controlled drugs. The CCG’s Clinical Director has overall responsibility. HE’s presentation would be circulated for future reference. PMy highlighted the need for the PCCC to be clear on its responsibility in this area. He felt that the focus should be on ensuring that resources are optimised. A balanced perspective was needed in reports, highlighting trends and adding narrative where appropriate. PCCC thanked HE for her presentation.

**Resolved:** The PCCC noted the Medicines Optimisation Overview.

<table>
<thead>
<tr>
<th>020/2016 PCCC</th>
<th>Primary Care Sustainability and Transformation Plan</th>
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<td>GD presented the report. In 2013 the CCG had developed a Primary Care Framework. Following the publication of the Five Year Forward View and GP Forward View, GD was seeking approval from the PCCC to develop a strategy for the sustainability and transformation of primary care. The proposed strategy would be developed within the context of the CCG’s Population Health Management (PHM) approach and New Models of Care agenda. The strategy would provide the CCG, member practices, partners, patients and the public with a clear description of the future vision of General Practice and primary care within North Leeds and the actions that will need to be undertaken to achieve this vision. To shape and develop the strategy and action plan, the CCG would continue to pursue effective engagement with practices and patients. PCCC asked if this matched expectation and maximised the opportunity of the co-commissioning strategy. NG added that we would want to see a city wide framework so that primary care looked similar across the city. GD confirmed that she met regularly with Leeds West and Leeds South and East CCG colleagues and would ensure that the strategy was fit for purpose locally and for the city. GD said that alignment was needed across Leeds and West Yorkshire, but that the strategy needed to provide the right level of detail for Leeds North. AL said that a city-wide approach would be useful in making links to the Sustainability and Transformation Plan (STP). NG / LJ will support GD in developing the strategy and ensuring linkages with the Health and Well Being strategy and STP. PMy noted Sections 14 &amp; 15 of the PCCC ToR and was keen to see explicit links between the strategy and the role of the PCCC. The philosophy and principles must be aligned to develop an action plan. Responsibilities must also be clearly defined.</td>
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Resolved: The PCCC:

- **Approved** the development of a draft LNCCG Primary Care Sustainability and Transformation Strategy to support the transformation and sustainability of primary care.
- **Noted** the areas that are likely to be described within the LNCCG Primary Care Sustainability and Transformation Strategy, including how the CCG will locally progress the GP Forward View
- **Noted** the connection and relationship between the LNCCG Primary Care Sustainability and Transformation Strategy and the CCG’s approach to Population Health Management.
- **Noted** that the draft Strategy and plan will be brought back to the PCCC in October 2016 for approval.

021/2016 PCCC Estates Technology Transformation Fund

At PCCC on 27 April GD had shared information on the Primary Care Transformation Fund – now known as the Estates and Technology Transformation Fund. GD’s paper outlined the process for encouraging general practices to apply for proposed developments to premises or technology, the governance arrangements for reviewing the bids and the list of prioritised bids recommended by the CCG Transformation Fund Panel. The CCG had actively encouraged bids from practices in areas of deprivation. Appendix 1 provided details of the submissions, all demonstrating whether national and local criteria had been met. GD added that recommendations and rankings were based on a local understanding of emerging estate development plans.

PMy highlighted the issue of ‘Implementation Risk’, which was usually much greater for technology than premises projects. GD confirmed that the Panel had considered implementation risks in assessing the bids.

PCCC noted that a clear and rigorous process had been conducted in a transparent and thorough way, which provided substantial assurance.

GD confirmed that funding was non-recurrent and general practices had received clear and concise information to this effect. No revenue support would be provided by the CCG. This had been acknowledged by each bidder.

The CCG would be informed by NHSE of successful bids by the end of August 2016.

Resolved: PCCC:

- **Confirmed** assurance of the outlined process
- **Approved** the prioritisation of the ETTF bids as outlined in Appendix One
- **Approved** the process for next steps
GD outlined NHSE plans to address the variation between funding received by general practice with a General Medical Service (GMS) and Primary Medical Service (PMS) contract. The objective was that by no later than 2020/21, all practices would receive the same funding per patient for the delivery of core primary medical care services.

Work had commenced to identify potential options for the investment of the PMS premium in Leeds North during 2016/17. PCCC was asked to approve engagement with member practices and other key stakeholders such as the LMC to identify recommended options. Following this period of engagement, the PCCC would be asked to approve how the PMS premium would be invested.

PMS Premium available for investment by the CCG in 2016/17 was £128k, increasing to £212k in 2017/18 and £295k in 2018/19. During the initial year of the CCG’s fully delegated responsibilities for the commissioning of primary care services, it was proposed that the PMS premium available in 2016/17 is initially invested on a non-recurrent basis to allow for the CCG to gain a clearer understanding of how the PMS premium should be prioritised in future years.

DH supported investment on a non-recurrent basis, which would be targeted at giving the best outcome in a short space of time.

MW said that, although the sums involved were relatively small, it was important for the CCG to have a transparent, open process for allocating the funds.

**Resolved:** The PCCC:
- **Noted** the current position regarding LNCCG’s responsibilities to reinvest the 2016/17 PMS Premium in General Practice within LNCCG.
- **Approved** the proposal to commence engagement with members and stakeholders regarding the options for the investment of the 2016/17 PMS Premium.
- **Agreed** to delegate to GD responsibility for implementing the process.

GD reported that once the newly merged Quality and Safety Committee was in place, assurances would come to the PCCC via that Committee.

GD advised that work around the development of the Primary Care quality dashboard is progressing. Quality concerns had been identified at one general practice, and would be reported to the next Quality and Safety committee.

**Resolved:** The PCCC noted the updates on general practice quality reporting.
MW updated PCCC on the allocations and budgets for Primary Care, including those delegated to the CCG, and current developments under co-commissioning arrangements.

The report included a summary of the CCG primary care financial position to May 2016. MW added that as it was early in the financial year and difficult to accurately forecast, the report also included a general introduction to primary care finance.

The CCG has received £26M from NHSE to support primary care. A shortfall of £65k was reported at the last meeting. This shortfall is now reduced to £47k. The CCG held a 1% uncommitted reserve (£0.26m), and will reinvest the PMS Premium (£0.13m).

The CCG would monitor spend against the primary care commissioning budgets for the remainder of 2016/17 financial year, with regular updates presented at PCCC. MW highlighted work in progress to develop a devolved budget scheme for acute/secondary care activity in 6 GP practices. Any savings would be invested in new models of care. The CCG would explore different ways of deploying primary care funding, taking into account the Five Year Forward View and the CCG’s broader strategic aims.

GPr thanked MW for his one to one support in sharing knowledge of the primary care financial budgets.

PMy said that it was important for the Committee to understand fully what expenditure could be influenced locally and what was locked into national contracts. It was also important that financial information was accompanied by narrative around the difference that it was making, such as additional capacity or more opportunity for treatment.

LJ highlighted the need to recognise the funding that goes into practices from the Local Authority.

Resolved: The PCCC noted the updates to the primary care allocations and associated budgets for 2016/17.

Any Other Business

None.

Review of the Meeting

PMy felt that there had been good robust discussion, based on clear reports. Under scrutiny, knowledgeable and concise answers were provided.

DH said that there was a need to review timings when guests are invited to present.

PCCC must not lose sight of the patient and must continually review engagement methods and the clarity of our reporting.

In response to a question from LSB, SG confirmed that electronic agenda papers were available 7 days before PCCC meetings. Hard copies would also be made available at future meetings.
### 027/2016 PCCC

**Public Bodies (Admissions to Meetings) Act 1960**

PCCC Resolved that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

### 027a/2016 PCCC

**Confidential Item: Potential Contractual Change requests from Practices**

GD reported that the CCG frequently received informal change requests from practices which did not materialise into formal change requests. Sharing this information publicly in advance of a formal request to commence engagement on a given change eg practice closure, would be likely to result in potentially unnecessary public concern.

The report provided an overview of potential future requests for General Practice Contract changes as at June 2016. It was proposed that each PCCC would include a private section where the Committee is informed of all requests received from Practices in relation to proposed contract changes. This would enable the PCCC to be sighted on more minor contractual changes authorised by CCG teams and which would not be presented to the PCCC for formal decision eg a contract variation to reflect a new partner on contract or approval to expand a practice boundary.

Formal major contractual changes and/or those which involved real or perceived conflicts of interest would be brought to the PCCC for a decision.

**Resolved:** The PCCC noted the potential future requests for General Practice Contract changes.

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**Date of next meeting:** 7 September 2016, 1:00pm
<table>
<thead>
<tr>
<th>Item No.</th>
<th>Action Required</th>
<th>By Whom</th>
<th>Completion Date</th>
<th>Progress</th>
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<tbody>
<tr>
<td>014/2016 PCCC</td>
<td>Welcome &amp; Apologies</td>
<td>SG</td>
<td>19/10/16</td>
<td>Complete. Cllr Charlwood, invited to future meetings.</td>
</tr>
<tr>
<td>015/2016 PCCC</td>
<td>Declarations of Interest</td>
<td>SG</td>
<td>19/10/16</td>
<td>Complete. Update on today’s agenda.</td>
</tr>
<tr>
<td>016/2016 PCCC</td>
<td>Questions from members of the public – A Patient’s Story</td>
<td>GD, NG</td>
<td>19/10/16</td>
<td>Complete. Member of primary care team met patient to discuss issues in detail.</td>
</tr>
<tr>
<td>017/2016 PCCC</td>
<td>Approval of PCCC Minutes – 27 April 2016</td>
<td>JF</td>
<td>19/10/16</td>
<td>Complete. Minutes amended.</td>
</tr>
<tr>
<td>018/2016 PCCC</td>
<td>Action from PCCC – 27 April 2016</td>
<td>NG</td>
<td></td>
<td>Complete. Director of Nursing and Quality to medicines optimisation issues at the PCCC.</td>
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<tr>
<td>Item No.</td>
<td>Action Required</td>
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<td><strong>PCCC Training Session</strong> is planned for 20 July 2016. A follow up session is planned on 4 August for those unable to attend the first date. GD to ensure calendar invitation is circulated.</td>
<td>GD</td>
<td>4/08/16</td>
<td><strong>Complete.</strong> Training session held.</td>
</tr>
</tbody>
</table>
| **020/2016 PCCC** | **Primary Care Sustainability and Transformation Plan**  
NG / LJ will support GD in developing the strategy and ensuring linkages with the Health and Well Being strategy and STP.  
PMy noted Sections 14 & 15 of the PCCC ToR and was keen to see explicit links between the strategy and the role of the PCCC. Responsibilities must also be clearly defined.  
The draft Strategy and plan will be brought back to the PCCC in October 2016 for approval. | NG/LJ/GD | | **In progress.** Update report on today’s agenda. |
|         | | GD | | As above. |
|         | | GD | | As above. |
| **026/2016 PCCC** | **Review of the Meeting**  
The timings when guests are invited to present would be reviewed.  
Electronic agenda papers would be available 7 days before PCCC meetings. Hard copies would also be made available at future meetings. | SG | 19/10/16 | **Complete.** Timings reviewed. |
|         | | JF | 19/10/16 | **Complete.** |
**Summary Report**

<table>
<thead>
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<th>Meeting:</th>
<th>Primary Care Commissioning Committee</th>
<th>Date: 19/10/16</th>
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<tbody>
<tr>
<td>Agenda Item:</td>
<td>033.2016</td>
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</tr>
<tr>
<td>Report Title:</td>
<td>GP forward view – planning and delivery</td>
<td></td>
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<tr>
<td>Prepared by:</td>
<td>Citywide Primary Care Teams</td>
<td></td>
</tr>
<tr>
<td>Executive Lead:</td>
<td>Gina Davy – Interim Director of Commissioning Primary Care and New Models of Care</td>
<td></td>
</tr>
<tr>
<td>Presented by:</td>
<td>Gina Davy – Interim Director of Commissioning Primary Care and New Models of Care</td>
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</table>

**Other meetings presented to:**

**Purpose of Report**

<table>
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<tr>
<th>Approval</th>
<th>Decision</th>
<th>Assurance</th>
<th>Information and Comment</th>
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</table>

**Strategic Objectives (tick all that apply)**

1. The people of North Leeds will live independent and healthier lives ✓
2. The people of North Leeds will receive accessible, quality and supportive services ✓
3. The CCG will deliver a well-led and sustainable health and social care system ✓

**Executive Summary**

The NHS Operational Planning and Contracting Guidance for 2017-2019 was released on the 27th September 2016. The Guidance includes specific planning requirements for CCG’s for the local implementation and delivery of the General Practice Forward View (GPFV) to achieve the sustainability and transformation of general practice.

The Guidance outlines that CCG’s are required to submit, by the 23rd of December 2016, plans and supporting financial trajectories, outlining how CCG’s will deliver the requirements of the GPFV. NHSE England North (Yorkshire and the Humber) have requested a specific Transformation Plan for delivering the GP Forward View from each CCG to be submitted as part of the wider STP submission on 21 October 2016.

The paper highlights key CCG requirements and responsibilities for local delivery of the GPFV including an outline of funding and key timescales for LNCCG. The paper then provides an update for PCCC on the process being undertaken, in partnership with the NHS Leeds West CCG and NHS Leeds South and East CCG, to develop a joint GPFV Delivery Plan for the 23rd of December submission deadline. This plan will incorporate all aspects of the proposed LNCCG Primary Care Sustainability and Transformation Plan agreed by PCCC in June 2016.

**Conflicts of Interest**

The CCG recognises that in developing the GPFV Delivery Plan real and perceived conflicts of interest will need to be managed carefully. The CCG will ensure that the development process complies with the CCG’s Managing Conflicts of Interest policy, and will report to the PCCC the arrangements for managing any conflicts.
Key Recommendations

Members of the Primary Care Commissioning Committee are asked to:

- **Note** the planning requirements and responsibilities for CCGs in the local implementation and investment in the GPFV.
- **Note** the requirement to submit, by the 21st October, plans and supporting financial trajectories, outlining how the CCG will deliver the requirements of the GPFV within the context of the STP with the ability to refresh and refine in preparation for the final submission by 23rd December 2016.
- **Note** the collaborative approach being undertaken with NHS Leeds South and East CCG (LSECCG) and NHS Leeds West CCG (LWCCG) to develop a citywide GPFV Delivery Plan by the 23rd of December, with an initial draft being prepared for the 21st of October.
- **Note** that the GPFV Delivery Plan will incorporate the aspects of the previously proposed LNCCG Primary Care Sustainability and Transformation Plan
- **Note** that the draft GPFV Delivery Plan will be presented to the PCCC in December 2016 for approval.

Assurance Framework

**Risk 4:** Providers fail to meet quality standards leading to poor quality and unsafe care.

**Risk 6:** Failure to achieve financial stability and sustainability leading to an inability to fund the CCG’s strategic objectives.

**Risk 9:** Inability to develop sustainable new models of care leading to a failure to shift care to out of hospital settings.

**Risk 10:** Failure to work successfully with partners to integrate services leading to duplication, waste and inefficiency.

Next Steps

- Continue to work with the LNCCG Central Delivery Unit, members, LSECCG, LWCCG and other key stakeholders in the development of the GPFV Local Delivery Plan.
- Submit a draft of the GPFV Delivery Plan to NHSE England North (Yorkshire and the Humber) by the 21st of October 2016,
- Present the draft GPFV Delivery Plan to PCCC in December 2016 for approval in advance of final submission on the 23rd of December.

Corporate Impact Assessment

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<th>Regulatory implications</th>
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<tr>
<td>Financial implications</td>
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<tr>
<td>Legal implications</td>
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<tr>
<td>Workforce implications</td>
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<tr>
<td>Equality impact assessment</td>
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1. Introduction

The General Practice Forward View (GPFV) was published in April 2016. It sets out a directive plan for how the sustainability and transformation of general practice (GP) will be achieved over the next 5 years. The GPFV sets out that funding into general practice services will increase by 2.4 billion a year by 2020/21.

Published on the 27th of September 2016, the NHS Operational Planning and Contracting Guidance for 2017-19 outlines the next 2 years funding allocations and the requirements of CCGs to support the implementation of the GPFV. The guidance specifies in 2017/18 and 2018/19 there will be an increase in funding for core primary medical allocations of £231 million then a further £188 million on top respectively. In addition to those allocations, other primary care funding will be available for specific purposes as part of the £500 million plus sustainability and transformation package.

The guidance focuses on the investment and the care redesign support which CCGs will play a greater role in delivering. Much more of the workforce and workload support and funding for GP will be delivered at a national and regional level by NHSE.

The Guidance outlines that CCG’s are required to submit, by the 23rd of December 2016, plans and supporting financial trajectories, outlining how CCG’s will deliver the requirements of the GPFV.

In addition, the NHS England – North (Yorkshire and the Humber) team have also stated that CCGs are required to submit a plan by October 21st 2016 outlining how CCG’s will locally implement the GPFV within the context of local STPs.

2. Key Planning Guidance Requirements Relating to the Implementation of the GPFV

The NHS Operational Planning and Contracting Guidance 2017-2019 specifies that CCGs should submit a GP Forward View plan by 23 December 2016 which as a minimum must include:

- how access to general practice will be improved
- how funds for practice transformational support will be create and deployed to support general practice
- how ring-fence funding being devolved to CCGs to support the training of care navigators and medical assistants and stimulate the use of online consultations will be deployed.

Table one provides an overview of the key requirements outlined in the Planning Guidance for CCG’s implementation and funding of the GPFV.
<table>
<thead>
<tr>
<th>GPFV area</th>
<th>Requirement</th>
<th>LNCCG Investment Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Submission</td>
<td>Submit a plan to NHSE on 23rd December 2016 setting out plans with a minimum of:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• How access will be improved</td>
<td>CCGs to invest non-recurrently £3 per head over 2 years 2017-19 = £645,000.</td>
</tr>
<tr>
<td></td>
<td>• How funds for GP transformation support will be created and deployed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• How devolved ring-fenced funding will be deployed</td>
<td></td>
</tr>
<tr>
<td>Investment – Transformation Support</td>
<td>To stimulate delivery at scale to improve access, to implement the 10 high impact actions to free up GP time to ensure sustainability.</td>
<td>In 2016/17, £18,000 has been devolved to LNCCG</td>
</tr>
<tr>
<td>On-line consultation software systems</td>
<td>To stimulate greater on-line access. Devolved funding &amp; accountability to CCGs with specification and monitoring requirements to follow. £15m nationally devolved in 2017/18 £20m nationally devolved in 2018/19</td>
<td>In 2017/18 &amp; 2018/19, £37,000 to be devolved in each year to LNCCG</td>
</tr>
<tr>
<td>Training care navigators and medical assistants</td>
<td>To invest in GP receptionist training around signposting and managing correspondence and introduce pilots of new medical assistant role to support GPs. Devolved funding with a specification on what needs to be delivered and monitoring arrangement to follow. £5m nationally devolved in 2016/17 and £10m nationally devolved in 2017/18 &amp; again in 2018/19</td>
<td>Funding allocated to Yorkshire &amp; Humber to support resilience programmes</td>
</tr>
<tr>
<td>GP Resilience Programme</td>
<td>To invest in vulnerable GP Practices. £40m non-recurrent funding over 4 years delegated to NHSE area teams to support. £16m allocated in 2016/17, £8m in 2017/18 and £8m in 2018/19. This is in addition to the £10m allocated nationally to support vulnerable practices in 2015/16.</td>
<td>Funding allocated to Yorkshire &amp; Humber to support resilience programmes</td>
</tr>
<tr>
<td>Estates &amp; Technology Transformation Fund</td>
<td>CCGs bid for funding in 2016/17 towards estates and technology solutions. All 8 bids (total estimated capital funding £2.6m) submitted by LNCCG through to ‘Stage 3’.</td>
<td></td>
</tr>
<tr>
<td>Investment - Uplift</td>
<td>CCGs to increase uplift on GP core contract, at least equal to and ideally more than the increases in CCG core allocations of 2% in 2017/18 and 2.15% in 2018/19.</td>
<td>LNCCG to provide an uplift on GP contract of: 2% - 2017/18</td>
</tr>
<tr>
<td>Section</td>
<td>Description</td>
<td>Notes</td>
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| Care Redesign    | Devalved national recurrent funding in 2017/18 of £138m for sites known as ‘Prime Ministers Challenge Fund’ or ‘GP Access Fund’ sites. In 2018/19, a total of £258m national recurrent allocated across remaining CCGs to support access. These CCGs needs to prove eligibility for funding by outline plans (submitted 23rd December 2016) to commission:  
  - Improved 8-8 weekday access to pre-bookable and same day appts on a hub basis  
  - Weekend access to pre-bookable and same day appts to meet local needs on a hub basis  
  - A local solution that maximizes digital technologies a local response to improve access in areas of inequalities and which is grounded in the STP. | In 2018/19 £3.34 devolved to CCGs per head of population = £724k  
From 2019/20 £6 per head of population devolved to CCGs recurrently = £1,310k. To align to urgent care services re-design and procurement. |
| Workforce        | CCGs to include in their planning submission on 23rd December:  
  - A workforce strategy linked to care re-design plans  
  - Future Multi-Disciplinary Team (MDT) ways of working, support for practice nursing and establishing PC at scale  
  - Initiatives to attract and recruit more GPs and other clinical staff  
  - Ensure GPs are operating at ‘the top of their license’ – i.e. use clinical pharmacist and skill mix others to free up GPs to manage complex  
  - Expand MDTs, integrate community services and fully utilise premises, diagnostics, technology and community assets | Further information about funding to establish clinical pharmacists in GP over the next 3 years expected in December 2016.  
To follow frameworks and models to expand physician associates, medical assistants and physiotherapists. |
| Workload         | CCGs to include in their planning some key deliverables to support workload:  
  - Using NHSE area team Resilience Programme for vulnerable practices  
  - How to deliver personalised care planning and a single care plan owned by the patient and more self-care  
  - Commissioners should establish pathways to integrate community pharmacy with LTCs management  
  - Digital Roadmap Links – How to deliver the GP IT operating model 2016/18. To include interoperability, innovative technologies to transform triage and consultations to alleviate workload. |
3. **The Leeds GPFV Delivery Plan**

Through the “One Voice” programme, significant work is currently being undertaken in Leeds to establish one consistent commissioning voice for the city. The primary care teams working within each of the Leeds CCGs believe this equally applies to the commissioning of primary care and primary medical care services.

In developing plans to deliver the requirements of the GPFV, the three Leeds CCGs are committed to delivering elements at scale and where possible adopting a city wide approach. However we know that the CCGs in Leeds have differential starting positions and that not all of our populations respond in the same way. For this reason, the need for local flexibility in local implementation is key.

The Leeds CCGs are working to develop a joint GPFV Delivery Plan outlining how the three Leeds CCGs will work together to deliver national expectations and enable the delivery of the West Yorkshire STP and ‘Leeds Plan. The GPFV Delivery Plan will reflect a consistent commitment to the population of Leeds by 2020/21 but allows for flexibility in local implementation based on local circumstances and population needs. A fundamental principle for the plan is how the additional investment supports the overall sustainability and transformation of general practice as part of a wider primary care services and within the context of developing new models of care and wider Population Health Management.

The joint GPFV Delivery Plan will include the key component parts that were previously proposed to be included within the Leeds North Primary Care Sustainability and Transformation including:

- the local vision for sustainable and transformed General Practice and primary care within Leeds North.
- the local strategy and plans to deliver the local vision, including the delivery of the five elements of the GP Forward View over the next four years.
- the local investment plan for general practice and primary care.
- be underpinned by the citywide Primary Care Estates strategy to be published city wide in November 2016.

4. **Next Steps**

In partnership with LWCCG and LNCCG, work is being undertaken to develop the Leeds GPFV Delivery Plan. An early draft will be submitted to the NHS England – North (Yorkshire and the Humber) by the 21st October to provide assurance on how the GPFV will be delivered as part of West Yorkshire STP and Leeds Plan and how transformation funding will be used.

The final GPFV Delivery Plan is required to be submitted to NSHE on 23rd December. Within LNCCG, Central Delivery Unit (CDU) will continue to oversee the GPFV delivery plan. Additional meetings with members of CDU will also be required to co-produce elements of the plan with clinical leads and subject matter experts.

A paper outlining the GPFV and the proposed approach to public and patient engagement in the development and implementation of the GPDV Delivery Plan was discussed with the Patients Assurance Group (PAG) on 20th September 2016. A commitment was made to ensure the PAG remains briefed on the development of the GPFV Delivery Plan.

Further engagement on the GPFV Delivery Plan will be undertaken with members at the November 2016 Council meeting and the final plan will be presented to PCCC on the 14th of December.
5. **Recommendations**

Members of the Primary Care Commissioning Committee are asked to:

- **Note** the planning requirements and responsibilities for CCGs in the local implementation and investment in the GPFV.

- **Note** the requirement to submit, by the 21st October, plans and supporting financial trajectories, outlining how the CCG will deliver the requirements of the GPFV within the context of the STP with the ability to refresh and refine in preparation for the final submission by 23rd December 2016.

- **Note** the collaborative approach being undertaken with NHS Leeds South and East CCG (LSECCG) and NHS Leeds West CCG (LWCCG) to develop a citywide GPFV Delivery Plan by the 23rd of December, with an initial draft being prepared for the 21st of October.

- **Note** that the GPFV Delivery Plan will incorporate the aspects of the previously proposed LNCCG Primary Care Sustainability and Transformation Plan

- **Note** that the draft GPFV Delivery Plan will be presented to the PCCC in December 2016 for approval.
Summary Report

Meeting: Primary Care Commissioning Committee
Date: 19 October 2016

Agenda Item: 034.2016
Report Title: PMS Premium Investment Scheme 2016-17 and PMS Objectives 2016-17
Prepared by: Lindsey Bell - Primary Care Commissioning & Contracts Manager
Executive Lead: Gina Davy - Interim Director of Commissioning Primary Care and New Models of Care
Presented by: Lindsey Bell - Primary Care Commissioning & Contracts Manager
Other meetings presented to: None

Purpose of Report

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<th>Approval</th>
<th>Decision</th>
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<td>✔️</td>
<td>✔️ Information and Comment</td>
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Strategic Objectives (tick all that apply)

1. The people of North Leeds will live independent and healthier lives ✔️
2. The people of North Leeds will receive accessible, quality and supportive services ✔️
3. The CCG will deliver a well-led and sustainable health and social care system

Executive Summary

Part 1 - PMS Premium Investment Scheme 2016-17

In June 2016 the NHS Leeds North CCG Primary Care Commissioning Committee (PCCC) delegated responsibility to the Interim Director of Primary Care Commissioning for Primary Care and New Models of Care to develop and implement a scheme for the local investment of the PMS Premium Funding for 2016-17. The purpose of this paper is to update the PCCC on the process undertaken to develop and implement the investment scheme and to assure the committee that the scheme meets the required investment criteria for PMS funding.

Part 2 - PMS Objectives 2016-17

The paper also updates the Primary Care Commissioning Committee on the proposed city wide approach to setting PMS Objectives for 2016/17 and asks for approval of this plan.

Key Recommendations

Primary Care Commissioning Committee is asked to:

Part 1 - PMS Premium Investment Scheme 2016-17

- **NOTE** the investment scheme and the process undertaken to develop this.
- **BE ASSURED** that the scheme meets the requirements outlined for PMS Premium investment.

Part 2 - PMS Objectives 2016-17

- **NOTE** the approach agreed between the three Leeds CCGs
- **RECOMMEND** that the approach outlined be adopted for PMS Objectives in 2016/17
Assurance Framework

Risk 2: Resources are not targeted effectively to areas of most need, leading to failure to improve health in the poorest areas

Risk 4: Providers fail to meet quality standards leading to poor quality and unsafe care

Risk 11: Member practices do not fully engage and participate, leading to decisions which are not clinically led

Next Steps

Part 1 - PMS Premium Investment Scheme 2016-17
- Formal service specification schedule to be updated.
- Evaluation of the scheme to be presented to Primary Care Commissioning Committee in April 2017.
- Options for PMS Premium investment in 2017/18 in the context of the wider primary care budgets and planning requirements to be brought to Primary Care Commissioning Committee in December 2016.

Part 2 - PMS Objectives 2016-17
- None required

Corporate Impact Assessment

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<td>Equality impact assessment</td>
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PART 1 - Investment of PMS Premium Funding 2016-17

1. Background

At the Primary Care Commissioning Committee (PCCC) on 22 June 2016 an introduction paper was submitted which:

- outlined the current position regarding LNCCG’s responsibilities to reinvest the 2016/17 PMS Premium in General Practice within LNCCG.
- sought approval for a proposal to commence engagement with members and stakeholders regarding the options for the investment of the 2016/17 PMS Premium.
- asked for recommendations on the draft potential options for the investment of the 2016/17 PMS Premium.

The PCCC delegated responsibility to the Interim Director of Commissioning Primary Care and New Models of Care to commence a period of engagement with key stakeholders and to develop and implement a scheme for the local investment of the premium in 2016/17.

The purpose of this paper is to update the PCCC on the process undertaken to develop the investment scheme and to assure the committee that the scheme meets the required investment criteria for PMS funding.

2. Process undertaken to develop the investment scheme

Following initial conversations and discussions with colleagues across the CCG, Public Health, the Area Team and LMC regarding investment options, the CCG engaged on the following options for the investment of the 2016/17 PMS Premium:

A. Invest monies in General Practice to specifically tackle health inequalities and improve the health of the poorest the fastest
B. Investment in Primary Care transformation initiatives across General Practice e.g. new joint shared posts across practices (investment could be weighted in relation to deprivation)
C. Universal investment across all practices to support delivery of CCG priorities over and above existing schemes e.g. primary prevention to reduce CVD (investment could be differentially weighted in relation to deprivation).

Engagement on the above options was undertaken with the Local Medical Committee, CCG Council of Members, NHS England Area Team and other local stakeholders. Though there was significant variation in feedback received in relation to the above options, a number of themes emerged as follows:

- Greater support to direct resources in relation to deprivation, though more in relation to the weighting of a universal offer as opposed to only allocating resources to the most deprived practices.
- Support to align initiatives with existing priorities.
- The importance of transparently describing what the funding will be used for.
- Not to make any associated initiatives overly complex, onerous and with complex reporting requirements.
3. Investment Scheme

Coronary Heart Disease (CHD) is one of the main causes of premature mortality within the spectrum of cardiovascular disease (CVD) and a key contributor to the gap in life expectancy within LNCCG. Hypertension is a key risk factor for coronary heart disease (CHD) and stroke and is currently under-reported across the CCG (Right Care Data shows LNCCG is in the fourth lowest quintile nationally for reported versus expected prevalence of hypertension).

Based on the national criteria for investment of PMS monies, local feedback in support of ‘Option C’ and the health priorities for LNCG outlined above, LNCCG developed a scheme to invest the 2016/17 £128,000 PMS Premium to **reduce premature mortality within the CCG’s most deprived population**.

This scheme aims to reduce premature mortality within the CCG’s most deprived population by **commissioning Practices to proactively identify patients with hypertension living in the CCG’s most deprived populations**. The Index of Multiple Deprivation (IMD) demonstrates that all LNCCG Practices have a proportion of registered patients living within the most deprived populations. The CCG has therefore used the IMD to weight the proportion of the £128,000 available to Practices, to reflect the amount of work to be undertaken across different Practices.

4. Rationale

This scheme was selected as it:

- uses limited, non-recurrent funding to directly support the CCG’s mission to improve the health of the poorest the fastest.
- offers equality of opportunity for all practices whilst also supporting the national PMS Premium investment criteria to reduce health inequalities.
- commissions practices to undertake a focussed piece of work over and above what would have been expected of core General Practice.
- will support the CCG’s achievement of one of three local Quality Premium’s (Reported prevalence of hypertension on GP registers as % of estimated prevalence) which, if achieved will enable further future investment to improve quality of care, health outcomes and/or reduce health inequalities.
- has been designed to minimise complex and onerous reporting for practices.

5. Uptake of the scheme

The available £128,000 has been allocated to practices using a weighting formula based on each Practice’s Index of Multiple Deprivation (IMD). Each practice has been informed of the proportion of £128,000 available for their delivery of the initiative.

In September 2016 all practices were invited to express an intention to participate in the scheme. All but one practice has confirmed their intention to deliver the scheme.

6. Timescales

Funding has now been allocated to almost all participating Practices with a view to all Practices completing the initiative by the end of March 2017. The evaluation of the scheme will come back to Primary Care Commissioning Committee in April 2017 for review.
7. Key recommendations

Primary Care Commissioning Committee is asked to:

- **NOTE** the investment scheme and the process undertaken to develop this.

- **BE ASSURED** that the scheme meets the requirements outlined for PMS Premium investment.

8. Next Steps

- Formal service specification schedule to be updated.

- Evaluation of the scheme to be presented to Primary Care Commissioning Committee in April 2017.

- Proposals for PMS Premium investment in 2017/18 to be brought to Primary Care Commissioning Committee in December 2016. These proposals will be contextualized within the wider GPFV Implementation Plan and associated investment plans.
PART 2 – Proposal for PMS Objectives 2016-17

1. Background and Proposal

The NHS England – North (Yorkshire and the Humber) completed the PMS equitable funding review in 2015. Following the review, the PMS contract values for each practice across Leeds were recalculated based on the weighted list sizes at January 2015.

From October 2015 the funding to practices started to be reduced and the offer of the non-re- current funding was based on the completion of 3 local objectives, previously shared and adopted by the 3 Leeds CCG’s. The objectives that are available to practices are:

1. Patient Experience, Access & Responsiveness
2. Clinical – Long Term Condition Management
3. Population Health Improvement – Immunisation and Screening

NHS England – North (Yorkshire and the Humber), with input from CCGs, formally agreed the objectives with practices and the number of objectives to be completed was based on the £ per patient received by the practice. This was based last year on the table below:

<table>
<thead>
<tr>
<th>Contract baseline £ per patient</th>
<th>No of objectives to be delivered</th>
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<tbody>
<tr>
<td>&lt;£85 per patient</td>
<td>0 Objectives</td>
</tr>
<tr>
<td>&gt;£85 to &lt;£95 per patient</td>
<td>1 Objective</td>
</tr>
<tr>
<td>&gt;£95 to &lt;£105 per patient</td>
<td>2 Objectives</td>
</tr>
<tr>
<td>&gt;£105 per patient</td>
<td>3 Objectives</td>
</tr>
</tbody>
</table>

This range was based on the GMS Global Sum at the time of £75.77 per weighted patient with a 10% threshold added. This has now been in place for 12 months and in April 2016 the price per patient was increased for all GMS and PMS practices. The GMS Global is now £80.59 from 1/4/2016.

The three Leeds CCG primary care teams met and discussed what effect this would have on the threshold for completion of objectives for 2016/17 and agreed it would be appropriate to increase the contract baseline £ per patient in line with last year’s calculation methodology. This would mean that a 10% threshold is added onto the £80.59 which would bring the baseline payment to £89 per patient.

It is therefore proposed that the number of objectives to be completed be based on the new £ per patient received by the practice.

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<thead>
<tr>
<th>Contract baseline £ per patient</th>
<th>No of objectives to be delivered</th>
</tr>
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<tbody>
<tr>
<td>&lt;£89 per patient</td>
<td>0 Objective</td>
</tr>
<tr>
<td>&gt;£89 to &lt;£99 per patient</td>
<td>1 Objective</td>
</tr>
<tr>
<td>&gt;£99 to &lt;£109 per patient</td>
<td>2 Objectives</td>
</tr>
<tr>
<td>&gt;£109 per patient</td>
<td>3 Objectives</td>
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It was decided to keep the objectives the same for the next six months and for this to be reviewed further at 31 March 2017.
Practices that now fall under £89.00 per patient will no longer need to complete any objectives. For 2016/17 there are no PMS practices funded over £89 per patient in Leeds North CCG therefore no practices will be required to undertake objectives.

The Leeds CCGs will shortly commence work, to review and evaluate the impact of the interventions progressed to date to deliver PMS objectives. This learning will be shared across the city and be used to inform future Primary Care commissioning.

2. Recommendation

Primary Care Commissioning Committee is asked to:

- **NOTE** the approach agreed between the three Leeds CCGs
- **RECOMMEND** that the approach outlined be adopted for PMS Objectives in 2016/17

3. Next Steps

Commence work to review and evaluate the impact of the interventions progressed to date to deliver PMS objectives.
Summary Report

Meeting: Primary Care Commissioning Committee  
Date: 19 October 2016

Agenda Item: 035.2016
Report Title: Primary Care Estates Summary Update
Prepared by: Lindsey Bell, Primary Care Commissioning & Contracts Manager

Executive Lead: Gina Davy – Interim Director of Commissioning Primary Care and New Models of Care
Presented by: Gina Davy – Interim Director of Commissioning Primary Care and New Models of Care
Lindsey Bell, Primary Care Commissioning & Contracts Manager

Other meetings presented to: None

Purpose of Report

<table>
<thead>
<tr>
<th>Approval</th>
<th>Decision</th>
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<tbody>
<tr>
<td>Assurance</td>
<td>Information and Comment</td>
</tr>
</tbody>
</table>

Strategic Objectives (tick all that apply)

1. The people of North Leeds will live independent and healthier lives ✓
2. The people of North Leeds will receive accessible, quality and supportive services ✓
3. The CCG will deliver a well-led and sustainable health and social care system ✓

Executive Summary

This paper updates LNCCG Primary Care Commissioning Committee on key estates programmes currently being undertaken in relation to primary care. These include the development of a comprehensive Leeds CCGs Primary Care Estates Strategy, the city-wide strategic estates workshops and the latest update on the Estates and Technology Transformation Fund (ETTF) bids.

Estates Strategy
A draft of the comprehensive Leeds CCGs primary care estates strategy was received by the CCG in early October for review. The estates strategy highlights the current location and condition of general practice premises across Leeds as well as the outcomes of a number of building surveys undertaken within practices. The result of these surveys along with local practice knowledge and intelligence regarding future housing and local infrastructure developments provides the rationale within the estates strategy for recommendations relating to the future investment and development of General Practice estate.

Following LNCCG’s feedback on the draft strategy, the expected timetable for approval will be to take the final version of the Estates Strategy to CCG Primary Care Commissioning Committees in December 16. This will align with the presentation of the GP Forward View Delivery Plan to the PCCC which is being submitted to the same meeting for approval.

City-wide Estates Development
Over the last six months, a number of Estates Workshops have been undertaken with representatives of key stakeholder groups. The workshops have reviewed the current collective stakeholder estate in each neighbourhood and identified any initial opportunities for collaborative estates development. Opportunities identified will be recommended to the Strategic Estates Group (local SEF) for approval to work up into a fully developed proposal. These workshops are due to complete the first round of neighbourhood reviews by January 2017. As estates development is an iterative process the need for the future workshops will be reviewed in January 2017.

Estates and Technology Transformation Fund 2016-17
Leeds North CCG has received confirmation from NHS England that ALL eight of the schemes recommended by the Primary Care Commissioning Committee for funding have passed the ‘Stage 2’ review stage.
The next stage of the process is ‘Stage 3: Due Diligence’. For all eight schemes, detailed information and project initiation documents will be required in preparation for business cases to be considered.

At present NHS England are focusing on schemes which are able to complete by 31 March 2017. The CCG will now work with NHS England and Scheme Leads to review those proposals that could be completed by March 2017 and prioritise gathering the relevant information required.

### Key Recommendations

Primary Care Commissioning Committee is asked to:

**REVIEW** and **NOTE** the Estates Update included with this paper.

### Assurance Framework

#### Board Assurance Framework

**Risk 4:** Providers fail to meet quality standards leading to poor quality and unsafe care.

**Risk 9:** Inability to develop sustainable new models of care leading to a failure to shift care to out of hospital settings.

### Next Steps

- Final version of the Leeds CCGs Primary Care Estates Strategy to be presented to the LNCCG Primary Care Commissioning in December 2016 for approval.

- Further update on progress of Estates and Technology Transformation Fund schemes to be presented to Primary Care Commissioning Committee in December 2016 for information.

### Corporate Impact Assessment

<table>
<thead>
<tr>
<th>Implication</th>
<th>Impact</th>
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<tbody>
<tr>
<td>Regulatory implications</td>
<td>None identified</td>
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<tr>
<td>Financial implications</td>
<td>Financial reviews of the Estates and Technology Transformation Fund schemes to be undertaken to ensure minimal recurrent cost implications.</td>
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<tr>
<td>Legal implications</td>
<td>None identified</td>
</tr>
<tr>
<td>Workforce implications</td>
<td>None identified</td>
</tr>
<tr>
<td>Equality impact assessment</td>
<td>Will be competed as part of individual scheme proposals</td>
</tr>
<tr>
<td>Information quality assured</td>
<td>None identified</td>
</tr>
</tbody>
</table>
Primary Care Estates Update  
October 2016

1. Background  
In June 2015, CCGs were asked to lead the development of Local Estates Strategies supported by advisors from NHS Property Services. A Framework for Commissioners was produced which outlined the process required and the timescales for the work to be undertaken. This process included the formation of Strategic Estates Forums (SEF). Within Leeds this is the Strategic Estates Group which includes representation from key commissioner and provider organisations across the city. Estates strategies were to be completed initially by December 2015.

In September 2015, local health and care systems were asked to produce Local Digital Roadmaps (LDRs) by 30 June 2016, setting out how they will achieve the ambition of ‘paper-free at the point of care’ by 2020.

In October 2015, CCGs were invited to put forward proposals to the Estates, Technology and Transformation Fund (ETTF) for future estates and technology investment in line with their local estates and digital plans. Eight proposals were received, reviewed and prioritised by LNCCG before being presented to the PCCC in June 2016 for decision. All eight proposals were supported by PCCC and were submitted as part of the national ‘Stage One’ process by 30 June 2016.

Investment in GP estate and technology is needed, not just to improve existing facilities and the quality of primary medical care received by patients, but to increase the sustainability and transformation of General Practice. The investment and development of flexible primary care estates and technology solutions underpin the delivery of the GP Forward View, New Models of Care and the wider establishment of a Population Health Management approach.

2. Leeds Primary Care Estates Strategy  
In 2015 the Leeds Strategic Estates Group commissioned Community Ventures to develop a Primary Care Estates Strategy for the city. The first draft of the Leeds CCGs Primary Care Estates Strategy has recently been received by LNCCG for comment. The significant challenge in receiving the draft strategy after the prioritisation and submission of ETTF bids has previously been raised with the PCCC.

This draft Leeds Primary Care Estates Strategy highlights the current location and condition of General Practice premises in Leeds. Where required, Practices have had new 6 Facet building surveys completed which included assessments of:

- Physical Condition Survey (Fabric & M&E)
- Statutory Compliance Audit (inc. Fire)
- Space Utilisation Audit
- Functional Suitability Review
- Quality Audit
- Environmental Management Audit

The result of these surveys, along with local practice knowledge and intelligence regarding future housing and local infrastructure developments, provides the rationale within the Primary Care Estates Strategy for recommendations relating to the future investment and development of general practice estate across the city.
The CCG has worked with Community Ventures in the development of the Primary Care Estates Strategy to ensure strategic fit with local Primary Care developments. The Leeds Primary Care Estates Strategy will underpin the implementation of the Leeds GPFV Delivery Plan currently being developed by the Leeds CCGs. It is therefore essential that the CCG’s feedback on the draft Primary Care Estates Strategy supports full alignment with the Leeds GPFV Delivery Plan, Leeds Plan, Sustainability and Transformation Plan and Local Digital Roadmap.

Priority areas identified within the Primary Care Estates strategy will be drawn into a pipeline of future investment and referenced back to ETTF funding as well as work being undertaken to maximize existing estates across health and social care providers at neighborhood level (see section 3 below).

Following LNCCG’s feedback on the draft strategy, the expected timetable for approval will be to take the final version of the Estates Strategy to the LNCCG PCCC in December 16. This will align with the presentation of the GP Forward View Delivery Plan to the PCCC which is being submitted to the same meeting for approval.

3. City-wide Estates Development
Over the last 3 months, a number of citywide Estates Workshops have been undertaken with representatives from key stakeholder groups including, Leeds CCGs, Leeds City Council, Leeds Community Healthcare, Leeds Partnership NHS Foundation Trust and Leeds Teaching Hospitals NHS Trust. The workshops have reviewed current stakeholder estates by ‘Neighbourhood’ and identified any initial opportunities for collaborative estates development and utilisation. Opportunities identified will be recommended to the Leeds Strategic Estates Group for approval and to work up into a fully developed proposal. It is important that the development of proposals fully aligns with Primary Care Estates Strategy for the city.

This approach to considering the totality of available public service estate, irrespective of organisational ownership, supports the wider Leeds Sustainability and Transformation Plan and CCG’s approach to Population Health Management (PHM) and new Models of Care.

The Estates Workshops are reviewing estate, by neighbourhood, to ensure all estate and surrounding area impacts are considered. Neighbourhoods reviewed to date include Seacroft, City & Hunslet, Beeston & Holbeck, Middleton Park, Horsforth, Chapel Allerton, Gipton & Harehills and Pudsey. The remaining first round of neighbourhood reviews are due to complete by January 2017. As estates development is an iterative process the need for the future workshops will be reviewed in January 2017.

4. Estates and Technology Transformation Fund (ETTF) 2016-17
Leeds North CCG has received confirmation from NHS England that ALL eight of the ETTF schemes recommended by the LNCCG PCCC and submitted by LNCCG to NHS England (Stage 1) have passed NHSE’s initial review stage (Stage 2).

Recommended schemes included one new build, six refurbishment/extensions and one technology scheme made up of 4 elements. The total estimated capital requirement for these schemes was £2.6m.

The next stage of the process is Stage 3: Due Diligence. For all eight schemes, detailed information and project initiation documents will be required in preparation for business cases to be considered. The categories of information and degree of detail will vary with respect to the type and scale of
scheme that has been recommended. Schemes will need to demonstrate that the proposal will deliver benefits for patients and that improved access to care is central.

At present NHS England are focusing on schemes which are able to complete by 31 March 2017. The CCG will now work with NHS England and Scheme Leads to review those proposals that could be completed by March 2017 and prioritise gathering the relevant information required. The CCG is also waiting for revised overall timescales for Stage 3 of the process as this was originally planned to start in September 2016. The CCG has been in touch individual practices who have submitted schemes regarding next steps.

5. **Next Steps**
   - Final version of the Leeds CCGs Primary Care Estates Strategy to be presented to Primary Care Commissioning in December 2016 for approval.
   - Further update on progress of Estates and Technology Transformation Fund schemes to be presented to PCCC in December 2016 for information.

6. **Recommendations**
The Primary Care Commissioning Committee is asked to:
   - REVIEW and NOTE the Estates Update included with this paper.
## Summary Report

**Meeting:** Primary Care Commissioning Committee  
**Date:** 19/10/16

**Agenda Item:** 036/2016  
**Report Title:** Primary Care Quality - Themes and Concerns  
**Prepared by:** Helen Wilkinson - Primary Care Locality Manager  
Gina Davy - Interim Director of Commissioning Primary Care and New Models of Care  
**Executive Lead:** Gina Davy – Interim Director of Commissioning Primary Care and New Models of Care  
**Presented by:** Gina Davy – Interim Director of Commissioning Primary Care and New Models of Care

**Other meetings presented to:**

### Purpose of Report

<table>
<thead>
<tr>
<th>Approval</th>
<th>Decision</th>
<th>Assurance</th>
<th>Information and Comment</th>
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<tr>
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<td></td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

### Strategic Objectives (tick all that apply)

1. The people of North Leeds will live independent and healthier lives  
2. The people of North Leeds will receive accessible, quality and supportive services ✓  
3. The CCG will deliver a well-led and sustainable health and social care system

### Executive Summary

The report describes key quality themes and concerns, relating to the delivery of primary care medical services, at CCG level and at General Practice level within NHS Leeds North Clinical Commissioning Group (LNCCG).

The themes, specific quality concerns and mitigating actions contained within the report were reviewed and discussed by the LNCCG Primary Care Quality Improvement Group (PCQIG) on the 5th August 2016. Following discussions, the group was assured regarding the mitigating actions already in place or those planned, to address the specific quality concerns and themes identified.

This report was reviewed by the joint NHS Leeds North CCG and Leeds South and East CCG Joint Quality and Safety Committee on the 29th September 2016. The committee were assured regarding the processes and actions in place to address the quality and safety issues.

### Key Recommendations

Members of the PCCC are asked to:

- **Note** the content of the report relating to quality of General Practice providers within NHS Leeds North CCG

### Assurance Framework

**LNCCG Board Assurance Framework**

**Risk 4:** Providers fail to meet quality standards leading to poor quality and unsafe care

**LNCCG Internal Risk Register**

**Risk 600:** There is a risk that the CCG is unable to be fully assured regarding the quality of contracted general practice services; due to delays in the establishment of a General Practice Quality Dashboard; resulting in inability of the CCG to respond to quality issues and concerns at CCG level and individual practice level
<table>
<thead>
<tr>
<th>Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corporate Impact Assessment</strong></td>
</tr>
<tr>
<td>Regulatory implications</td>
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<tr>
<td>Financial implications</td>
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<tr>
<td>Legal implications</td>
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<tr>
<td>Workforce implications</td>
</tr>
<tr>
<td>Equality impact assessment</td>
</tr>
</tbody>
</table>
Report from the Primary Care Quality Improvement Group on General Practice Quality Themes and Concerns

1. Background

1.1 The content and issues described in this paper were discussed by the LNCCG Primary Care Quality Improvement Group (PCQIG) on Friday 5th August 2016. The group was assured by the mitigating actions being progressed to manage the key quality concerns identified at specific practice level.

2. Key Quality and Safety Concerns

2.1 One of the key quality concerns identified in the last report was regarding Practice A. Please see the summary below of the initial concerns and the most recent actions that have been undertaken.

<table>
<thead>
<tr>
<th>Provider</th>
<th>General Practice A</th>
</tr>
</thead>
</table>
| **Summary of concerns** | • CCG identified a number of quality concerns through internal quality tracker. These include:  
  o Practice classified as under review on the Primary Care Web Tool (Highest number of Level 1 and Level 2 PCWT triggers in CCG)  
  o Prescribing concerns  
  o High staff turnover  
  o Lowest recorded levels of patient experience within the CCG and national outlier  
  • Review and discussion of concerns at PCQIG, agreement to develop Quality Risk Profile.  
  • Quality Risk Profile developed and reviewed with CQC and Area Team - concerns and Key Lines of Inquiry where assurance sought were identified. |
| **Mitigating actions** | • Practice Quality Visit planned and undertaken by CCG to seek assurance in relation to Key Lines of Inquiry identified through Risk Profiling exercise – Visiting team made up from CCG and NHS England GP, Nursing, Practice Manager, Medicines Optimisation and Management leads.  
  • Information triangulated and presented back to Practice within a report including a number of recommendations requiring actions within 14, 30 and 60 days  
  • Contractual breach notice issued by CCG in relation to some of the quality issues identified as part of the visit.  
  • Agreement with Practice to suspend Practice’s participation in CCG schemes to enable focus on rectifying quality and safety issues.  
  • Ongoing feedback and discussions with Practice regarding actions required to provide assurance.  
  • Internal review of information provided back to CCG as per 14 day and 30 day timescales for action  
  • Formal meetings between CCG and Practice to feedback on progress and information provided in relations to agreed actions. |
| **Current Position** | • The Practice is working closely with the CCG and has undertaken a significant amount of work to deliver actions within the timescales specified.  
  • The CCG has had three formal meetings with the Practice to ensure that this process is undertaken properly and to provide support to the practice. |
• Ongoing audits in some areas throughout the year to provide assurance that the changes have been embedded.
• CCG tracker is being closely monitored by the Primary Care Team to ensure the actions are quality assured before they are signed off as complete.

| Overall Assurance | A discussion was held in the PCQIG to review the outcomes of the quality visit and planned next steps. The group was assured on the process in hand to ensure that Practice A addresses all of the actions that were highlighted as part of the quality visit. |

3. **Lessons learned in relation to planning and undertaking the Quality Visit with Practice A**

3.1 As part of the PCQIG’s review of the process and outcomes of the Quality Visit of Practice A, the group also reviewed and discussed key learning. This learning is already being incorporated into the ongoing quality review process with this Practice as well as the development of future quality and safety review processes.

4. **Quality Themes at CCG level**

Members of the PCQIG reviewed the quality themes across General Practices at CCG level that were identified at the last meeting on 10\textsuperscript{th} June 2016. There was a discussion on actions that have been undertaken in relation to these themes. Table 2 provides an update on actions in place to address existing quality themes identified at CCG level. The review of these themes and actions is a standing item on the agenda and will be discussed at each meeting.

It was acknowledged that as the Primary Care Web Tool is updated quarterly, due to the timing of the meeting, insufficient time has elapsed since the previous meeting for data to be updated and further themes to be identified.
Table 2 – Quality Themes across General Practices at CCG level

<table>
<thead>
<tr>
<th>Quality Theme</th>
<th>Actions</th>
</tr>
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</table>
| **1 Care Quality Commission Visits** | • All practices visited by CQC in the CCG and all but one practice has a good overall rating [updated to reflect publication of final 2 reports, 28/09/16].  
• Three practices have been highlighted as having ‘outstanding practice’ in one of the domains. |
| | • Where CQC have noted specific areas for improvement, the CCG will work with practices to support improvement within these areas as part of the CCG’s quality improvement plan process.  
• The CCG is in the process of compiling a report on the CQC reports. This will identify areas of good practice and those where things can be improved. |
| **2 Primary Care Web Tool (PCWT)** | • Following the recent refresh of data within the PCWT and the assessment of where practices are ‘triggering’ in relation to different quality indicators, the PCWT classifies LNCCG practices as follows:  
  ➢ 2 practices are noted as ‘Higher Achieving’.  
  ➢ 14 practices are noted as ‘Achieving’  
  ➢ 9 practices are noted as ‘Approaching Review’  
  ➢ 2 practices are noted as ‘Review Identified’. |
| | • Achieving practice’.  
• These practices have had a discussion with the primary care team as part of routine meetings to understand the reasons for triggers.  
  ‘Approaching review’  
• The primary care team has contacted practices to discuss this.  
  ‘Review identified’.  
• An improvement plan is in place; these are currently being updated following the recent update of the PCWT. |
| **3 Prescribing** | • The Medicines Optimisation Team has a systematic process in place to ensure that quality issues in prescribing are picked up.  
• This quarter there are four member practices where quality issues have been identified. |
| | • The Medicines Optimisation Team are working closely with the practices that have been identified as having quality issues.  
• The PCQIG will be updated as to whether the actions have addressed the quality issues or whether there needs to be further action. |
<p>| <strong>4 Patient Experience</strong> | • 88% of patients reported satisfaction with their overall experience of GP surgery, (national figure 85%); 88% of patients reported satisfaction success in getting appointment (85% national figure). |
| | • The CCG is supporting practices to begin using MJOG a patient text messaging service which can be used to implement the FFT. It is hoped that implementation of MJOG will gain better uptake of FFT this year resulting in more reliable results. |</p>
<table>
<thead>
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<tbody>
<tr>
<td><strong>Patient satisfaction</strong></td>
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<tr>
<td><strong>Incidents</strong></td>
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<tr>
<td>• Leeds North CCG practices have reported 121 incidents during April &amp; June 2016. The learning has been completed for 95% of the incidents reported.</td>
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<tr>
<td></td>
<td>• The level of incidents registered on to DATIX has dropped over the last few months but is starting to increase.</td>
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<tr>
<td><strong>Workforce</strong></td>
<td></td>
</tr>
<tr>
<td><strong>and staffing</strong></td>
<td></td>
</tr>
<tr>
<td>• There is an inevitable relationship between practice workforce issues and levels of safety and quality provided to patients.</td>
<td></td>
</tr>
<tr>
<td>• It is acknowledged that there is a gap in the assurance regarding the systematic recording of workforce issues such as turnover, recruitment, retention and leadership within practices.</td>
<td></td>
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<tr>
<td><strong>Summary Report</strong></td>
<td></td>
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<td>-------------------</td>
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<tr>
<td><strong>Meeting:</strong> Primary Care Commissioning Committee</td>
<td><strong>Date:</strong> 19/10/16</td>
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<tr>
<td><strong>Agenda Item:</strong> 037/2016</td>
<td></td>
</tr>
<tr>
<td><strong>Report Title:</strong> Current risks in Primary Care</td>
<td></td>
</tr>
<tr>
<td><strong>Prepared by:</strong> Helen Wilkinson - Primary Care Locality Manager Gina Davy - Interim Director of Commissioning Primary Care and New Models of Care</td>
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<tr>
<td><strong>Executive Lead:</strong> Gina Davy – Interim Director of Commissioning Primary Care and New Models of Care</td>
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<tr>
<td><strong>Presented by:</strong> Gina Davy – Interim Director of Commissioning Primary Care and New Models of Care</td>
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| **Other meetings presented to:** |

<table>
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<tr>
<th><strong>Purpose of Report</strong></th>
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<tbody>
<tr>
<td><strong>Approval</strong></td>
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<table>
<thead>
<tr>
<th><strong>Strategic Objectives (tick all that apply)</strong></th>
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<tbody>
<tr>
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<td>3. The CCG will deliver a well-led and sustainable health and social care system</td>
</tr>
</tbody>
</table>

| **Executive Summary** |

This paper provides a summary of risks in relation to General Practices and the delivery of primary medical care services as at October 2016.

The risk register is a record of all significant risks which include the controls and assurances that are in place.

In total there are currently ten operational risks on Datix regarding General Practice. All are medium risks and these vary between risk scores of 6 and 12 in the amber scoring matrix. There is a summary of these in this report.

The LNCCG Executive Management Team (EMT) review the full risk register twice a year and risks of 12 and above are reviewed as a standing item at Governance Performance and Risk committee. Going forward, a summary of these risks will be incorporated within the Quality Paper that goes to the Primary Care Quality Improvement Group and the Joint Quality and Safety Committee to provide assurance.

<table>
<thead>
<tr>
<th><strong>Key Recommendations</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Members of the PCCC are asked to:</td>
</tr>
<tr>
<td>• <strong>Note</strong> the content of the report relating to the current risks identified in General Practice providers within NHS Leeds North CCG</td>
</tr>
<tr>
<td>• <strong>Note</strong> that going forward, risks will be incorporated into the Quality report.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Assurance Framework</strong></th>
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<tbody>
<tr>
<td>All</td>
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<tr>
<td>Next Steps</td>
</tr>
<tr>
<td>------------</td>
</tr>
<tr>
<td>Corporate Impact Assessment</td>
</tr>
<tr>
<td>Regulatory implications</td>
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<td>Financial implications</td>
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<tr>
<td>Legal implications</td>
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<tr>
<td>Workforce implications</td>
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<td>Equality impact assessment</td>
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<td>2.593</td>
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<tr>
<td>3.596</td>
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<td>Risk Area</td>
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<tr>
<td>-----------</td>
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<tr>
<td><strong>4.600 Dashboard</strong></td>
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<tr>
<td><strong>5.597 Relationship and Engagement</strong></td>
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<td><strong>6.595 Equitable funding</strong></td>
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<td><strong>7.594 Capacity for delivery</strong></td>
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<td>9.472</td>
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<td>10.958</td>
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### Purpose of Report

<table>
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<tr>
<th>Approval</th>
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</table>

### Strategic Objectives (tick all that apply)

1. The people of North Leeds will live independent and healthier lives ✓
2. The people of North Leeds will receive accessible, quality and supportive services ✓
3. The CCG will deliver a well-led and sustainable health and social care system ✓

### Executive Summary

This paper updates the Primary Care Commissioning Committee of the financial position of Primary Care, including delegated co-commissioning for the CCG. It also informs of the current developments under co-commissioning arrangements from 1 April 2016.

### Key Recommendations

Members of the PCCC are asked to:
- **Note** the financial position of Primary Care and current developments for 2016/17 and future years

### Assurance Framework

Risk 6 - Failure to achieve financial stability and sustainability, leading to an inability to fund the CCG’s strategic objectives

### Next Steps

Continuation of monitoring and update of primary care expenditure for 2016/17 against budgets and forecasts.

### Corporate Impact Assessment

<table>
<thead>
<tr>
<th>Regulatory implications</th>
<th>Financial implications ✓</th>
<th>Legal implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workforce implications</td>
<td>Equality impact assessment</td>
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</table>
Overview of Primary Care Co-commissioning Finance

This paper provides an update of the primary care financial position, including delegated co-commissioning for the CCG. It also informs of the current and future developments taking place within primary care including co-commissioning.

CCG Primary Care Financial Position

A summary of the CCG primary care position as at August 2016 is shown below:

<table>
<thead>
<tr>
<th>Primary Care – Month 05</th>
<th>Year to date</th>
<th>Full year forecast</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Budget £’000</td>
<td>Expend. £’000</td>
</tr>
<tr>
<td>Primary Care Co-Commissioning</td>
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<td>10,847</td>
</tr>
<tr>
<td>Local Enhanced Services</td>
<td>120</td>
<td>119</td>
</tr>
<tr>
<td>Clinical Engagement</td>
<td>696</td>
<td>696</td>
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<tr>
<td>Clinical Leads</td>
<td>68</td>
<td>68</td>
</tr>
<tr>
<td>GP IT</td>
<td>223</td>
<td>223</td>
</tr>
<tr>
<td>GP Prescribing</td>
<td>12,878</td>
<td>12,851</td>
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<tr>
<td>Central Drugs</td>
<td>290</td>
<td>321</td>
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<tr>
<td>Out of Hours</td>
<td>65</td>
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<tr>
<td>Oxygen</td>
<td>94</td>
<td>93</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>182</td>
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<tr>
<td>GPSIs &amp; AQP</td>
<td>558</td>
<td>558</td>
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<tr>
<td>Total – Primary Care</td>
<td>26,022</td>
<td>26,022</td>
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</tbody>
</table>

At the end of August 2016, the forecast for primary care is expected to remain within the budget allocated, with the exception of GP Special Interest (GPSI) and Any Qualified Provider (AQP).

Financial Risks

All risks are currently managed and mitigated within the co-commissioning delegated budgets for 2016-17, through strict financial controls. Looking forward, 2017/18 and beyond will be challenging with the following financial risks identified as follows:

- Delivery of core GP services within available resources, whilst continuing to meet business rules, changes agreed nationally, growth in demand of services and increasing estates costs
- Potentially insufficient resources to deliver General Practice Forward View (GPFV) within allocation. Further details below and in the GP Forward View update.

The controls in place to mitigate the risks in 2017/18 include the development of an underpinning financial plan within the GPFV delivery plan. The plan will consider core and
additional transformation funding flows, and opportunities to utilise non-recurrent reserves as detailed in the NHS Operational Planning & Contracting Guidance 2017-2019.

**Primary Care Co-commissioning Forecast 2016/17**

Work continues in collaboration with NHS England, to understand details of costs at practice level and to produce forecasts, to monitor against revised budgets as presented at the previous Primary Care Co-Commissioning meeting (PCCC).

A summary of the current position of forecasted expenditure against budget is summarised below. The forecast for co-commissioning remains on target to spend within the allocation received, with all risks currently managed within the forecast. The CCG will continue to monitor spend against the budgets for the remainder of the 2016/17 financial year, with regular updates presented at PCCC meetings.

<table>
<thead>
<tr>
<th>Primary Care Co-Commissioning Month 5</th>
<th>Budget</th>
<th>Forecast</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>GMS</td>
<td>7,553</td>
<td>7,601</td>
<td>48</td>
</tr>
<tr>
<td>PMS</td>
<td>8,389</td>
<td>8,381</td>
<td>(8)</td>
</tr>
<tr>
<td>APMS</td>
<td>1,416</td>
<td>1,475</td>
<td>59</td>
</tr>
<tr>
<td>Premises Costs</td>
<td>3,248</td>
<td>3,249</td>
<td>1</td>
</tr>
<tr>
<td>Enhanced Services</td>
<td>1,286</td>
<td>1,286</td>
<td>(0)</td>
</tr>
<tr>
<td>QOF</td>
<td>2,541</td>
<td>2,508</td>
<td>(33)</td>
</tr>
<tr>
<td>Other GP Services</td>
<td>978</td>
<td>888</td>
<td>(90)</td>
</tr>
<tr>
<td>Premises Cost Reserve</td>
<td>284</td>
<td>285</td>
<td>1</td>
</tr>
<tr>
<td>PMS Premium</td>
<td>128</td>
<td>128</td>
<td>0</td>
</tr>
<tr>
<td>Shortfall</td>
<td>(47)</td>
<td>(24)</td>
<td>23</td>
</tr>
<tr>
<td>Contingency</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total - Primary Care</strong></td>
<td>25,776</td>
<td>25,776</td>
<td>0</td>
</tr>
<tr>
<td><strong>1% Uncommitted Reserve</strong></td>
<td>260</td>
<td>260</td>
<td>0</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>26,036</td>
<td>26,036</td>
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</table>

**PMS Premium**

The PMS Premium proposal has been agreed by Practices. Based on the national criteria and local feedback on options, it was proposed that LNCCG invests the 2016/17 £128,000 PMS Premium, to reduce premature mortality within the CCG’s most deprived population, by commissioning practices to proactively identify patients with hypertension living within the most deprived populations.

The majority of payments have been paid in September 2016.

Further information is provided in the PMS Premium Update.
Estates and Technology Transformation Fund (ETTF)

LNCCG submitted eight ETTF bids in priority order to NHS England on the 30th June 2016, and has just received preliminary feedback. All eight bids have passed the initial review stage and will now move to the next stage of assessment, where the bids will be analysed in more detail and further questions may be asked and information sought. As yet, there is no estimated timescale for the completion of the next stage, but further information from the local regional team at NHS England has been requested.

Further information will be provided in the GP Forward View update.

Devolved Budgets

The pilot of the devolved budget scheme is now in operation and activity data has been provided up until the end of July 2016. Work continues to identify areas of focus for practices’ influence, new ways of working and implementing quality improvement initiatives.

The scheme is due to have its 6 month review when 6 months of data is available (data is 2 months in arrears) – this is estimated to be November 2016. The review will include insights and feedback for the project so far, and enables the CCG to review any initial outcomes of the scheme. Further updates will continue to be provided.

Planning 2017/18, 2018/19 & 2019/20

The NHS Operational Planning & Contracting Guidance 2017-2019, was published at the end of September 2016. Within this guidance, further information has been released around the General Practice Forward View (GPFV). It outlines the requirements of CCGs to support its implementation to deliver the sustainability and transformation of general practice.

The GPFV states that in 2017/18 and 2018/19 nationally; there will be an increase in funding for core local primary medical allocations of £231 million and then a further £188 million increase respectively. In addition to those allocations, other primary care funding will be available for specific purposes as part of the £500 million sustainability and transformation package. The guidance includes further details of new investments and which funds are from existing budgets, for specific schemes to support improvements in access to general practice and improvements in estates and technology.

The guidance outlines that CCG’s are required to submit plans and supporting financial trajectories, outlining how CCG’s will deliver the requirements of the GPFV. A collaborative approach will be adopted with NHS Leeds West CCG and NHS Leeds South & East CCG, to develop a citywide GPFV delivery plan, with an initial draft being prepared for the 21st October and for final submission by the 23rd December to NHS England.

Further details can be found in the GP Forward View update.
Summary Report

Meeting: Primary Care Commissioning Committee  Date: 19th October 2016

Agenda Item: 039/2016 PCCC
Report Title: PCCC – Terms of reference and scheme of delegation
Prepared by: Stephen Gregg – Head of Governance and Corporate Services
Executive Lead: Nigel Gray – Chief Officer
Presented by: Stephen Gregg

Other meetings presented to:

Purpose of Report

Approval  Decision  ✓
Assurance  Information and Comment  ✓

Strategic Objectives (tick all that apply)

1. The people of North Leeds will live independent and healthier lives
2. The people of North Leeds will receive accessible, quality and supportive services
3. The CCG will deliver a well-led and sustainable health and social care system  ✓

Executive Summary

The Primary Care Commissioning Committee (PCCC) was established to make collective decisions on the review, planning and procurement of primary care services in Leeds North, following delegation from NHS England. The PCCC has delegated authority from the CCG Board to make decisions on:

- Financial Plans in respect of primary medical services
- Procurement of primary medical services
- Practice payments and reimbursement
- Investment in practice development
- Contractual compliance and sanctions

Committee Terms of Reference

The first six months of delegated commissioning have highlighted the need for a mechanism for making decisions on urgent matters arising between meetings of the Committee. To address this, it is recommended that the following be added to the Committee’s Terms of Reference:

URGENT MATTERS ARISING BETWEEN MEETINGS

A sub-group consisting of the Lay Member – Patient and Public Involvement, one additional Lay Member, the Chief Officer and Chief Financial Officer is authorised to make decisions on urgent matters arising between meetings of the Committee. Such decisions will be ratified at the next meeting of the Committee.

To ensure appropriate Executive representation, it is also recommended that the Director of Nursing and Quality be added to the membership of the Committee.
Outline scheme of delegation

Implementing delegated commissioning has highlighted the need for the Committee to formally delegate some elements of its functions to other groups or individuals within the CCG.

To address this, a proposed outline scheme of delegation for the PCCC is attached. The detail of this will be developed alongside a review of the CCG’s wider scheme of delegation and within the context of ongoing work as part of ‘One Voice’ to join up approaches to commissioning across the city.

The PCCC will remain accountable for, and will receive regular reports on all of its functions, including those that it delegates to other groups or individuals within the CCG. For example through the reports on the investment of PMS monies and the general practice potential contract change tracker on today’s agenda.

Key Recommendations

The Committee is recommended to comment on the proposed amendments to the PCCC’s terms of reference, and the principles in the outline PCCC scheme of delegation.

Assurance Framework

Risk 7 Governance and risk management arrangements are not clear, robust and transparent, leading to poorly informed decisions and reputational harm to the CCG.

Next Steps

The principles in the outline PCCC scheme of delegation will be developed into a detailed scheme of delegation which will be submitted to the PCCC for approval.

The PCCC’s revised Terms of Reference will be submitted to the Board for approval.

Corporate Impact Assessment

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<table>
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<tr>
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<td>Legal implications</td>
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<td>Information quality assured</td>
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Primary Care Commissioning Committee – Outline scheme of delegation

| Financial Plans in respect of primary medical services, practice payments and reimbursement |
|---------------------------------------------------------------|-----------------|-----------------|
| Primary care budget                                         | Approve          | Prepare, Monitor|
| Management of delegated funds                               | Approve          | Monitor         |
| Premises development schemes                                | Approve          | Review          |
| Discretionary payments *(in line with scheme of financial delegation)* | Approve          |                  |
| Premises costs directions                                   | Plans being developed for a city-wide group to support decision making and ensure city-wide parity. |

**Procurement of primary medical services (including commissioning and contracting)**

<table>
<thead>
<tr>
<th>Reviewing primary medical care services</th>
<th>Approve outcomes</th>
<th>Review</th>
<th>Review</th>
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<tbody>
<tr>
<td>New GP practices</td>
<td>Approve</td>
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<tr>
<td>Enhanced services</td>
<td>Approve</td>
<td></td>
<td>Develop</td>
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<td>Local incentive schemes</td>
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<td>Monitor</td>
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<td>Review</td>
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<td>APMS procurement</td>
<td>Approve</td>
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<tr>
<td>Primary care business cases</td>
<td>Approve</td>
<td></td>
<td>Develop</td>
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<td>Practice list size reviews</td>
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<td>Practice closures</td>
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<td>Local contract variations</td>
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<td>Authorise</td>
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<td>Commissioning urgent care for out of area patients</td>
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<td>Develop</td>
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<td>Joint Quality and Safety Committee</td>
<td>Governance, Performance and Risk Committee</td>
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<td>Investment in practice development, contractual compliance and sanctions (including quality and performance management)</td>
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<tr>
<td>Primary care quality</td>
<td>Review</td>
<td>Assure</td>
<td>Review</td>
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<tr>
<td>Feedback from complaints, incidents, patient and public engagement</td>
<td>Review</td>
<td></td>
<td></td>
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<tr>
<td>Contractual and practice performance</td>
<td>Review</td>
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<td>Breach notices</td>
<td>Approve (retrospective)</td>
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<td>Improvement plans</td>
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<tr>
<td>Formal contractual disputes</td>
<td>Approve</td>
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### Summary Report

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<th>Primary Care Commissioning Committee</th>
<th>19 October 2016</th>
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<tbody>
<tr>
<td>Agenda Item:</td>
<td>040/2016</td>
<td></td>
</tr>
<tr>
<td>Report Title:</td>
<td>Managing conflicts of interest, Standards of Business conduct - revised policies</td>
<td></td>
</tr>
<tr>
<td>Prepared by:</td>
<td>Stephen Gregg, Head of Governance and Corporate Services</td>
<td></td>
</tr>
<tr>
<td>Executive Lead:</td>
<td>Martin Wright, Chief Financial Officer</td>
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<td>Stephen Gregg, Head of Governance and Corporate Services</td>
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#### Purpose of Report

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<tr>
<th>Approval</th>
<th>Decision</th>
<th>Assurance</th>
<th>Information and Comment</th>
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#### Strategic Objectives (tick all that apply)

1. The people of North Leeds will live independent and healthier lives
2. The people of North Leeds will receive accessible, quality and supportive services
3. The CCG will deliver a well-led and sustainable health and social care system

#### Executive Summary

Following new guidance from NHSE on managing conflicts of interest, the CCG has reviewed its policy on managing conflicts of interest, and widened its policy on gifts, hospitality and sponsorship into a Standards of Business Conduct policy. These draft policies were approved by the CCG’s Governance, Performance and Risk Committee on 15th September and presented to the Board on 28th September.

The delegation of primary care commissioning to CCGs was one of the main drivers behind the new guidance. The new policies are presented to the PCCC for assurance.

Key elements in the new guidance include:

- The recommendation for CCGs to have a minimum of three lay members
- The appointment of a conflict of interest guardian – the Audit Chair - as point of contact for any conflict of interest queries
- Declarations and registers to set out explicitly the arrangements for mitigating risks associated with conflicts.
- A robust process for managing breaches, and breaches to be published on the CCG website
- Strengthened provisions around decision making when a member of the Board, committee or sub-committee is conflicted
- The need for prompt declarations and a publicly accessible register of gifts and hospitality
- An annual audit of conflicts of interest management is to be included in the annual end of year governance statement
- The inclusion of conflicts of interest as a ‘key indicator’ in the NHSE Improvement and Assessment Framework for 2016/17
- A requirement for all CCG staff (including Board, committee members and GP members) to complete mandatory online conflicts of interest training.

The CCG’s policies and procedures have been reviewed and revised to ensure that the CCG complies with the new guidance. The recommendation that CCGs have a minimum of three lay members on their governing body, and that ‘ideally’ the Chair of the Audit Committee should not be Deputy Chair of the PCCC, is being addressed through a forthcoming recruitment process.

The new policies apply to all CCG staff, Board and Committee members and member practices - defined as ‘GP partners (or where the practice is a company, each director) and any individual directly involved with the business or decision making of the CCG (e.g. representatives at the Council of Members, GP portfolio leads)’

In developing the policies, we circulated drafts to all CCG staff and Practice Managers for comment. We have also sought to ensure a consistent approach with the other Leeds CCGs.

**Key Recommendations**
The PCCC is recommended to note the revised policies.

**Assurance Framework**
Risk 7: Governance and risk management arrangements are not clear, robust and transparent, leading to poorly informed decisions and reputational harm to the CCG

**Next Steps**
The new policies and procedures will be rolled out to CCG staff, Board and Committee members and member practices in October and November.

**Corporate Impact Assessment**

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<thead>
<tr>
<th>Impact Type</th>
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<tr>
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<td>Workforce implications</td>
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<td>Equality impact assessment</td>
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## Managing Conflicts of Interest Policy

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Author</th>
<th>Description of change</th>
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<tr>
<td>0.1</td>
<td>18.08.16</td>
<td>Stephen Gregg</td>
<td>Amendments to reflect 2016 NHS England guidance and to ensure consistency with other Leeds CCGs</td>
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<tr>
<td>0.2</td>
<td>06.09.16</td>
<td>Stephen Gregg</td>
<td>Amendments following consultation with CCG staff, practices and Local Counter Fraud Specialist</td>
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<tr>
<td>0.3</td>
<td>11.10.16</td>
<td>Stephen Gregg</td>
<td>Final version approved by GPRC</td>
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<th>Page</th>
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<td>2. Definition of an interest</td>
<td>4</td>
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<td>3. Principles</td>
<td>6</td>
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<td>4. Equality statement</td>
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<td>6. Declaring interests</td>
<td>8</td>
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<tr>
<td>7. Register of interests</td>
<td>10</td>
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<td>11</td>
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<td>Appendix 2 - Register of interests template</td>
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<td>Appendix 6 - Register of procurement decisions template</td>
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<tr>
<td>Appendix 7 - Declaration of interests for bidders/contractors - template</td>
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1. Introduction

1.1 Managing conflicts of interest appropriately is essential for protecting the integrity of the NHS commissioning system and to protect Leeds North CCG and GP practices from any perceptions of wrongdoing. Commissioners need the highest level of transparency so they can demonstrate that conflicts of interest are managed in a way that cannot undermine the probity and accountability of the organisation.

1.2 It will not be possible to avoid conflicts of interest. They are inevitable in many aspects of public life, including the NHS. Healthcare professionals have always had to manage competing interests. However, by recognising where and how they arise and dealing with them appropriately, commissioners will be able to ensure proper governance, robust decision-making and appropriate decisions about the use of public money.

1.3 A conflict of interest occurs:

Where an individual’s ability to exercise judgement, or act in a role is, could be, or is seen to be impaired or otherwise influenced by his or her involvement in another role or relationship. In some circumstances, it could be reasonably considered that a conflict exists even when there is no actual conflict. In these cases it is important to still manage these perceived conflicts in order to maintain public trust.

1.4 This policy seeks to ensure that conflicts are identified, declared and recorded, and that clear mechanisms exist to manage or diffuse conflicts of interest when they arise. It is important to acknowledge that conflicts may not always be obvious to, or recognised by, the individuals concerned. Therefore, a policy based on full disclosure of competing interests will best safeguard healthcare professionals as they exercise their new commissioning responsibilities. NHS Leeds North CCG’s Managing Conflicts of Interest Policy is based on the principle of: “If in doubt, disclose”.

1.5 Whilst all individuals have a responsibility to identify and declare conflicts of interest as they encounter them, it is incumbent on the CCG to have in place both appropriate policies and strong governance structures for managing conflicts of interest, which are fully embedded in the organisation. The Health and Social Care Act 2012 places a duty on NHS England to publish guidance for CCGs on managing conflicts of interest, and a duty on CCGs to have regard to such guidance. It also requires that CCGs set out in their constitution their proposed arrangements for managing conflicts of interest (see section 8.2 of the Leeds North CCG constitution).

1.6 This policy provides more specific, additional safeguards that the CCG has put in place. It reflects the revised statutory guidance for CCGs on Managing Conflicts of Interest, issued by NHSE in June 2016 and applies to:
• All CCG employees, including all full and part-time staff, staff on sessional or short term contracts, students and trainees (including apprentices), agency staff and seconded staff.

In addition, any self-employed consultants or other individuals working for the CCG under a contract for services should make a declaration of interest in accordance with this guidance, as if they were CCG employees.

• Members of the CCG’s Board, Committees, Sub Committees and Sub Groups, including co-opted members, appointed deputies and members of committees/groups from other organisations (where the CCG is participating in a joint committee alongside other CCGs, any interests which are declared by the committee members should be recorded on the register(s) of interest of each participating CCG).

• Members of the CCG – defined as GP partners (or where the practice is a company, each director) and any individual directly involved with the business or decision making of the CCG (e.g. representatives at the Council of Members, GP portfolio leads)

Who are referred to collectively in this policy as ‘individuals within the CCG’.

2. Definition of an Interest

2.1 Conflicts of interest can arise in many situations, with an increased risk in primary care commissioning, out-of-hours commissioning and involvement with integrated care organisations, as clinical commissioners may find themselves in a position of being at once commissioner and provider of services. Conflicts of interest can arise throughout the whole commissioning cycle, from needs assessment, to procurement exercises; to contract monitoring. The following types of conflict are likely to affect CCGs:

2.2 Financial Interests

This is where an individual may get direct financial benefits from the consequences of a commissioning decision. This could, for example, include an individual being:

• A director, including a non-executive director, or senior employee in a private company or public limited company or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations;

• A shareholder (or similar ownership interests), a partner or owner of a private or not-for-profit company, business, partnership or consultancy which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations;

• A management consultant for a provider;
• In secondary employment;
• In receipt of secondary income from a provider;
• In receipt of a grant from a provider;
• In receipt of any payments (for example honoraria, one-off payments, day allowances or travel or subsistence) from a provider;
• In receipt of research funding, including grants that may be received by the individual or any organisation in which they have an interest or role; or
• Having a pension that is funded by a provider (where the value of this might be affected by the success or failure of the provider).

2.3 Non-financial Professional Interests

This is where an individual may obtain a non-financial professional benefit from the consequences of a commissioning decision, such as increasing their professional reputation or status or promoting their professional career. This may, for example, include situations where the individual is:

- An advocate for a particular group of patients;
- A GP with special interests e.g. in dermatology, acupuncture etc.;
- A member of a particular specialist professional body (although routine GP membership of the RCGP, British Medical Association (BMA) or a medical defence organisation would not usually by itself amount to an interest which needed to be declared);
- An advisor for the Care Quality Commission (CQC) or the National Institute for Health and Care Excellence (NICE);
- A medical researcher.

GPs and practice managers, who are members of the Board or committees of the CCG, should declare details of their roles and responsibilities held within their GP practices.

2.4 Non-financial Personal Interests

This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include, for example, where the individual is:

- A voluntary sector champion for a provider;
- A volunteer for a provider;
- A member of a voluntary sector board or has any other position of authority in or connection with a voluntary sector organisation;
- Suffering from a particular condition requiring individually funded treatment;
- A member of a lobby or pressure group with an interest in health.
2.5 **Indirect Interests**

This is where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a commissioning decision (as described above) for example, a:

- Spouse / partner
- Close relative e.g., parent, grandparent, child, grandchild or sibling;
- Close friend;
- Business partner.

A declaration of interest for a “business partner” in a GP partnership should include all relevant collective interests of the partnership, and all interests of their fellow GP partners (which could be done by cross referring to the separate declarations made by those GP partners, rather than by repeating the same information verbatim).

Whether an interest held by another person gives rise to a conflict of interests will depend upon the nature of the relationship between that person and the individual, and the role of the individual within the CCG.

2.6 NHS England has published conflicts of interests’ case studies which are available on its website [here](#).

### 3. Principles

3.1 The CCG observes the following principles of good governance:

- The Nolan Principles of selflessness, integrity, objectivity, accountability, openness, honesty and leadership
- The Good Governance Standards for Public Services (2004), Office for Public Management (OPM) and Chartered Institute of Public Finance and Accountancy (CIPFA)
- The seven key principles of the NHS Constitution
- The Equality Act 2010
- The UK Corporate Governance Code
- Standards for members of NHS boards and CCG governing bodies in England

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3. *The seven key principles of the NHS Constitution* [http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhscoreprinciples.aspx](http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhscoreprinciples.aspx)
3.2 The CCG endorses other principles that can safeguard against conflicts of interest:

- Doing business appropriately;
- Being proactive about identifying and minimising the risks of conflicts;
- Being balanced and proportionate in managing conflicts;
- Being transparent and documenting every stage in the commissioning cycle; and
- Creating an environment and culture where individuals feel supported and confident in declaring relevant information and raising any concerns.

3.3 The CCG also recognises that:

- A perception of wrongdoing, impaired judgement or undue influence can be as detrimental as any of them actually occurring;
- If in doubt, it is better to assume the existence of a conflict of interest and manage it appropriately rather than ignore it.
- For a conflict of interest to exist, financial gain is not necessary.

3.4 This policy reflects ‘Managing Conflicts of Interests: Statutory Guidance for CCGs’ (Issued by NHS England, June 2016). It should be read alongside the following Leeds North CCG documents:

- Anti-Fraud, Bribery and Corruption Policy;
- Code of Conduct for NHS Managers, also contained within individual contracts of employment;
- Whistleblowing Policy;
- Working Time Regulations Policy (including Secondary Employment);
- Disciplinary Policy;
- Procurement policy; and Standards of Business Conduct policy.

4. Equality Statement

4.1 This policy applies to all employees, Board and Committee members and members of NHS Leeds North CCG irrespective of age, race, colour, religion, disability, nationality, ethnic origin, gender, sexual orientation or marital status, domestic circumstances, social and employment status, HIV status, gender reassignment, political affiliation or trade union membership.

4.2 A full Equality Impact Assessment is not considered to be necessary as this policy will not have a detrimental impact on a particular group.

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6 Standards for members of NHS boards and CCG governing bodies in England
5. **Roles and Responsibilities**

5.1 The **Accountable Officer** has overall accountability for the CCG’s management of conflicts of interest.

5.2 The **Conflicts of Interest Guardian**, who will be the Chair of the Audit Committee, will:

- Act as a conduit for GP practice staff, members of the public and healthcare professionals who have any concerns with regards to conflicts of interest;
- Be a safe point of contact for employees or workers of the CCG to raise any concerns in relation to this policy;
- Support the rigorous application of conflict of interest principles and policies;
- Provide independent advice and judgment where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation;
- Provide advice on minimising the risks of conflicts of interest;
- If an individual requests that information is not included in the public register(s), decide whether the information should be published or not.

5.3 The **Head of Governance and Corporate Services** has day to day responsibility for managing conflict of interests, including:

- Maintaining the CCG’s register(s) of interest and the other registers referred to in this policy;
- Supporting the Conflicts of Interest Guardian to enable them to carry out the role effectively;
- Providing advice, support, and guidance on how conflicts of interest should be managed; and
- Ensuring that appropriate administrative processes are put in place.

5.4 All members of the **Board** must act in accordance with this policy and lead by example in acting with the utmost integrity and ensuring adherence to all relevant regulations, policies and procedures.

5.5 **Line Managers** are responsible for assisting employees in complying with this policy by ensuring that this policy and its requirements are brought to the attention of employees for whom they are responsible, and that those employees are aware of its implications for their work.

5.5 All **individuals within the CCG** are required to be aware of and comply with the policy.
5.6 If any individual within the CCG has any doubt about the relevance of an interest, this should be discussed with the Conflicts of Interest Guardian or the Head of Governance & Corporate Services.

6. Declaring Interests

6.1 All individuals within the CCG must declare any interests that might have any bearing on the work of the CCG:

a) **on appointment** - applicants for any appointment to the CCG or its Board or any committees should be asked to declare any relevant interests. When an appointment is made, a formal declaration of interests should again be made and recorded.

b) **six-monthly** - declarations will be sought from all relevant individuals every six months and where there are no interests or changes to declare, a “nil return” will be recorded.

c) **at meetings** - all attendees are required to declare their interests as a standing agenda item for every Board, committee, sub-committee or working group meeting, before the item is discussed. Even if an interest has been recorded in the register of interests, it should still be declared in meetings where matters relating to that interest are discussed.

d) **on changing role or responsibilities** - whenever an individual’s role, responsibility or circumstances change in a way that affects the individual’s interests (e.g., where an individual takes on a new role outside the CCG or enters into a new business or relationship), a further declaration should be made to reflect the change in circumstances as soon as possible, and in any event within 14 days. This could involve a conflict of interest ceasing to exist or a new one materialising. It is the individual’s responsibility to make a further declaration as soon as possible, rather than waiting to be asked.

e) if they come to know that the **CCG has entered into (or proposes to enter into) a financial arrangement** in which they or any person connected with them has any interest, direct or indirect.

6.2 **CCG Staff** should declare any interests by completing the declaration of interests form at Appendix 1 and submitting this to their Line Manager, within 14 days. Line Managers will record the interests and make a decision on whether the declaration is deemed to require any action to ensure transparency and avoid a conflict of interest. If required, Line Managers should seek advice on appropriate action from the Head of Governance and Corporate Services and/or Conflicts of Interest Guardian.

6.3 **Line Managers** should hold any interests declared on the individual’s personal file. All interests should be declared as and when they arise. Individuals are responsible for ensuring that their registered interests are kept up to date at all times.
6.4 Once any arrangements for mitigating the risk have been agreed by the individual’s Line Manager, these should be documented on the approved form and submitted to the Head of Governance and Corporate Services. Such arrangements will specify:

- whether and when an individual should withdraw from a specified activity, on a temporary or permanent basis; and
- monitoring of the specified activity undertaken by the individual, either by a line manager, colleague or other designated individual.

6.5 Where an individual is unclear about the arrangements for managing the interest, they should seek advice from their Line Manager.

6.6 All other individuals should submit declarations directly to the Head of Governance and Corporate Services using the form at Appendix 1, who will decide, in conjunction with the Conflicts of Interest Guardian, whether any specific arrangements are required to manage the conflicts or potential conflicts declared.

6.7 Although the interest may be declared, this does not remove the individual’s personal responsibilities of removing themselves from a position or situation which may result in a potential breach of this policy.

7. Register of Interests

7.1 Registers will be maintained of the interests of individuals within the CCG, specified in paragraph 1.6.

7.2 The registers for all the above will be published on the CCG’s website and maintained by the Head of Governance and Corporate Services. The register(s) will be reviewed six-monthly, and updated as necessary. For a new declaration, the relevant register will be updated inside 28 days. All individuals within the CCG must submit a nil declaration where they have no interests or changes to declare. All interests will remain on the register for a minimum of 6 months after the interest has expired. The CCG will retain a private record of historic interests for a minimum of 6 years after the date on which it expired.

7.3 Where an individual is unable to provide a declaration in writing, e.g. if a conflict becomes apparent in the course of a meeting, they will make an oral declaration before witnesses, and provide a written declaration as soon as possible thereafter.

7.4 Registers will include:

- Name of the person declaring the interest;
- Position within, or relationship with, the CCG (or NHS England in the event of joint committees);
Type of interest e.g., financial interests, non-financial professional interests;
Description of interest, including for indirect interests details of the relationship with the person who has the interest;
The dates from which the interest relates; and
The actions to be taken to mitigate risk - these should be agreed with the individual's line manager or a senior manager within the CCG.

7.5 A template is attached at Appendix 2.

7.6 The Board register of interests will be reviewed at every Board meeting. All registers of interest will be reviewed twice yearly by the Audit Committee.

8. **Publication of Registers**

8.1 The CCG will publish the register of interest and gifts and hospitality and the register of procurement decisions described below, in a prominent place on the CCG's website.

8.2 In exceptional circumstances, where the public disclosure of information could give rise to a real risk of harm or is prohibited by law, an individual's name and/or other information may be redacted from the publicly available register(s). Where an individual believes that substantial damage or distress may be caused, to him/herself or somebody else by the publication of information about them, they are entitled to request that the information is not published. Such requests must be made in writing. Decisions not to publish information must be made by the Conflicts of Interest Guardian for the CCG, who should seek appropriate legal advice where required, and the CCG should retain a confidential un-redacted version of the register(s).

8.3 All persons who are required to make a declaration of interests will be made aware that the register will be published in advance of publication. This will be done by providing a fair processing notice that details the identity of the data controller, the purposes for which the registers are held and published, and contact details for the data protection officer. This information will also be provided to individuals identified in the registers due to their relationship with the person making the declaration.

9. **Appointing Board or Committee Members and Senior Staff**

9.1 On appointing Board, committee or sub-committee members and senior staff, the CCG will consider whether conflicts of interest should exclude individuals from being appointed to the relevant role. The CCG will assess the materiality of the interest, in particular whether the individual (or any person with whom they have a close association could benefit (whether financially or otherwise) from any decision the CCG might make. This will be particularly relevant for Board, committee and sub-committee appointments, but should also be considered for all employees and especially those operating at senior level.
9.2 The CCG will also determine the extent of the interest and the nature of the appointee's proposed role within the CCG. If the interest is related to an area of business significant enough that the individual would be unable to operate effectively and make a full and proper contribution in the proposed role, then that individual should not be appointed to the role.

9.3 Any individual who has a material interest in an organisation which provides, or is likely to provide, substantial services to the CCG (whether as a provider of healthcare or commissioning support services, or otherwise) should recognise the inherent conflict of interest risk that may arise and should not be a member of the Board or of a committee or sub-committee of the CCG, in particular if the nature and extent of their interest and the nature of their proposed role is such that they are likely to need to exclude themselves from decision-making on so regular a basis that it significantly limits their ability to effectively perform that role.

10. Conflicts of Interest at Meetings

10.1 Declarations of interests will be a standing item on all meeting agendas. The chair of a meeting of the CCG’s Board or any of its committees, sub-committees or groups has ultimate responsibility for deciding whether there is a conflict of interest and for taking the appropriate course of action in order to manage the conflict of interest.

10.2 In the event that the chair of a meeting has a conflict of interest, the vice chair is responsible for deciding the appropriate course of action in order to manage the conflict of interest. If the vice chair is also conflicted then the remaining non-conflicted voting members of the meeting should agree between themselves how to manage the conflict(s).

10.3 In making such decisions, the chair (or vice chair or remaining non-conflicted members as above) may wish to consult with the Conflicts of Interest Guardian or another member.

10.4 It is good practice for the chair, with support of the CCG’s Head of Governance & Corporate Services and, if required, the Conflicts of Interest Guardian, to proactively consider ahead of meetings what conflicts are likely to arise and how they should be managed, including taking steps to ensure that supporting papers for particular agenda items of private sessions/meetings are not sent to conflicted individuals in advance of the meeting where relevant.

10.5 Chairs will be provided with a declaration of interest checklist (attached at Appendix 3) with the meeting papers, to help them manage conflicts of interest.

10.6 The Chair should ask at the beginning of each meeting if anyone has any conflicts of interest to declare in relation to the business to be transacted at the meeting. Each member of the group should declare any interests which are relevant to the business
of the meeting whether or not those interests have previously been declared. Any new interests which are declared at a meeting must be included on the CCG’s relevant register of interests to ensure it is up-to-date. Similarly, any new offers of gifts or hospitality which are declared at a meeting must be added to the register of gifts and hospitality.

10.7 It is the responsibility of each individual member of the meeting to declare any relevant interests which they may have. However, should the chair or any other member of the meeting be aware of facts or circumstances which may give rise to a conflict of interests but which have not been declared then they should bring this to the attention of the chair who will decide whether there is a conflict of interest and the appropriate course of action to take in order to manage the conflict of interest.

10.8 When a member of the meeting (including the chair or vice chair) has a conflict of interest in relation to one or more items of business, the chair (or vice chair or remaining non-conflicted members where relevant as described above) must decide how to manage the conflict. The appropriate course of action will depend on the particular circumstances, but could include one or more of the following:

- Where the chair has a conflict of interest, deciding that the vice chair (or another non-conflicted member of the meeting if the vice chair is also conflicted) should chair all or part of the meeting;
- Requiring the individual who has a conflict of interest (including the chair or vice chair if necessary) not to attend the meeting;
- Ensuring that the individual does not receive the supporting papers or minutes of the meeting which relate to the matter(s) which give rise to the conflict;
- Requiring the individual to leave the discussion when the relevant matter(s) are being discussed and when any decisions are being taken in relation to those matter(s). In private meetings, this could include requiring the individual to leave the room and in public meetings to either leave the room or join the audience in the public gallery;
- Allowing the individual to participate in some or all of the discussion when the relevant matter(s) are being discussed but requiring them to leave the meeting when any decisions are being taken in relation to those matter(s). This may be appropriate where, for example, the conflicted individual has important relevant knowledge and experience of the matter(s) under discussion, which it would be of benefit for the meeting to hear, but this will depend on the nature and extent of the interest which has been declared;
- Noting the interest and ensuring that all attendees are aware of the nature and extent of the interest, but allowing the individual to remain and participate in both the discussion and in any decisions. This is only likely to be the appropriate course of action where it is decided that the interest which has been declared is either immaterial or not relevant to the matter(s) under discussion.
10.9 Where over half of members withdraw from a part of a meeting - due to the arrangements agreed for the management of conflicts of interests - the chair (or deputy) will determine whether or not the discussion can proceed. In making this decision the chair will consider whether the meeting is quorate in accordance with the required number/balance of membership.

10.10 Where the meeting is not quorate the discussion will be deferred until such time as a quorum can be convened. Where a quorum cannot be convened from the membership of the meeting, owing to the arrangements for managing conflicts of interest or potential conflicts of interests, the chair of the meeting shall consult with the Conflicts of Interest Guardian on the action to be taken. This may include:

- requiring another committee or sub-committee which can be quorate to progress the item of business,

or if this is not possible,

- inviting on a temporary basis one or more of the following to make up the quorum (where these are permitted members of the Board/sub-committee in question) so that the group can progress the item of business:
  - a member of the CCG who is interest free;
  - an individual nominated by a member to act on their behalf in the dealings between it and the CCG;
  - a member of a relevant Health and Wellbeing Board;
  - a member of a board/Governing Body for another CCG.

10.11 The minutes will record all declarations of interest and actions taken in mitigation. A minute template for recording declarations is attached at Appendix 4.

11. Managing Conflicts of Interest throughout the Commissioning Cycle

11.1 Conflicts of interest need to be managed appropriately throughout the whole commissioning cycle. At the outset of a commissioning process, the relevant interests of all individuals involved should be identified and clear arrangements put in place to manage any conflicts of interest. This includes consideration as to which stages of the process an individual should not participate in, and, in some circumstances, whether they should be involved in the process at all.

Designing Service Requirements

11.2 The way in which services are designed can either increase or decrease perceived or actual conflicts of interest. Public involvement supports transparent and credible commissioning decisions. It should happen at every stage of the commissioning cycle from needs assessment, planning and prioritisation to service design,
procurement and monitoring. The CCG has a legal duty under the Act to involve patients and the public in their respective commissioning processes and decisions.

Provider Engagement

11.3 It is good practice to engage relevant providers, especially clinicians, in confirming that the design of service specifications will meet patient needs. This may include providers from the acute, primary, community, and mental health sectors, and may include NHS, third sector and private sector providers. Such engagement, done transparently and fairly, is entirely legal. However, conflicts of interest, as well as challenges to the fairness of the procurement process, can arise if a commissioner engages selectively with only certain providers (be they incumbent or potential new providers) in developing a service specification for a contract for which they may later bid.

11.4 Provider engagement should follow the three main principles of procurement law, namely equal treatment, non-discrimination and transparency. This includes ensuring that the same information is given to all at the same time and procedures are transparent. This mitigates the risk of potential legal challenge.

11.5 As the service design develops, it is good practice to engage with a range of providers on an on-going basis to seek comments on the proposed design e.g., via the commissioners website and/or via workshops with interested parties (ensuring a record is kept of all interaction). NHS Improvement has issued guidance on the use of provider boards in service design.7

11.6 Engagement should help to shape the requirement to meet patient need, but it is important not to gear the requirement in favour of any particular provider(s). If appropriate, the advice of an independent clinical adviser on the design of the service should be secured.

Specifications

11.7 The CCG will seek, as far as possible, to specify the outcomes that it wishes to see delivered through a new service, rather than the process by which these outcomes are to be achieved. As well as supporting innovation, this helps prevent bias towards particular providers in the specification of services. The CCG will also ensure that careful consideration is given to the appropriate degree of financial risk transfer in any new contractual model.

Procurement and Awarding Grants

11.8 The CCG will seek to recognise and manage any conflicts or potential conflicts of interest that may arise in relation to the procurement of any services or the administration of grants. “Procurement” relates to any purchase of goods, services or

works and the term “procurement decision” should be understood in a wide sense to ensure transparency of decision making on spending public funds. The decision to use a single tender action, for instance, is a procurement decision and if it results in the commissioner entering into a new contract, extending an existing contract, or materially altering the terms of an existing contract, then it is a decision that should be recorded.

11.9 NHS England and CCGs must comply with two different regimes of procurement law and regulation when commissioning healthcare services: the NHS procurement regime, and the European procurement regime:

- The NHS procurement regime – the NHS (Procurement, Patient Choice and Competition (No.2)) Regulations 2013: made under S75 of the 2012 Act; apply only to NHS England and CCGs; enforced by NHS Improvement; and
- The European procurement regime – Public Contracts Regulations 2015 (PCR 2015): incorporate the European Public Contracts Directive into national law; apply to all public contracts over the threshold value; enforced through the Courts. The general principles arising under the Treaty on the Functioning of the European Union of equal treatment, transparency, mutual recognition, non-discrimination and proportionality may apply even to public contracts for healthcare services falling below the threshold value if there is likely to be interest from providers in other member states.

11.10 Whilst the two regimes overlap in terms of some of their requirements, they are not the same – so compliance with one regime does not automatically mean compliance with the other. The National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 state:

- CCGs must not award a contract for the provision of NHS health care services where conflicts, or potential conflicts, between the interests involved in commissioning such services and the interests involved in providing them affect, or appear to affect, the integrity of the award of that contract; and
- CCGs must keep a record of how it managed any such conflict in relation to NHS commissioning contracts it has entered into.

11.11 Paragraph 24 of PCR 2015 states: “Contracting authorities shall take appropriate measures to effectively prevent, identify and remedy conflicts of interest arising in the conduct of procurement procedures so as to avoid any distortion of competition and to ensure equal treatment of all economic operators”. Conflicts of interest are described as “any situation where relevant staff members have, directly or indirectly, a financial, economic or other personal interest which might be perceived to compromise their impartiality and independence in the context of the procurement procedure”.

11.12 The Procurement, Patient Choice and Competition Regulations (PPCCR) place requirements on commissioners to ensure that they adhere to good practice in relation to procurement, run a fair, transparent process that does not discriminate
against any provider, do not engage in anti-competitive behaviour that is against the interest of patients, and protect the right of patients to make choices about their healthcare. Furthermore the PPCCR places requirements on commissioners to secure high quality, efficient NHS healthcare services that meet the needs of the people who use those services. The PCR 2015 are focussed on ensuring a fair and open selection process for providers.

11.13 The CCG will use a procurement checklist (see Appendix 5) to record the factors that the CCG should address when drawing up its plans to commission services. This will help to evidence the CCG’s deliberations on conflicts of interest. The CCG will make the evidence of its management of conflicts publicly available, and the relevant information from the procurement template will be used to complete the register of procurement decisions. Complete transparency around procurement will provide:

- Evidence that the CCG is seeking and encouraging scrutiny of its decision-making process;
- A record of the public involvement throughout the commissioning of the service;
- A record of how the proposed service meets local needs and priorities for partners such as the Health and Wellbeing Boards, local Healthwatch and local communities;
- Evidence to the audit committee and internal and external auditors that a robust process has been followed in deciding to commission the service, in selecting the appropriate procurement route, and in addressing potential conflicts.

11.14 External services such as commissioning support services (CSSs) can play an important role in helping CCGs decide the most appropriate procurement route, undertake procurements and manage contracts in ways that manage conflicts of interest and preserve the integrity of decision-making. The CCG will assure itself that a CSS’ business processes are robust and enable the CCG to meet its duties in relation to procurement (including those relating to the management of conflicts of interest). This will require the CSS to declare any conflicts of interest it may have in relation to the work commissioned by the CCG.

11.15 A CCG cannot, however, lawfully delegate commissioning decisions to an external provider of commissioning support. Although CSSs are likely to play a key role in helping to develop specifications, preparing tender documentation, inviting expressions of interest and inviting tenders, the CCG itself will need to:

- Determine and sign off the specification and evaluation criteria;
- Decide and sign off decisions on which providers to invite to tender; and
- Make final decisions on the selection of the provider.
Register of Procurement Decisions

11.16 The CCG will maintain a register of procurement decisions taken with a value in excess of £75,000, either for the procurement of a new service or any extension or material variation of a current contract. This will include:

- The details of the decision;
- Who was involved in making the decision (including the name of the CCG clinical lead, the CCG contract manager, the name of the decision making committee and the name of any other individuals with decision-making responsibility);
- A summary of any conflicts of interest in relation to the decision and how this was managed by the CCG; and
- The award decision taken.

11.17 The register of procurement decisions will be updated whenever a procurement decision is taken, using the register at Appendix 6. The Procurement, Patient Choice and Competition Regulations 9(1) place a requirement on commissioners to maintain and publish on their website a record of each contract it awards. The register of procurement decisions will be made publicly available and easily accessible to patients and the public by:

- Ensuring that the register is available in a prominent place on the CCG’s website; and
- Making the register available upon request for inspection at the CCG’s headquarters

Declarations of Interests for Bidders / Contractors

11.18 As part of the CCG’s procurement processes, bidders will be asked to declare any conflicts of interest. This allows the CCG to ensure that it complies with the principles of equal treatment and transparency. When a bidder declares a conflict, the CCG will decide how best to deal with it to ensure that no bidder is treated differently to any other. A declaration of interests for bidders/ contractors template is attached at Appendix 7.

11.19 It will not usually be appropriate to declare such a conflict on the register of procurement decisions, as it may compromise the anonymity of bidders during the procurement process. However, the CCG will retain an internal audit trail of how the conflict or perceived conflict was dealt with to allow it to provide information at a later date if required. The CCG is required under regulation 84 of the Public Contract Regulations 2015 to make and retain records of contract award decisions and key decisions that are made during the procurement process (there is no obligation to publish them). Such records must include “communications with economic operators and internal deliberations” which should include decisions made in relation to actual or perceived conflicts of interest declared by bidders. These records must be retained for a period of at least three years from the date of award of the contract.
Contract Monitoring

11.20 The management of conflicts of interest applies to all aspects of the commissioning cycle, including contract management. Any contract monitoring will consider conflicts of interest as part of the process i.e., the chair of a contract management meeting will invite declarations of interests; record any declared interests in the minutes of the meeting; and manage any conflicts appropriately and in line with this guidance. This equally applies where a contract is held jointly with another organisation such as the Local Authority or with other CCGs under lead commissioner arrangements.

11.21 The individuals involved in the monitoring of a contract should not have any direct or indirect financial, professional or personal interest in the incumbent provider or in any other provider that could prevent them, or be perceived to prevent them, from carrying out their role in an impartial, fair and transparent manner. The CCG will be mindful of any potential conflicts of interest when it disseminates any contract or performance information/reports on providers, and manage the risks appropriately.

12. Raising Concerns and Breaches

12.1 It is the duty of every individual within the CCG to speak up about genuine concerns in relation to the management of conflicts of interests, and to report any concerns in accordance with the terms of this policy and the CCG’s Whistleblowing Policy or with the whistleblowing policy of the relevant employer organisation (where the breach is being reported by an employee or worker of another organisation). Individuals should not ignore their suspicions or seek to investigate them, but speak to the CCG’s Conflict of Interest Guardian or the Head of Governance and Corporate Services.

12.2 Where a breach is suspected or has occurred, this will be investigated by the Head of Governance and Corporate Services who will draw on other expertise available to the organisation such as internal audit. The findings will be shared with the Conflicts of Interest Guardian and the breach formally reported to the Audit Committee.

12.3 A review of lessons learned will be conducted by the Head of Governance and Corporate Services following any incident of non-compliance with this policy and the report reviewed by the CCG’s Audit Committee. Anonymised details of breaches will be published on the CCG’s website for the purpose of learning and development.

12.4 Anyone who wishes to report a suspected or known breach of the policy, who is not an employee or worker of the CCG, should ensure that they comply with their own organisation’s whistleblowing policy, since most such policies should provide protection against detriment or dismissal.

12.5 All notifications will be treated with appropriate confidentiality at all times, in accordance with the CCG’s policies and applicable laws, and the person making such disclosures can expect an appropriate explanation of any decisions taken as a result of any investigation.
12.6 Providers, patients and other third parties can make a complaint to NHS Improvement in relation to a commissioner’s conduct under the Procurement Patient Choice and Competition Regulations. The regulations are designed as an accessible and effective alternative to challenging decisions in the courts.

**Fraud or Bribery**

12.7 Any suspicions or concerns of acts of fraud or bribery can be reported online via [https://www.reportnhsfraud.nhs.uk/](https://www.reportnhsfraud.nhs.uk/) or via the NHS Fraud and Corruption Reporting Line on 0800 0284060. This provides an easily accessible and confidential route for the reporting of genuine suspicions of fraud within or affecting the NHS. All calls are dealt with by experienced trained staff and any caller who wishes to remain anonymous may do so. Please refer to the CCG’s Anti-Fraud, Bribery and Corruption Policy for further details.

**Impact of Non-compliance**

12.8 Failure to comply with the CCG’s policy on conflicts of interest management can have serious implications for the CCG and any individuals concerned.

**Civil Implications**

12.9 If conflicts of interest are not effectively managed, the CCG could face civil challenges to its decisions. For instance, if breaches occur during a service re-design or procurement exercise, the CCG risks a legal challenge from providers that could potentially overturn the award of a contract, lead to damages claims against the CCG, and necessitate a repeat of the procurement process. This could delay the development of better services and care for patients, waste public money and damage the CCG’s reputation. In extreme cases, staff and other individuals could face personal civil liability, for example a claim for misfeasance in public office.

**Criminal Implications**

12.10 Failure to manage conflicts of interest could lead to criminal proceedings including for offences such as fraud, bribery and corruption. This could have implications for CCGs and linked organisations, and the individuals who are engaged by them. The Fraud Act 2006 created a criminal offence of fraud and defines three ways of committing it:

- Fraud by false representation;
- Fraud by failing to disclose information; and,
- Fraud by abuse of position.

12.11 An essential ingredient of the offences is that, the offender’s conduct must be dishonest and their intention must be to make a gain, or cause a loss (or the risk of a loss) to another. Fraud carries a maximum sentence of 10 years imprisonment and/or a fine if convicted in the Crown Court or 6 months imprisonment and/or a fine in the Magistrates’ Court. The offences can be committed by a body corporate.
12.12 Bribery is generally defined as giving or offering someone a financial or other advantage to encourage that person to perform their functions or activities. The Bribery Act 2010 reformed the criminal law of bribery, making it easier to tackle this offence proactively in both the public and private sectors. It introduced a corporate offence which means that commercial organisations, including NHS bodies, will be exposed to criminal liability, punishable by an unlimited fine, for failing to prevent bribery. The offences of bribing another person, being bribed and bribery of foreign public officials can also be committed by a body corporate. The Act repealed the UK’s previous anti-corruption legislation (the Public Bodies Corrupt Practices Act 1889, the Prevention of Corruption Acts of 1906 and 1916 and the common law offence of bribery) and provides an updated and extended framework of offences to cover bribery both in the UK and abroad. The offences of bribing another person, being bribed or bribery of foreign public officials in relation to an individual carries a maximum sentence of 10 years imprisonment and/or a fine if convicted in the Crown Court and 6 months imprisonment and/or a fine in the Magistrates’ Court. In relation to a body corporate the penalty for these offences is a fine.

Disciplinary Implications

12.13 Individuals who fail to disclose any relevant interests or who otherwise breach this policy will be subject to investigation and, where appropriate, to disciplinary action in accordance with the CCG’s Disciplinary Policy. Individuals should be aware that the outcomes of such action may, if appropriate, result in the termination of their employment or position with the CCG.

Professional Regulatory Implications

12.14 Statutorily regulated healthcare professionals who work for, or are engaged by, CCGs are under professional duties imposed by their relevant regulator to act appropriately with regard to conflicts of interest. The CCG will report statutorily regulated healthcare professionals to their regulator if they believe that they have acted improperly, so that these concerns can be investigated. Statutorily regulated healthcare professionals should be made aware that the consequences for inappropriate action could include fitness to practise proceedings being brought against them, and that they could, if appropriate, be struck off by their professional regulator as a result.

13. Conflicts of Interest Training

13.1 The CCG will ensure that training is offered to all individuals within the CCG on the management of conflicts of interest. This is to ensure staff and others within the CCG understand what conflicts are and how to manage them effectively. All individuals within the CCG are required to complete this mandatory training on an annual basis.
Appendix 1: Declaration of interests form

<table>
<thead>
<tr>
<th>Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Position within, or relationship with, the CCG (or NHS England in the event of joint committees)</td>
<td></td>
</tr>
</tbody>
</table>

**Details of interest held (complete all that are applicable)**

<table>
<thead>
<tr>
<th>Type of interest* (see reverse of form)</th>
<th>Description of interest (including for indirect interests, details of the relationship with the person who has the interest)</th>
<th>Date of interest From &amp; To</th>
<th>Actions to be taken to mitigate risk (if required) To be agreed with line manager (CCG employees only)</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

The information submitted will be held by the CCG for personnel or other reasons specified on this form and to comply with the organisation’s policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act.
1998. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and published in registers that the CCG holds.

I confirm that the information provided above is complete and correct. I acknowledge that any changes in these declarations must be notified to the CCG as soon as practicable and no later than 14 days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then civil, criminal, or internal disciplinary action may result.

I do / do not [delete as applicable] give my consent for this information to be published on registers that the CCG holds. If consent is NOT given please give reasons:

Declarer's signature: …………………………………          Date: ………………..

Where mitigating actions are required

Name of line manager: …………………………………

Position: …………………………………

Signature: …………………………………          Date: ………………………

Please return electronically to lenoccg.governance@nhs.net with a hard copy to the Head of Governance and Corporate Services, NHS Leeds North CCG, Leafield House, 107-109 King Lane Leeds LS17 5BP
## Types of interest

<table>
<thead>
<tr>
<th>Type of interest</th>
<th>Description</th>
</tr>
</thead>
</table>
| **Financial Interests** | An individual may get direct financial benefits from the consequences of a commissioning decision. This could, for example, include being:  
- A director, including a non-executive director, or senior employee in a private company or public limited company or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations;  
- A shareholder (or similar owner interests), a partner or owner of a private or not-for-profit company, business, partnership or consultancy which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations.  
- A management consultant for a provider;  
- In secondary employment (see paragraph 56 to 57);  
- In receipt of secondary income from a provider;  
- In receipt of a grant from a provider;  
- In receipt of any payments (for example honoraria, one off payments, day allowances or travel or subsistence) from a provider  
- In receipt of research funding, including grants that may be received by the individual or any organisation in which they have an interest or role  
- Having a pension that is funded by a provider (where the value of this might be affected by the success or failure of the provider) |
| **Non-Financial Interests** | An individual may obtain a non-financial professional benefit from the consequences of a commissioning decision, such as increasing their professional reputation or status or promoting their professional career. This may, for example, include situations where the individual is:  
- An advocate for a particular group of patients;  
- A GP with special interests e.g., in dermatology, acupuncture etc.  
- A member of a particular specialist professional body (although routine GP membership of the RCGP, BMA or a medical defence organisation would not usually by itself amount to an interest which needed to be declared); |
### Non-Financial Personal Interests

An individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include, for example, where the individual is:

- A voluntary sector champion for a provider;
- A volunteer for a provider;
- A member of a voluntary sector board or has any other position of authority in or connection with a voluntary sector organisation;
- Suffering from a particular condition requiring individually funded treatment;
- A member of a lobby or pressure group with an interest in health

### Indirect Interests

An individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a commissioning decision (as those categories are described above). For example, this should include:

- Spouse / partner;
- Close relative e.g., parent, grandparent, child, grandchild or sibling;
- Close friend;
- Business partner
<table>
<thead>
<tr>
<th>Name</th>
<th>Current position held in the CCG (i.e Board member, Committee member, GP Partner, Council Member, employee)</th>
<th>Type of interest</th>
<th>Description of interest</th>
<th>Date of interest From To</th>
<th>Action taken to mitigate risk</th>
<th>Date of Declaration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Financial Non-financial professional Non-financial personal Indirect No interest to declare</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 3 - Declarations of interest checklist for Chairs

Under the Health and Social Care Act 2012, there is a legal obligation to manage conflicts of interest appropriately. It is essential that declarations of interest and actions arising from the declarations are recorded formally and consistently across all CCG governing body, committee and sub-committee meetings. This checklist has been developed with the intention of providing support in conflicts of interest management to the Chair of the meeting-prior to, during and following the meeting. It does not cover the requirements for declaring interests outside of the committee process.

<table>
<thead>
<tr>
<th>Timing</th>
<th>Checklist for Chairs</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>In advance of the meeting</td>
<td>1. The agenda to include a standing item on declaration of interests to enable individuals to raise any issues and/or make a declaration at the meeting.</td>
<td>Meeting Chair and secretariat</td>
</tr>
<tr>
<td></td>
<td>2. A definition of conflicts of interest should also be accompanied with each agenda to provide clarity for all recipients.</td>
<td>Meeting Chair and secretariat</td>
</tr>
<tr>
<td></td>
<td>3. Agenda to be circulated to enable attendees (including visitors) to identify any interests relating specifically to the agenda items being considered.</td>
<td>Meeting Chair and secretariat</td>
</tr>
<tr>
<td></td>
<td>4. Members should contact the Chair as soon as an actual or potential conflict is identified.</td>
<td>Meeting members</td>
</tr>
<tr>
<td></td>
<td>5. Chair to review a summary report from preceding meetings i.e., sub-committee, working group, etc., detailing any conflicts of interest declared and how this was managed.</td>
<td>Meeting Chair</td>
</tr>
<tr>
<td></td>
<td>6. A copy of the members’ declared interests is checked to establish any actual or potential conflicts of interest that may occur during the meeting</td>
<td>Meeting Chair</td>
</tr>
<tr>
<td>During the meeting</td>
<td>7. Check and declare the meeting is quorate and ensure that this is noted in the minutes of the meeting.</td>
<td></td>
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<tr>
<td>-------------------</td>
<td>---------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8. Chair requests <strong>members to declare any interests in agenda items</strong>, including the nature of the conflict.</td>
<td></td>
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<tr>
<td></td>
<td>9. <strong>Chair makes a decision</strong> as to how to manage each interest which has been declared, including whether / to what extent the individual member should continue to participate in the meeting, on a case by case basis, and this decision is recorded.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>10. As minimum requirement</strong>, the following should be <strong>recorded in the minutes of the meeting</strong>:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Individual declaring the interest;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• At what point the interest was declared;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The nature of the interest;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The Chair’s decision and resulting action taken;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The point during the meeting at which any individuals retired from and returned to the meeting - even if an interest has not been declared</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>11. Visitors in attendance</strong> who participate in the meeting must also follow the meeting protocol and declare any interests in a timely manner</td>
<td></td>
</tr>
<tr>
<td>Following the meeting</td>
<td><strong>12. All new interests declared</strong> at the meeting should be promptly updated onto the declaration of interest form;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>**13. All new completed declarations of interest should be <strong>transferred onto the register of interests.</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Roles:
- **Meeting Chair**
- **Meeting Chair**
- **Meeting Chair and secretariat**
- **Secretariat**
- **Individual(s) declaring interest(s)**
- **Designated person responsible for registers of interest**
## Appendix 4: Template for Recording Minutes

<table>
<thead>
<tr>
<th>Item no</th>
<th>Agenda item</th>
<th>Actions</th>
</tr>
</thead>
</table>
|         | **Declarations of interest**<br>SK reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the CCG.<br><br>Declarations are listed in the CCG’s Register of Interests. The Register is available via the CCG website at the following link:<br><br>[https://www.leedsnorthccg.nhs.uk/publications/](https://www.leedsnorthccg.nhs.uk/publications/)**<br><br>**Declarations of interest from sub committees.**<br>None declared<br><br>**Declarations of interest from today’s meeting**<br>The following update was received at the meeting:<br>☐With reference to business to be discussed at this meeting, MS declared that he is a shareholder in XXX Care Ltd.<br><br>SK declared that the meeting is quorate and that MS would not be included in any discussions on agenda item X due to a direct conflict of interest which could potentially lead to financial gain for MS.<br><br>SK and MS discussed the conflict of interest, which is recorded on the register of interest, before the meeting and MS agreed to remove himself from the table and not be involved in the discussion around agenda item X.**<br><br>**Agenda Item**<br><br>MS left the meeting, excluding himself from the discussion regarding xx.<br><br><i><u>conclude decision has been made</u></i>**<br><br><i><u>Note the agenda item xx</u></i>**<br><br>MS was brought back into the meeting.**
## Appendix 5 Procurement checklist

<table>
<thead>
<tr>
<th>Question</th>
<th>Comment/Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How does the proposal deliver good or improved outcomes and value for money - what are the estimated benefits? How does it reflect the CCG’s proposed commissioning priorities? How does it comply with the CCG’s commissioning obligations?</td>
<td></td>
</tr>
<tr>
<td>2. How have you involved the public in the decision to commission this service?</td>
<td></td>
</tr>
<tr>
<td>3. What range of health professionals have been involved in considering the proposals?</td>
<td></td>
</tr>
<tr>
<td>4. What range of potential providers have been involved in considering the proposals?</td>
<td></td>
</tr>
<tr>
<td>5. How have you involved the Health and Wellbeing Board? How does the proposal support the priorities in the joint health and wellbeing strategy?</td>
<td></td>
</tr>
<tr>
<td>6. What are the proposals for monitoring the quality of the service?</td>
<td></td>
</tr>
<tr>
<td>7. What systems will there be to monitor and publish data on referral patterns?</td>
<td></td>
</tr>
<tr>
<td>8. Have all conflicts and potential conflicts of interests been appropriately declared and entered on registers?</td>
<td></td>
</tr>
<tr>
<td>9. In respect of every conflict or potential conflict, you must record how you have managed that conflict or potential conflict. Has the management of all conflicts been recorded with a brief explanation of how they have been managed?</td>
<td></td>
</tr>
<tr>
<td>10. Why have you chosen this procurement route e.g. Single action tender? *</td>
<td></td>
</tr>
<tr>
<td>11. What additional external involvement will there be in scrutinising the proposed decisions?</td>
<td></td>
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</tbody>
</table>
12. How will the CCG make its final commissioning decision in ways that preserve the integrity of the decision-making process and award of the contract?

**Additional question when qualifying a provider on a list or framework or pre selection for tender (including but not limited to any qualified provider) or direct award (for services where national tariffs do not apply)**

13. How have you determined a fair price for the service?

**Additional question when qualifying a provider on a list or framework or pre selection for tender (including but not limited to any qualified provider) where GP practices are likely to be qualified providers**

14. How will you ensure that patients are aware of the full range of qualified providers from whom they can choose?

**Additional questions for proposed direct awards to GP providers**

15. What steps have been taken to demonstrate that the services to which the contract relates are capable of being provided by only one provider?

16. In what ways does the proposed service go beyond what GP practices should expect to provide under the GP contract?

17. What assurances will there be that a GP practice is providing high quality services under the GP contract before it has the opportunity to provide any new services?

*Taking into account all relevant regulations (e.g. the NHS (Procurement, patient choice and completion) (NO2 Regulations 2013 and guidance (e.g. that of Monitor)*
## Appendix 6 - Register of Procurement Decisions

<table>
<thead>
<tr>
<th>NHS Leeds North CCG - Register of procurement decisions</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Ref.</th>
<th>Date of decision</th>
<th>Procurement description</th>
<th>Clinical lead</th>
<th>CCG Contract Manager</th>
<th>Decision making process, including who was involved</th>
<th>Conflicts of interest declared and how these were managed</th>
<th>Contract awarded (supplier name and registered address)</th>
<th>Contract value (£) to CCG</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>
Appendix 7 - Template of Conflict of Interests for bidders/contractors

This page requires completion of details of organisations. Page 2 overleaf requires completion of details of individuals.

<table>
<thead>
<tr>
<th>Name of organisation:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Details of interest held</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of interest</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provision of services or other work for the CCG or NHS England</td>
<td></td>
</tr>
<tr>
<td>Provision of services or other work for any other potential bidder in respect of this project or procurement process</td>
<td></td>
</tr>
<tr>
<td>Any other connection with the CCG or NHS England or professional, which the public could perceive may impair or otherwise influence the CCG’s or any of its members or employees’ judgments, decisions or actions</td>
<td></td>
</tr>
<tr>
<td>Name of relevant person</td>
<td>(complete for all relevant persons)</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-------------------------------------</td>
</tr>
</tbody>
</table>

**Details of interest held:**

<table>
<thead>
<tr>
<th>Type of interest</th>
<th>Details</th>
<th>Personal interest or that of a family member, close friend or other acquaintance?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provision of services or other work for the CCG or NHS England</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provision of services or other work for any other potential bidder in respect of this project or procurement process</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any other connection with the CCG or NHS England or professional, which the public could perceive may impair or otherwise influence the CCG or any of its members or employees judgments, decisions or actions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

To the best of my knowledge and belief, the above information is complete and correct. I undertake to update the information as necessary.

Signed:

On behalf of

Date
Contents

Paragraph                                      Page
1    Introduction                              3
2    Purpose                                  3
3    Scope                                    3
4    Duties                                   4
5    Offers of Hospitality, Gifts and Commercial Sponsorship 5
6    Outside Employment                       8
7    Contracts for Goods and Services         9
8    Intellectual Property                    10
9    Confidentiality                          10
10   The Bribery Act 2010                     10
11   Equality Impact Assessment               11
12   Monitoring Compliance and Effectiveness  12
13   Associated Documentation                 12
14   References                               12

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Appendix 2  Standards of Business Conduct - Quick Guide  14
Appendix 3  Declaration of Gift/Hospitality/Sponsorship Form  15
Appendix 4  Non Disclosure Agreement          18
Appendix 5  Policy Consultation Process       19
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1 Introduction

1.1 The Code of Conduct and Code of Accountability in the NHS (second revision July 2004) sets out the following three public service values which are central to the work of the NHS:

- **Accountability** - everything done by those who work in the NHS must be able to stand the test of parliamentary scrutiny, public judgements on propriety and professional codes of conduct.
- **Probity** - there should be an absolute standard of honesty in dealing with the assets of the NHS: integrity should be the hallmark of all personal conduct in decisions affecting patients, officers and members and suppliers, and in the use of information acquired in the course of NHS duties.
- **Openness** - there should be sufficient transparency about NHS activities to promote confidence between the NHS and its staff, patients and the public.

1.2 In addition to the public service values described above, all individuals within the CCG should follow the Seven Principles of Public Life (the Nolan Principles) - see Appendix 1.

1.3 All individuals within the CCG are responsible for ensuring that they are not placed in a position which risks conflict between their private interests and their NHS duties. Every individual is responsible for ensuring that they comply with this policy. Some individuals may additionally be required to adhere to a code of conduct of their own professional body.

2 Purpose

2.1 This policy provides guidance on what is deemed to be acceptable in terms of receipt of gifts, hospitality and sponsorship and provides a code of conduct that individuals within the CCG are expected to follow.

2.2 This policy reflects and builds on the following national guidance:
- HSG(93)5 Standards of Business Conduct for NHS Staff
- Seven Principles of Public Life
- The Codes of Conduct and Accountability in the NHS 2004
- The Code of Conduct for NHS Managers 2002
- Managing Conflicts of Interest: Revised Statutory Guidance for CCGs 2016

2.3 This policy should be read in partnership with the CCG’s Managing Conflicts of Interest Policy, the Anti-Fraud and Bribery Policy, the Working Time Regulations Policy (in relation to secondary employment) and the Procurement Policy.
3 Scope

3.1 This policy applies to:

- All CCG employees, including all full and part-time staff, staff on sessional or short term contracts, students and trainees (including apprentices), agency staff, seconded staff
- Members of the CCG’s Board, Committees, Sub Committees and Sub Groups, including co-opted members, appointed deputies and members of committees/groups from other organisations
- Members of the CCG – defined as GP partners (or where the practice is a company, each director) and any individual directly involved with the business or decision making of the CCG e.g. representatives at the Council of Members, GP portfolio leads

Who are referred to collectively in this policy as ‘individuals within the CCG’.

4 Duties

4.1 The **Chief Officer** is the organisation’s designated ‘Accountable Officer’ and has overall responsibility for ensuring that the CCG operates efficiently, economically and with probity. The Chief Officer (alongside other members of the Board) has a duty to ensure that the CCG provides a secure environment in which to work, and one in which people are confident to raise concerns which will be listened to and addressed.

4.2 The **Chief Financial Officer** is responsible for ensuring this policy is in place. The Chief Financial Officer, in conjunction with the Chief Officer, monitors and ensures compliance with NHS Protect Standards for Commissioners regarding fraud, bribery and corruption. In addition and in consultation with the Local Counter Fraud Specialist (LCFS), the Chief Financial Officer will decide whether there is sufficient cause to conduct an investigation in relation to bribery, and whether the Police and external audit need to be informed.

4.3 The **Head of Governance and Corporate Services** is responsible for administering this policy and reporting to the Audit Committee.

4.4 All members of the **Board** must act in accordance with this policy and lead by example in acting with the utmost integrity and ensuring adherence to all relevant regulations, policies and procedures. Board members must abide by the Professional Standards Authority [Standards for Members of NHS Boards and Clinical Commissioning Group Governing Bodies in England](https://www.gov.uk/government/publications/standards-for-members-of-nhs-boards-and-clinical-commissioning-group-governing-bodies-in-england).

4.5 **Line Managers** are responsible for assisting employees in complying with this policy by ensuring that this policy and its requirements are brought to the attention of employees for whom they are responsible, and that those employees are aware of its implications for their work.

4.6 **All individuals within the CCG** are required to:
• Act honestly and with integrity at all times and to safeguard the organisation’s resources for which they are responsible.
• Ensure that they read, understand and comply with this policy.
• Adhere to all relevant regulations, policies and procedures.
• Raise concerns as soon as possible if they believe or suspect that a conflict with this policy has occurred, or may occur in the future.
• Ensure that the interests of patients remain paramount at all times.
• Be impartial and honest in the conduct of their official business.
• Use the public funds entrusted to them to the best advantage of the service, always ensuring value for money.
• Not abuse their official position for personal gain or to benefit their family or friends.
• Not seek to gain advantage or further private business or other interests, in the course of their official duties.
• Be aware that it is both a serious criminal offence (under the Bribery Act 2010, the Theft Act 1968 and the Fraud Act 2006) and disciplinary matter to corruptly receive or give any fee, loan, gift, reward or other advantage in return for doing (or not doing) anything or showing favour (or disfavour) to any person or organisation.
• Understand that failure to follow this policy may damage the CCG and its work and so may be viewed as a disciplinary matter. The organisation’s Disciplinary Policy makes it clear that bringing the organisation into disrepute is potentially gross misconduct. As well as the possibility of civil and criminal prosecution, individuals that breach this policy will face disciplinary action, which could result in dismissal for gross misconduct.

5 Offers of Hospitality, Gifts and Commercial Sponsorship

Hospitality

5.1 For the purpose of this policy, hospitality is defined as the receipt of entertainment, e.g. meals, lunches, functions, events, etc. or equivalent, for personal use or benefit to the individual, their family, relatives or friends, from either commercial or non-commercial (i.e. patients, carers or relatives), charitable or non-profit making bodies sources.

5.2 A blanket ban on accepting or providing hospitality is neither practical nor desirable from a business point of view. However, individuals should be able to demonstrate that the acceptance or provision of hospitality would benefit the NHS or CCG. Hospitality should always be secondary to the purpose of the meeting, event, function or contact and the level of hospitality offered must be appropriate and in proportion to the occasion.

5.3 Modest hospitality provided in normal and reasonable circumstances may be acceptable, although it should be on a similar scale to that which the CCG might offer in similar circumstances (e.g., tea, coffee, light refreshments at meetings). A common sense approach should be adopted as to whether hospitality offered is modest or not. Hospitality of this nature does not need to be declared to the Head of Governance and Corporate Services, unless it is...
offered by suppliers or contractors linked (currently or prospectively) to the CCG’s business in which case all such offers (whether or not accepted) should be declared and recorded.

5.4 Offers of hospitality which go beyond modest or of a type that the CCG itself might offer, should be politely refused. A non-exhaustive list of examples includes:

- Hospitality of a value of above £25; and
- In particular, offers of foreign travel and accommodation

5.5 All offers of hospitality or entertainment worth more than £25 should be declined, unless there are exceptional circumstances. Before accepting such offers, express prior approval should be sought from the appropriate delegated manager as set out in Appendix 6, and the reasons for acceptance should be recorded in the CCG’s register of gifts and hospitality.

5.6 All hospitality of this nature should be declared to the Head of Governance and Corporate Services, and recorded on the register, whether accepted or not. Particular caution should be exercised where hospitality is offered by suppliers or contractors linked (currently or prospectively) to the CCG’s business. Offers of this nature can be accepted if they are modest and reasonable but advice should always be sought from the Chief Financial Officer or the Head of Governance & Corporate Services as there may be particular sensitivities, for example if a contract re-tender is imminent. All offers of hospitality from actual or prospective suppliers or contractors (whether or not accepted) should be declared and recorded.

5.7 Individuals must declare the offer and/or acceptance of hospitality (regardless of the value) within 2 weeks of receipt using the form at Appendix 3. It is not necessary to declare modest hospitality as described in paragraph 5.3.

Gifts

5.8 For the purpose of this policy a gift is defined as any good, cash or equivalent, voucher, service or promotional material etc. for personal use or benefit to the individual, their family, relatives or friends, from either commercial or non-commercial (i.e. patients, carers or relatives), charitable or non-profit making body’s sources.

5.9 All gifts of any nature offered to individuals within the CCG by suppliers or contractors linked (currently or prospectively) to the CCG’s business should be declined, whatever their value. The person to whom the gifts were offered should also declare the offer to the Head of Governance and Corporate Services so that the offer which has been declined can be recorded on the register.
5.10 Gifts offered from other sources should also be declined if accepting them might give rise to perceptions of bias or favouritism, and a common sense approach should be adopted as to whether or not this is the case. The only exceptions to the presumption to decline gifts relates to items of little financial value (i.e., less than £10) such as diaries, calendars, stationery and other gifts acquired from meetings, events or conferences, and items such as flowers and small tokens of appreciation from members of the public to staff for work well done. Gifts of this nature do not need to be declared to the Head of Governance and Corporate Services, nor recorded on the register.

5.11 Any personal gift of cash or cash equivalents (e.g. vouchers, tokens, offers of remuneration to attend meetings whilst in a capacity working for or representing the CCG) must always be declined, whatever their value and whatever their source, and the offer which has been declined must be declared to the Head of Governance and Corporate Services and recorded on the register.

5.12 Individuals must declare the offer of all gifts, except those with a value of less than £10, within 2 weeks, using the form at Appendix 3.

**Commercial Sponsorship**

5.13 For the purpose of this policy, commercial sponsorship is defined as including:

- NHS funding from an external source, including funding of all or part of the costs of a member of staff, research, staff training, pharmaceuticals, equipment, meeting rooms, costs associated with meetings, meals, hotel and transport costs (including trips abroad), provision of free services (speakers), buildings or premises.

5.14 Individuals within the CCG may be offered commercial sponsorship for courses, conferences, post/project funding, meetings and publications in connection with the activities which they carry out for or on behalf of the CCG or their GP practices. All such offers (whether accepted or declined) must be declared using the form at Appendix 3, so that they can be included on the CCG’s register. If such offers are reasonably justifiable and otherwise in accordance with this policy then they may be accepted, with the prior approval of the appropriate delegated manager as set out in Appendix 6.

5.15 Notwithstanding the above, acceptance of commercial sponsorship should not in any way compromise commissioning decisions of the CCG or be dependent on the purchase or supply of goods or services. Sponsors should not have any influence over the content of an event, meeting, seminar, publication or training event. The CCG should not endorse individual companies or their products. It should be made clear that the fact of sponsorship does not mean that the CCG endorses a company’s products or services. During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection legislation. Furthermore, no information should be supplied to a company for their commercial gain unless there is a clear benefit to the
NHS. As a general rule, information which is not in the public domain should not normally be supplied.

**Publication of Gifts, Hospitality and Sponsorship Register**

5.16 All completed record of hospitality/gift/sponsorship forms should be submitted to the Head of Governance & Corporate Services for incorporating into the central register. In order to demonstrate openness, the register is available on the CCG’s website. Also, the register is reviewed by the Audit Committee on a six-monthly basis.

5.17 In exceptional circumstances, where the public disclosure of information could give rise to a real risk of harm or is prohibited by law, an individual’s name and/or other information may be redacted from the publicly available register. Where an individual believes that substantial damage or distress may be caused, to him/herself or somebody else by the publication of information about them, they are entitled to request that the information is not published. Such requests must be made in writing. Decisions not to publish information must be made by the Conflicts of Interest Guardian for the CCG, who should seek appropriate legal advice where required, and the CCG will retain a confidential un-redacted version of the register.

5.18 All persons who are required to make a declaration of gifts or hospitality will be made aware that the register will be published in advance of publication. This will be done by providing a fair processing notice that details the identity of the data controller, the purposes for which the registers are held and published, and contact details for the data protection officer. This information will also be provided to individuals identified in the registers due to their relationship with the person making the declaration.

**Inappropriate Offers of Hospitality/Gifts/Sponsorship**

5.19 All staff and members must notify the Head of Governance and Corporate Services of any inappropriate/overly generous offers of hospitality, gifts or sponsorship within 2 weeks of the offer being made. This includes any offers that would constitute a bribe, i.e. offers of a financial or other advantage as an incentive or reward to improperly perform your function or activities. For further information, please see the Anti Fraud and Bribery Policy. The Head of Governance and Corporate Services will make the Audit Committee aware of the inappropriate offer at the next meeting.

6 **Outside Employment**

6.1 In accordance with the CCG’s Working Time Regulations Policy, individuals who are directly employed by the CCG must notify their line manager of their intention to undertake secondary employment by completing the Declaration of Secondary Employment form. Amongst other things, the purpose of this is to ensure that the CCG is aware of any potential conflict with their CCG
employment. For further information, please see the Managing Conflicts of Interest Policy.

6.2 Examples of work which might conflict with the business of the CCG, including part-time, temporary and fixed term contact work, include:

- Employment with another NHS body;
- Employment with another organisation which might be in a position to supply goods/services to the CCG;
- Directorship of a GP federation
- Self employment, including private practice, in a capacity which might conflict with the work of the CCG or which might be in a position to supply goods/services to the CCG.

6.3 Permission to engage in secondary employment will be required and the CCG reserves the right to refuse permission where it believes a conflict will arise. In particular, it is unacceptable for pharmacy advisers or other advisers, employees or consultants to the CCG on matters of procurement to themselves be in receipt of payments from the pharmaceutical or devices sector.

7 Contracts for Goods and Services

7.1 All staff who are in contact with suppliers and contractors (including external consultants), and in particular those who are authorised to sign Purchase Orders or place contracts for goods, materials or services, are expected to adhere to professional standards of the kind set out in the Code of Conduct of the Chartered Institute of Purchasing and Supply (CIPS).

7.2 Fair and open competition between prospective contractors or suppliers for NHS contracts is a requirement of NHS Standing Orders and of EU Directives on Public Purchasing for Works and Supplies. This means that:

- No private, public or voluntary organisation which may bid for NHS business should be given any advantage over its competitors, such as advance notice of NHS requirements. This applies to all potential contractors, whether or not there is a relationship between them and the CCG, such as a long-running series of previous contracts.
- Each new contract should be awarded solely on merit, taking into account the requirements of the NHS and the ability of the contractors to fulfil them.

7.3 Individuals should ensure that no special favour is shown to current or former employees or their close relatives or associates in awarding contracts to private or other businesses run by them or employing them in a senior or relevant managerial capacity. Contracts may be awarded to such businesses where they are won in fair competition against other tenders, but scrupulous care must be taken to ensure that the selection process is conducted impartially, and that individuals who are known to have a relevant interest play
no part in the selection. Such interests must also be declared in accordance with the Managing Conflicts of Interest Policy.

7.4 Individuals must not seek, or accept, preferential rates or benefits in kind for private transactions carried out with companies with which they have had, or may have, official dealings on behalf of the CCG. This does not apply to officers’ and members’ benefit schemes offered by the NHS or trade unions.

7.5 Every invitation to tender to a prospective bidder for CCG business must require each bidder to give a written undertaking not to engage in collusive tendering or other restrictive practice, and not to engage in canvassing the CCG, its employees or officers concerning the contract opportunity tendered.

8 Intellectual Property

8.1 Any patents, designs, trademarks or copyright resulting from the work (e.g. research) of an individual, carried out as part of their work with the CCG, shall be the Intellectual Property of the CCG.

8.2 Approval should be sought from the appropriate line manager prior to entering into an obligation to undertake external work connected with the business of the CCG, e.g. writing articles for publication, speaking at conferences.

8.3 Where the undertaking of external work, gaining patent or copyright or the involvement in innovative work, benefits or enhances the CCG’s reputation or results in financial gain for the CCG, consideration will be given to rewarding employees subject to any relevant guidance for the management of Intellectual Property in the NHS issued by the Department of Health.

9 Confidentiality

9.1 Information concerning the CCG which is not in the public domain must not at any time be divulged to any unauthorised person. Similarly, patient data or personal data concerning staff must not be divulged, in line with the Data Protection Act, 1998. This duty of confidence remains after termination of employment and applies to all individuals within the CCG.

9.2 Care should be taken that confidentiality is not breached inadvertently by, for instance discussing confidential matters in public places, such as whilst travelling by train, or by leaving portable IT equipment containing confidential information where it might easily be stolen, such as on full view in a parked car. Data should only be distributed using mechanisms with an appropriate level of security. For further information please see the Information Security Policy.

9.3 Individuals must maintain confidentiality of information at all times, both commercial data and personal data, as defined by the Data Protection Act.

9.4 Individuals should guard against providing information on the operations of the CCG which might provide a commercial advantage to any organisation
(private or NHS) in a position to supply goods or services to the CCG. For particularly sensitive procurements/contracts, individuals may be asked to sign a non-disclosure agreement, a copy of which can be found at Appendix 4.

9.5 Please note that nothing in this policy prevents an individual from raising a concern in line with the CCG’s Whistleblowing Policy.

10 **The Bribery Act 2010**

10.1 The Bribery Act 2010 defines bribery as:

“Inducement for an action which is illegal, unethical or a breach of trust. Inducements can take the form of gifts, loans, fees, rewards or other privileges” and

“giving (or offering) or receiving (or requesting) a financial or other advantage in connection with the improper performance of a position of trust, or a function that is expected to be performed impartially or in good faith”.

10.2 This can be broadly defined as the offering or acceptance of inducements, gifts, favours, payment or benefit-in-kind which may influence the action of any person. Bribery does not always result in a loss. The corrupt person may not benefit directly from their deeds; however, they may be unreasonably using their position to give some advantage to another.

10.3 The Act also introduces a corporate offence of failing to prevent bribery where the organisation (which includes all NHS bodies) does not have adequate preventative procedures in place.

10.4 Should members or staff wish to report any concerns or allegations they have a number of options available to them:

- Report all suspected irregularities to the Chief Financial Officer who is also the contact point for NHS Protect, the Police and External Audit.
- Contact the Local Counter Fraud Specialist on 01904 725145 / 01423 554548 for any potential fraud related queries.
- Contact the NHS Protect Fraud and Corruption Reporting Line
  - 0800 028 4060
  - [www.reportnhssfraud.nhs.uk](http://www.reportnhssfraud.nhs.uk)
- Contact the Public Concern at Work line on 0207 404 6609.
- Follow the CCG’s own Whistleblowing Policy guidelines.

10.5 Failure to disclose or providing falsified information is considered as gross misconduct and may lead to internal disciplinary action and/or include the involvement of the CCG’s Local Counter Fraud Specialist in line with the CCG’s Anti-Fraud and Bribery Policy.

11 **Equality Impact Assessment (EIA)**
11.1 A full Equality Impact Assessment is not considered to be necessary as this policy will not have a detrimental impact on a particular group.

12 Monitoring Compliance and Effectiveness

12.1 Effectiveness is monitored by the Audit Committee through regular reports on declarations made in line with the policy.

12.2 Individuals should be aware that a breach of this policy could render them liable to prosecution as well as leading to the termination of their employment or position with the CCG.

13 Associated Documentation

- Managing Conflicts of Interest Policy
- Anti-Fraud and Bribery Policy
- Working Time Regulations Policy
- Procurement Policy
- Whistleblowing Policy
- Information Security Policy

14 References

- HSG(93)5 Standards of Business Conduct for NHS Staff
- Nolan Principles of Public Life
- The Codes of Conduct and Accountability in the NHS 2004
- The Code of Conduct for NHS Managers 2002
- Bribery Act 2010
- Chartered Institute of Purchasing and Supply (CIPS) Code of Conduct
- Managing Conflicts of Interest: Statutory Guidance for CCGs 2016
Appendix 1 – The Seven Principles of Public Life (Nolan Principles)

- **Selflessness** - Holders of public office should act solely in terms of the public interest.

- **Integrity** - Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.

- **Objectivity** - Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.

- **Accountability** - Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.

- **Openness** - Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.

- **Honesty** - Holders of public office should be truthful.

- **Leadership** - Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.
Appendix 2 - Standards of Business Conduct – Quick Guide

- Make sure you understand the guidelines on standards of business conduct, and consult your line manager if you are not sure.
- Make sure you are not in a position where your private interests and NHS duties may conflict.
- Declare any relevant interests in line with the Managing Conflicts of Interest Policy. If in doubt, ask yourself:
  
  i. Am I, or might I be, in a position where I (or my family/friends) could gain from the connection between my private interests and my employment?  
  ii. Do I have access to information which could influence purchasing decisions?  
  iii. Could my outside interest be in any way detrimental to the NHS or to patients' interests?  
  iv. Do I have any other reason to think I may be risking a conflict of interest?  

  If still unsure - Declare it!

- Declare the offer and receipt of gifts and hospitality within 2 weeks (except refreshments/meals provided at meetings, training etc.) using the form at Appendix 3. Gifts with a value of more than £10 and hospitality with a value of more than £25 should be declined unless there are exceptional circumstances. If you wish to accept hospitality or gifts in excess of these limits, this must be approved by the appropriate delegated manager as set out in Appendix 6, and they must complete section 9 below.
- Report any inappropriate offers of gifts/hospitality/sponsorship to the Head of Governance and Corporate Services within 2 weeks of the offer being made.
- Obtain permission from the appropriate delegated manager as set out in Appendix 6 (using the form at Appendix 3) before accepting any commercial sponsorship.
- Adhere to the code of conduct of the Institute of Purchasing and Supply if you are involved in any way with the acquisition of goods and services.
- Inform your line manager if you are intending to take on outside work, including any potential conflicts of interest this may cause.
- Do not abuse your past or present official position to obtain preferential rates for private deals.
- Do not unfairly advantage one competitor over another or show favouritism in awarding contracts.
- Do not misuse or make available official "commercial in confidence" information.
Appendix 3

RECORD OF HOSPITALITY/GIFTS/SPONSORSHIP – DECLARATION FORM

This form should be used to record any offers and/or acceptance of hospitality, gifts and sponsorship. Please note

- It is not necessary to declare refreshments such as tea, coffee etc. or to declare meals provided during a meeting/course/seminar.
- Gifts with a value of more than £10 must be declined and hospitality with a value of more than £25 should be declined unless there are exceptional circumstances. If you wish to accept hospitality in excess of £25, this must be approved by the appropriate delegated manager as set out in Appendix 6, who must complete section 12 below.
- If you have declined the hospitality/gift, or if the value is below the above limits, there is no need to complete section 12.
- If you wish to enter into a sponsorship agreement, this must be approved by the appropriate delegated manager as set out in Appendix 6, and they must complete section 12 below.

<table>
<thead>
<tr>
<th>1. Name and position/role:</th>
<th></th>
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<tbody>
<tr>
<td>2. Organisation: Leeds North CCG/member practice (please delete as appropriate)</td>
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</tr>
<tr>
<td>3. Are you responsible for contract monitoring, ordering or approval powers?</td>
<td>Yes / No (please delete as appropriate) If yes, please specify:</td>
</tr>
</tbody>
</table>

**Details of Hospitality/Gifts/Sponsorship Offered**

| 4. Details of the hospitality/gift/sponsorship: |  |
| 5. Approximate value: |  |
| 6. Reason why the hospitality/gift/sponsorship is being offered: |  |
| 7a. Name of organisation/individual offering hospitality or gift/sponsorship: |  |
| 7b. Name of the organisation representative: |  |
8. Products/services provided by the organisation/individual to NHS Leeds North CCG, (where applicable):

9. Are the products or services being offered either used or ordered by the individual in the course of their duties?
   **Yes** / **No** (please delete as appropriate)

10. Decision: **Declined** / **Accepted** (please delete as appropriate)
    If you wish to accept hospitality worth more than £25, please explain why below.

11. Declaration:

   I declare that the information I have given on this form is correct and complete. I understand that if I knowingly provide false information this may result in disciplinary action and I may be liable for prosecution and civil recovery proceedings. I consent to the disclosure of this information for the purposes of prevention, detection and prosecution of fraud.

   The information will be held by the CCG for personnel or other reasons specified on this form and to comply with CCG policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act 1998. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and published in registers that the CCG holds.

   I do/do not (delete as applicable) give my consent for this information to be published on registers that the CCG holds. If consent is NOT given please give reasons:

   Signed:

   Name:

   Designation:

   Date:
12. Approved: Yes / No (please delete as appropriate)
If yes, reason for approval / If no, reason offer declined (Continue overleaf if necessary):

Signed:
Name:
Designation:
Date:

Please return electronically to lenoccg.governance@nhs.net or by hard copy to the Head of Governance and Corporate Services, NHS Leeds North CCG, Leafield House, 107-109 King Lane Leeds LS17 5BP
Appendix 4 – Non Disclosure Agreement Template

NHS Leeds North CCG - express requirement for confidentiality

You have been requested to be involved in [INSERT DETAILS] (the “Project”).

NHS Leeds North CCG or other parties participating in the Project may provide you with, as part of your role in respect of the Project, access to certain confidential information relating to the Project (whether before or after the date of this letter), in writing, by email, orally or by other means (including from or pursuant to discussions with any other party or which is obtained through attendance at meetings related to the Project) and trade secrets including, without limitation, technical data and know-how relating to the Project, including in particular (by way of illustration only and without limitation) [EXAMPLES] and including (but not limited to) information that you may create, develop, receive or obtain in connection with your engagement on the Project, whether or not such information (if in anything other than oral form) is marked confidential (the "Confidential Information").

Accordingly we draw to your attention that as part of your role for NHS Leeds North CCG you are required to:

1.1. maintain the Confidential Information in the strictest confidence and not divulge any of the Confidential Information to any third party without the prior written permission of NHS Leeds North CCG; and

1.2. not make use of, reproduce, copy, discuss, disclose or distribute the Confidential Information other than for use as part of your role in the Project.

The above obligations in respect of this Confidential Information are supplemental to any prior representation, understanding and commitment (whether oral or written) between us. The terms of this Letter can only be changed by a written document, agreed upon by both of us and signed by duly authorised persons. These provisions shall be governed and construed by English law.

Yours faithfully

For and on behalf of NHS Leeds North CCG

By signing this letter you agree to comply with these terms.

Signed: ____________________________
Date: ____________________________
Print Name: ________________________
### Appendix 5 - Policy Consultation Process

<table>
<thead>
<tr>
<th>Title of document</th>
<th>Standards of Business Conduct Policy</th>
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<tbody>
<tr>
<td>Author</td>
<td>Stephen Gregg, Head of Governance &amp; Corporate Services</td>
</tr>
<tr>
<td>New / Revised document</td>
<td>Revised</td>
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</table>
| Lists of persons involved in developing the policy | Chief Financial Officer  
Local Counter Fraud Specialist  
Governance Team |
| List of persons involved in the consultation process: | CCG employees  
Internal and External Audit  
Audit Committee |
DELEGATED MANAGERS

Below is a list of managers who have the authority to approve/decline offers of hospitality, gifts and sponsorship.

<table>
<thead>
<tr>
<th>Director or Area of Management</th>
<th>Delegated Manager</th>
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<tr>
<td>Chief Officer/Members</td>
<td>Clinical Chair</td>
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<td>Directors</td>
<td>Chief Officer</td>
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<td>Finance, Contracting staff</td>
<td>Chief Financial Officer</td>
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<tr>
<td>Other CCG staff</td>
<td>Directors</td>
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Appendix 7 Hospitality Flowchart

Is the hospitality worth more than £25?

NO

Is the hospitality being offered by suppliers linked (currently or prospectively) to the CCG’s business?

NO

The hospitality can be accepted and does not need to be declared.

YES

The hospitality can be accepted, but must be declared. Complete sections 1 to 11 of the declaration form whether you accept or decline the hospitality.

YES

Do you wish to accept the hospitality?

NO

Complete sections 1 to 11 of the declaration form.

YES

The offer should be declined unless there are exceptional circumstances - prior approval must be sought. Complete sections 1 to 11 of the declaration form and submit to the appropriate Director (CCG staff) or the Clinical Chair (member practices) to complete section 12.

Submit the completed declaration form to the Head of Governance & Corporate Services (lenoccg.governance@nhs.net)
Appendix 7 Gifts Flowchart

Is the gift worth more than £10?

- YES
  - The gift must be declined.

- NO
  - Is the gift being offered by suppliers linked (currently or prospectively) to the CCG’s business and/or does it constitute cash or cash equivalents?
    - NO
      - The gift can be accepted and does not need to be declared.
    - YES
      - Complete sections 1 to 11 of the declaration form.

Submit the completed declaration form to the Head of Governance and Corporate Services (lenoccg.governance@nhs.net)

Chairman’s Summary report

Purpose

- The Leeds North Patient Assurance Group (LNPAG) is an independent public and patient group of volunteers who review and provide feedback and recommendations on the plans for, and implementation of, effective and meaningful patient and public involvement in the understanding, design, and delivery of local health and wellbeing services and their continual improvement.
- This report highlights key points for the Board’s attention from the meeting of the LNPAG on 20 September 2016 when 79% of members attended the meeting.

For the Board to note

- Members were concerned about the apparent limited resources available to support the development of Patient Participation Groups in GP practices.
- Members supportive of ongoing developments in social prescribing and recommended further support for patient behaviour change to encourage greater and timely access to these resources.
- During current rapid change and development members requested that decision making was open and transparent with the public and that involvement would be as authentic as possible and as soon as possible.
- Regarding the General Practice STP members requested further support for the development of effective Patient Participation Groups and felt that the Virtual Network to support these groups was of increasing importance and urgency.
- The work on the Leeds Care Record was presented by an involved PAG member as a good example of how to authentically involve local people and how that involvement had shaped and influenced the outcome.
- There was a general request and agreement for much greater clarity on patient access to their own records in primary care.
Emergency Preparedness, Resilience and Response

- **Noted** the self-assessment against the core standards for EPRR and **approved** the CCG’s statement of compliance as substantially assured.
- **Agreed** the improvement plan to move the CCG to full compliance and **agreed** that the update be presented to the Board.

Risk management

- **Noted** the Board Assurance framework, and the need to realign the risks in the light of the CCG’s revised strategic objectives, joint work with partners through the STP and the recent appointment of the Director of Nursing and Quality.

Policy approval

- **Approved** the revised policies on Managing conflicts of interest and standards of business conduct.
- **Approved** the Education, Training & Development Policy.
- **Approved** the Concerns, Complaints, Comments & Compliments Policy.
### Primary Care Commissioning Committee – Forward work plan 2016-2017

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</tr>
</tbody>
</table>