NHS
Barnsley Clinical Commissioning Group

Putting Barnsley People First

A meeting of the NHS Barnsley Clinical Commissioning Group Primary Care Commissioning Committee will be held on Thursday 30 April 2015 at 9.30 am in the Boardroom, Hillder House 49/51 Gawber Road, Barnsley, S75 2PY

PUBLIC AGENDA

Item	Session	Committee Requested to	Enclosure Lead	Time
1.	Apologies			9.30am
2.	Declarations of Interest		Vicky Peverelle PCCC 15/04/02	9.30am 5 mins
3.	Adoption of the CCG's objectives and the Nolan Principles	Adopt	Vicky Peverelle PCCC 15/04/03	9.35am 5 mins
4.	Questions from the Public		Chris Millington	9.40am 5 mins
5.	Minutes of the Planning Meeting held on 25 March 2015		Chris Millington PCCC 15/04/05	9.45am 5 mins
6.	Matters Arising		Chris Millington PCCC 15/04/06	9.50am 5 mins
	Quality, Finance, and Performance			
7.	Care Quality Commission Update	Receive	Vicky Peverelle PCCC 15/04/07	9.55am 5 mins
8.	Integrated Performance Report	Receive	Vicky Peverelle Verbal	10.00am 5 mins
	Strategy & Planning			
9.	Premises Approval Process	Receive	Vicky Peverelle PCCC 15/04/09	10.05am 10mins
	Contracting, investment, and procurement			
10.	No items			
	Governance Risk, and Assurance			
11.	Governance Update, covering: • Terms of Reference • Meeting Dates • Committee Work Plan	Receive	Richard Walker PCCC 15/04/11	10.15am 15 mins

12.	Risk Register	Receive	Richard Walker PCCC 15/04/12	10.30am 10 mins
	Committee Reports and Minutes			
	No items			
	Any other Business			
13.	Items for reporting: • to Governing Body • to NHS England	Decide	Chris Millington Verbal	10.40am 10 mins
14.	Any other business			
15.	**Date and Time of the Next Meeting:** The next meeting of the Primary Care Commissioning Committee will be held at 1pm on 28 May 2015, Hillder House, 49 – 51 Gawber Road, Barnsley, S75 2PY.			Close 10.50am

Exclusion of the Public:

The Primary Care Commissioning Committee should consider the following resolution:
***"That representatives of the press and other members of the public be excluded from the remainder of this meeting due to the confidential nature of the business to be transacted -* publicity on which would be prejudicial to the public interest"**
Section 1 (2) Public Bodies (Admission to meetings) Act 1960

Barnsley Clinical Commissioning Group
Putting Barnsley People First

PRIMARY CARE COMMISSIONING COMMITTEE

30 April 2015

Declarations of Interests Report

1.	**PURPOSE OF THE REPORT**
	To provide the Primary Care Commissioning Committee with the Committee members declarations of interest.
2.	**EXECUTIVE SUMMARY**
	This report details all Committee members declared interests for members to update and to enable the Chair and members to foresee any potential conflicts of interests.
3.	**THE COMMITTEE IS ASKED TO:** • Review that their individual declared interests are up to date • Receive and note the Committee members declarations of interest

Agenda time allocation for report:	5 minutes

Report of: Vicky Peverelle

Designation: Chief of Corporate Affairs

Report Prepared by: Lynne Richards

Designation: Governance, Assurance and Engagement Facilitator.

1.	**SUPPORTING INFORMATION**	
1.1	**Links to the Assurance Framework**	
	The report is especially relevant to the following risks on the Gb Assurance Framework: 2.1 and 5.2.	
1.2	**Links to Objectives**	
	To have the highest quality of governance and processes to support its business	✓
	To commission high quality health care that meets the needs of individuals and groups	
	Wherever it makes safe clinical sense to bring care closer to home	
	To support a safe and sustainable local hospital, supporting them to transform the way they provide services so that they are as efficient and effective as possible for the people of Barnsley	
	To develop services through real partnerships with mutual accountability and strong governance that improve health and health care and effectively use the Barnsley £.	
1.3	**Governance Arrangements Checklist**	**Has the area been considered (yes / no / not relevant)?**
	Financial Implications	Not relevant
	Contracting Implications	Not relevant
	Quality	Not relevant
	Consultation / Engagement	Not relevant
	Equality and Diversity	Not relevant
	Information Governance	Not relevant
	Environmental Sustainability	Not relevant
	Human Resources	Not relevant

REGISTER OF INTERESTS

NHS Barnsley Clinical Commissioning Group

This register of interests includes all interests declared by members and employees of Barnsley Clinical Commissioning Group. In accordance with the Clinical Commissioning Groups constitution and the Clinical Commissioning Groups Accountable Officer will be informed of any conflict of interest that needs to be included in the register within not more than 28 days of any relevant event (e.g. appointment, change of circumstances) and the register will be updated regularly (at no more than 3-monthly intervals)

Register: Primary Care Commissioning Committee

GOVERNING BODY		
Name	**Position**	**Details of interest**
Anne Arnold	Lay Member - Barnsley Clinical Commissioning Group	No Interests to declare
Nick Balac	Chair of Barnsley Clinical Commissioning Group	• Partner at St Georges Medical Practice (PMS) • Practice holds Barnsley Clinical Commissioning Group Vasectomy contract • Member of Barnsley People's First Limited Liability Partnership • Member Royal College General Practitioners

GOVERNING BODY		
Name	**Position**	**Details of interest**
		• Member of the British Medical Association • Member Medical Protection Society
Mehrban Ghani	Medical Director for Barnsley Clinical Commissioning Group	• GP Partner at White Rose Medical Practice, Cudworth, Barnsley • Directorship at SAAG Ltd, 15 Newham Road, Rotherham.
Madhavi Guntamukkala	GP Member Barnsley Clinical Commissioning Group	
Chris Millington	Lay Member, Barnsley Clinical Commissioning Group	• No interests to declare
Vicky Peverelle	Chief of Corporate Affairs, Barnsley Clinical Commissioning Group	• No interests to declare
Lesley Smith	Interim Chief Officer, Barnsley Clinical Commissioning Group	• Husband is Director of Ben Johnson Ltd a York based business offering office interiors solutions, furniture, equipment and supplies for private and public sector clients. • Owner of Unlimited Potential a provider of leadership development and executive coaching to private and public sector clients, including NHS clients.

GOVERNING BODY		
Name	**Position**	**Details of interest**
		• Holds Associate agreements with a number of national and local management consultancy firms providing consultancy support to the NHS. A full list can be provided. Would declare an interest and refrain from taking part in any decision involving the award of a contract to any of these firms.

Barnsley Clinical Commissioning Group
Putting Barnsley People First

PRIMARY CARE COMMISSIONING COMMITTEE

30 April 2015

Adoption of the CCG's objectives and the Nolan Principles

1.	**PURPOSE OF THE REPORT**
	To provide the Primary Care Commissioning Committee with the CCG's strategic commissioning objectives and the Nolan Principles.
2.	**EXECUTIVE SUMMARY**
	In accordance with the Primary Care Commissioning Committee's intention to conduct its business in a way which promotes the delivery of the CCG's objectives for the people of Barnsley and complies with the highest standards of conduct and governance, the Committee is requested to review and formally adopt: • The CCG's strategic objectives, and • The Nolan Principles.
3.	**THE COMMITTEE IS ASKED TO:** The Committee is requested to review and formally adopt: • The CCG's strategic objectives, and • The Nolan Principles.

Agenda time allocation for report:	5 minutes

Report of: Vicky Peverelle

Designation: Chief of Corporate Affairs

Report Prepared by: Richard Walker

Designation: Head of Assurance

1.	**SUPPORTING INFORMATION**	
1.1	**Links to the Assurance Framework**	
	The report is especially relevant to the following risks on the Gb Assurance Framework: 2.1 and 5.2.	
1.2	**Links to Objectives**	
	To have the highest quality of governance and processes to support its business	✓
	To commission high quality health care that meets the needs of individuals and groups	
	Wherever it makes safe clinical sense to bring care closer to home	
	To support a safe and sustainable local hospital, supporting them to transform the way they provide services so that they are as efficient and effective as possible for the people of Barnsley	
	To develop services through real partnerships with mutual accountability and strong governance that improve health and health care and effectively use the Barnsley £.	
1.3	**Governance Arrangements Checklist**	**Has the area been considered (yes / no / not relevant)?**
	Financial Implications	Not relevant
	Contracting Implications	Not relevant
	Quality	Not relevant
	Consultation / Engagement	Not relevant
	Equality and Diversity	Not relevant
	Information Governance	Not relevant
	Environmental Sustainability	Not relevant
	Human Resources	Not relevant

Appendix A – Vision, values, principles and objectives

SECTION 4 - VISION, VALUES AND AIMS

Vision (or mission)

34. The Vision agreed by the Barnsley Clinical Commissioning Group is:

> "We are a clinically led commissioning organisation that is accountable to the people of Barnsley. We are committed to ensuring high quality and sustainable health care by putting the people of Barnsley first"

35. The Group will, through this Constitution and its actions, promote good governance and proper stewardship of public resources in pursuance of its goals and in meeting its statutory duties.

Values

36. Good corporate governance arrangements are critical to achieving the Group's objectives.

37. Services will be commissioned so that they have at their heart the following values:

a) Equity and Fairness
b) Services are designed to put people first
c) They are needs led and resources are targeted according to needs
d) Quality Care delivered by vibrant Primary and Community care or in a safe and sustainable local hospital
e) Excellent communication with patients

Principles

38. In carrying out its business the Clinical Commissioning Group will adhere to the following principles:

a) We will use allocated resources to commission the highest quality of care possible
b) There will be no compromise on the safety of care
c) Major decisions will result from listening to patients and the public as well as to members
d) All decision making is clear and transparent – all written communications/documents for the public will be jargon free
e) We will work together with providers and other commissioners to develop integrated care for patients across all pathways
f) We will be professional and honest at all times
g) The Governing Body and staff are accountable to members
h) Protecting and using well the resources we have – making the best and most effective use of the Barnsley £
i) There will be excellent communication with all of our stakeholders

Appendix A – Vision, values, principles and objectives

Objectives

39. In carrying out its business the Clinical Commissioning Group will strive to meet the following objectives:

a) To have the highest quality of governance and processes to support its business
b) To commission high quality health care that meets the needs of individuals and groups
c) Wherever it makes safe clinical sense to bring care closer to home
d) To support safe sustainable and accessible local hospital services, supporting them to transform the way they provide services so that they are as efficient and effective as possible for the people of Barnsley
e) To develop services through real partnerships with mutual accountability and strong governance that improve health and health care and effectively use the Barnsley £

Appendix B

The Seven Principles of Public Life set out by the Committee on Standards in Public Life (The Nolan Principles)

Selflessness

Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends

Integrity

Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties

Objectivity

In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit

Accountability

Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office

Openness

Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands it

Honesty

Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest

Leadership

Holders of public office should promote and support these principles by leadership and example

Barnsley Clinical Commissioning Group

Putting Barnsley People First

Minutes of the Planning Meeting of the BARNSLEY CLINICAL COMMISSIONING GROUP PRIMARY CARE COMMISSIONING COMMITTEE held on Wednesday 25 March 2015 at 2pm in the Boardroom, Hillder House, 49 – 51 Gawber Road S75 2PY.

MEMBERS PRESENT:

Mr Chris Ruddlesdin (in the chair)	Lay Member
Dr Nick Balac	CCG Chairman
Mrs Lesley Smith	Chief Officer
Mrs Vicky Peverelle	Chief of Corporate Affairs
Mr James Logan	Member
Dr Mehrban Ghani	Medical Director

IN ATTENDANCE:

Ms Louise Bond	Service Development Manager/NHS Trainee
Mr Gary Charlesworth	NHS England Primary Care Manager
Ms Lynne Richards	Governance Assurance and Engagement Facilitator
Mr Richard Walker	Head of Assurance

APOLOGIES:

Ms Anne Arnold	Lay Member

MEMBERS OF THE PUBLIC:

Mr Chris Millington	Member of the Public

Agenda Item	Note	Action	Deadline
PCCC 15/03/01	**DECLARATIONS OF INTEREST RELEVANT TO THE AGENDA**		
	The Chairman presented a report which detailed all members current declarations of interest. It was highlighted that receiving members declarations in this way was a new process that all Committee would follow. Members agreed that it would be useful for the declarations of interest report to be distributed with the papers in advance of the meeting to allow members and the Chair to identify any potential conflicts of interests prior to the meeting.	**LR**	**30.04.15**
	The Medical Director declared a potential declaration of interest in item 5, 'Option appraisal for Brierley Medical		

Agenda Item	Note	Action	Deadline
	practice', as he was partner at a neighbouring practice which could be directly affected by any change at the Brierley Medical Practice. The Committee Chair agreed that it was in the interest of the CCG that the Medical Director be allowed to participate in the discussion on item 5 due to his local expertise and role as Medical Director. However, it was noted that the Medical Director may be exempt from participating in any future decision making in relation to Brierley Medical Centre.		
	It was discussed that all Committee members who worked within Primary Care would have a potential conflict of interest related to Primary Care Commissioning and it was agreed that these conflicts needed to be managed as they could not be eliminated.		
FINANCE, GOVERNANCE AND PERFORMANCE			
PCCC 15/03/02	**ADOPTION OF THE CCG's OBJECTIVES AND NOLAN PRINCIPLES**		
	The Committee received the Nolan principals and CCG Objectives and agreed these as a standard for how the Committee would conduct its business. It was agreed to put these principals on the agenda for the April meeting.	**LR**	**30.04.15**
PCCC 15/03/03	**PRIMARY CARE COOMMISSIONING COMMITTEE GOVERNANCE ARRANGEMENTS**		
	The Chief of Corporate Affairs presented a report on the governance arrangement for the Committee which incorporated a number of documents that required discussion and agreement prior to the first formal meeting of the Committee in April.		
	NHSE approval letter Committee members noted the NHSE approval letter for Primary Care Commissioning and its contents. **Approval for changes to Constitution** The Committee noted that approval letter from NHS England on the CCG's changes to its constitution. **Delegation Agreement**		

Agenda Item	Note	Action	Deadline
	Members were informed that nationally there had been concerns regarding elements of the delegation agreement and that some CCG's had sought legal advice regarding clauses within the agreement. It was added that NHS England has issued an addendum and would be reissuing a revised delegation agreement to CCG's for signing by the Chief Officer on the following day. The Committee agreed that they would go through the delegation agreement to highlight the areas of concerns which would require amendment in the addendum: • The termination clause to be changed from the CCG require consent from NHSE to terminate agreement to the CCG could give 6 months' notice to terminate • The CCG's having liability for loses to NHSE but NHSE not having this liability in turn required amending • The CCG having responsibility for legal proceedings but NHSE could step in at any time required an addition that NHSE would not exercise this without first engaging with the CCG. The original delegation agreement referred to monthly assurance reports to NHSE, the addendum has changed this and Primary care Commissioning would be picked up as part of the established Quarterly assurance. The Committee had a discussion over changes to the financial allocation from NHSE and it was advised that this would only change in exceptional circumstances in line with national directive. **Committee Terms of Reference** The Committee were informed that the Terms of Reference had been approved by the Governing Body. It was agreed to amend the Terms of Reference to refer to the Primary Care Commissioning Committee consistently in all documents and not the Primary Care Co-commissioning Committee. **Meeting dates** Members received and noted the 2015 meeting dates. It was agreed to identify which meeting dates fell within the Barnsley, Sheffield and Doncaster school holidays to ensure that the meeting did not clash with Annual Leave	**RW**	**30.04.15**

Agenda Item	Note	Action	Deadline
	and would therefore be quorate. **Attendees** Members agreed that they were happy with the current members of the Committee. It was added that NHS England, Healthwatch and Local authority representatives would be in attendance at the meetings. In addition the Committee agreed that they would require a primary care, finance and quality lead to attend the meetings to present on agenda items. The Committee agreed that there was a necessity for a Public Health representative to attend the Committee meetings in addition the Health and Wellbeing Board representative. The Head of Assurance agreed to write out to Public Health. ***Post Meeting Note:*** *The Health and Wellbeing Board nominated the Director of Public Health as the regular attendee as a consequence of discussions with them consequently no formal letter was sent..* **Reporting arrangements** Members agreed that the Committee minutes would go the Governing Body and NHS England. It was added that NHSE required a quarterly executive summary and also that the delegation agreement would form part of the quarterly assurance meeting. In addition, it was also agreed that an escalation/highlight report would go to Governing Body meeting to ensure GB members were made aware of any issues on a timely basis. **Draft Committee work plan** The Committee received the draft Committee work plan. It was agreed to add the following items to the work plan - Escalation report to the Governing Body - Overarching transformation strategy instead of Primary Care strategy - Primary Care Commissioning Annual Reports and quarterly executive summaries to NHS England It was agreed that the work plan would be reviewed and updated by the Committee on a quarterly basis. Members discussed the potential need to have a private meeting to discuss commercially sensitive issues and	**LR** **RW** **RW**	**30.04.15** **30.04.15** **30.04.15**

Agenda Item	Note	Action	Deadline
	creativity planning. It was agreed that these would be added as and when required. **Allocation of tasks & functions between CCG and NHSE** Members noted the allocations of tasks and functions between CCG and NHSE and it was advised that there were some minor additional alterations were required which would be completed by NHS England. **Primary care risks** The Head of Assurance presented the Primary Care Risk Register and comments were invited. It was added that the document would require updating as the context of the existing register related to the application for delegated Primary Care Commissioning, not delivering it in practice. **Action:** It was agreed that the Head of assurance would update the Risk Register and present it to the next meeting for review and adoption. It was agreed that an integrated performance report would be developed for Primary Care Commissioning that would form part of the CCG's wider Management Framework and integrated reporting monthly.	**RW**	**30.04.15**
	The Committee noted the governance arrangements and thanked the Corporate Affairs team for their work.		
CONTRACTING, INVESTMENT AND PROCUREMENT			
PCCC 15/03/04	**OPTIONS APPRAISAL FOR BRIELEY PRACTICE**		
	The NHS England Primary Care Manager presented the draft options appraisal report for Brierley Medical Practice. Committee Members were reminded that the Medical Director had declared a potential conflict of interest in this item but could participate in the discussion due to his local knowledge and expertise as Medical Director.		
	The report presented the Committee with 3 options for GP services in Brierley and Shafton which were - **Option 1 –** Dispersal of practice list to		

Agenda Item	Note	Action	Deadline
	neighbouring practices - **Option 2** -- re-procure services at both Brierley and Shafton - **Option 3** -- Procure services at Brierley main site only		
	Members held a discussion around the timescales and who would make this decision. It was agreed to propose that this Committee should make the final decision and not NHS England due to the CCG being a membership organisation with the delegated responsibility for commissioning Primary Care. It was also agreed to propose to seek a 3 month extension to the existing contract to provide time for a robust decision making process accepting restrictions linked to purdah. Members then agreed that the decision making process at this point would lie with the CCG. Members were informed that the lease for Brierley Medical Centre would come to an end with the former partner of the practice on 30 June 2015. The NHS England Primary Care Manager clarified that if the current landlord did not re-lease the property then it would become the responsibility of the new provider to find new premises. Members held a discussion on the potential for a development of a building in Brierley as there were currently concerns on if the current Brierley Medical Centre was CQC complaint. Members agreed that this could be a potential option from the NHSE infrastructure monies requiring capital bids. The Medical Director advised that Whiterose Practice and Lundwood Medical Centre would need adding to the Locality map within the options appraisal as they were currently omitted. It was also added that Caxton House practice had been listed twice.	**GC** **GC**	**30.04.15** **30.04.15**
	Members discussed that they were less inclined to go for Option 1 as Brierley was a bespoke area which needed its own GP Practice. It was agreed that the most likely option would be option 3 accepting that, Patient and Public Engagement exercises were needed to gain the views of patients.		

Agenda Item	Note	Action	Deadline
	The CCG Chairman queried the value for money figures on page 25 which indicated that the equitable funding price per patient would be £78.53. It was stated that the CCG were under the impression that the £78.53 would be after 4 years and not from April. It was agreed to gain clarification on this from NHS England. ***Post Meeting Note:*** *clarity was sought and this target price would be reached over 4 years.*	**GC**	**30.04.15**
	It was queried how local practices would be informed if Brierley Medical Practice went out the re-procurement. It was stated an advert would be placed on OJEU but it was agreed to see if the CCG could inform local practices of the advert. ***Post Meeting Note:*** *NHSE notified the CCG that they had written to all practices.*	**GC**	**30.04.15**
	Finally, members discussed that this was a good opportunity to work on so early in the Primary Care Commissioning Process but it was queried if the CCG would have the resources should a similar issue to Brierley Medical Centre happen again. The NHS England Primary Care Manager advised that it was detailed in the RASCI document that should a similar situation happen NHS England would work with the CCG and lead together.		
	The Committee thanked the NHS England Primary Care Manager for presenting the option appraisal and agreed the following: - **A 3 month extension be sought from the Sheffield Care Trust** - **There was a need to start a patient and public engagement exercise** - **The final decision should come back to the CCG Primary Care Commissioning Committee.**		
PCCC 15/03/05	**EQUITABLE FUNDING IN PRIMARY MEDICAL SERVICES UPDATE**		
	The Chief of Corporate Affairs presented the Equitable funding in Primary Medical Services update and the following points were highlighted:		

Agenda Item	Note	Action	Deadline
	- 5 GP Practices were currently being over funded - 3 out of the 5 practices had been met with to discuss this already the other 2 were scheduled - The Committee would be responsible for reinvesting the monies saved from the over funding of the 5 practices over the next 5 years.		
	The CCG Chairman queried if there was a way to accelerate the equalisation process for underfunded practices in Barnsley. The NHS England Primary Care Manager informed members that PMS practices would automatically move to the £78.53 funding on 01 April 2015. Members queried this information as it was inconsistent with what had been previously been communicated and it was agreed to clarify this with NHS England. ***Post Meeting Note:*** *clarity was sought and this target price would be reached over 4 years.*	**GC** **GC**	**30.04.15** **30.04.15**
	The Committee thanked the Chief of Corporate Affairs for the Equitable Funding in Primary Care Update.		
OTHER			
PCCC 15/03/06	**PRIMARY CARE COMMISSIONING WORKSHOP FOR CCG STAFF**		
	The Chief of Corporate Affairs presented the Primary Care Commissioning Workshop report. The report detailed that a workshop would be held for CCG staff on 06 May at 1.30pm which would cover: • Co-Commissioning in Barnsley update by CCG representative • Overview of current NHS structure • Legal context • Contracting routes • Contracted services		
	It was agreed to invite all Primary Care Committee members and attendees to the workshop.	**LR**	**30.04.15**

Agenda Item	Note	Action	Deadline
PCCC 15/03/07	**DATE AND TIME OF THE NEXT MEETING**		
	The next meeting of the Primary Care Commissioning Committee will be held on 30 April 2015 at 9.30am in the Boardroom Hillder House, 49/51 Gawber Road, Barnsley S75 2PY.		

MATTERS ARISING REPORT TO THE PRIMARY CARE COMMISSIONING COMMITTEE

30 April 2015

1. MATTERS ARISING

The table below provides an update on actions arising from the planning meeting of the Primary Care Commissioning Committee held on 25 March 2015

Minute ref	Issue	Action	Outcome/Action
PCCC 15/03/01	**DECLARATIONS OF INTEREST RELEVANT TO THE AGENDA** Members agreed that it would be useful for the declarations of interest report to be distributed with the papers in advance of the meeting to allow members and the Chair to identify any potential conflicts of interests prior to the meeting.	**LR**	**COMPLETED** – distributed with the meeting papers
PCCC 15/03/02	**ADOPTION OF THE CCG's OBJECTIVES AND NOLAN PRINCIPLES** The Committee received the Nolan principals and CCG Objectives and agreed these as a standard for how the Committee would conduct its business. It was agreed to put these principals on the agenda for the April meeting.	**LR**	**COMPLETED** - on the agenda (item 4)
PCCC 15/03/03	**PRIMARY CARE COOMMISSIONING COMMITTEE GOVERNANCE ARRANGEMENTS** It was agreed to amend the Terms of Reference to refer to the Primary Care Commissioning Committee consistently in all documents and not the Primary Care Co-commissioning Committee.	**RW**	**COMPLETED**
	Meeting dates Members received and noted the 2015 meeting dates. It was agreed to identify which meeting dates fell within the Barnsley, Sheffield and Doncaster school holidays to ensure that the meeting did not clash with Annual Leave and would therefore be quorate.	**LR**	**COMPLETED** – Meeting dates now moved to Thursdays. Meeting dates with school holidays are included within item 11.

	Attendees The Committee agreed that there was a necessity for a Public Health representative to attend the Committee meetings in addition the Health and Wellbeing Board representative. The Head of Assurance agreed to write out to Public Health.	**RW**	**COMPLETED** – Julia Burrows will be attending the Committee on behalf of the Health and Wellbeing Board and Public Health
	Draft Committee work plan The Committee received the draft Committee work plan. It was agreed to add the following items to the work plan - Escalation report to the Governing Body - Overarching transformation strategy instead of Primary Care strategy - Primary Care Commissioning Annual Reports and quarterly executive summaries to NHS England	**RW**	**COMPLETED**
	Primary Care Risks It was agreed that the Head of assurance would update the Risk Register and present it to the next meeting for review and adoption.	**RW**	**COMPLETED**
PCCC 15/03/04	**OPTIONS APPRAISAL FOR BRIELEY PRACTICE** It was also agreed to propose to seek a 3 month extension to the existing contract to provide time for a robust decision making process accepting restrictions linked to purdah. Members then agreed that the decision making process at this point would lie with the CCG.	**GC**	
	The Medical Director advised that Whiterose Practice and Lundwood Medical Centre would need adding to the Locality map within the options appraisal as they were currently omitted. It was also added that Caxton House practice had been listed twice.	**GC**	
	The CCG Chairman queried the value for money figures on page 25 which indicated that the equitable funding price per patient would be £78.53. It was stated that the CCG were under the impression that the £78.53 would be after 4 years and not from April. It was agreed to gain clarification on this from NHS England.	**GC**	**COMPLETED** - clarity was sought and this target price would be reached over 4 years.

	It was queried how local practices would be informed if Brierley Medical Practice went out the re-procurement. It was stated an advert would be placed on OJEU but it was agreed to see if the CCG could inform local practices of the advert.	**GC**	**COMPLETED** - NHSE notified the CCG that they had written to all practices.
PCCC 15/03/05	**EQUITABLE FUNDING IN PRIMARY MEDICAL SERVICES UPDATE** The CCG Chairman queried if there was a way to accelerate the equalisation process for underfunded practices in Barnsley.	**GC**	
PCCC 15/03/06	**PRIMARY CARE COMMISSIONING WORKSHOP FOR CCG STAFF** It was agreed to invite all Primary Care Committee members and attendees to the workshop.	**LR**	**COMPLETED** – All Committee members have had a meeting request sent to them for the workshop on 06 May 2015.

Barnsley Clinical Commissioning Group
Putting Barnsley People First

PRIMARY CARE COMMISSIONING COMMITTEE

30 April 2015

Care Quality Commission Update

1.	**PURPOSE OF THE REPORT**
	To receive an updated report of the practice review visits undertaken by the CQC of Barnsley GP practices in November and December 2014 (Appendix A).
2.	**EXECUTIVE SUMMARY**
	15 Barnsley GP practices were subject to review visits undertaken by the CQC in November and December 2014. A summary of the findings is as follows. 2 practices scored Good and outstanding 8 practices scored Good across the board 3 practices had issues identified 2 practices are awaiting report
3.	**THE COMMITTEE IS ASKED TO:** • To receive the updated report of the practice review visits undertaken by the CQC of Barnsley GP practices in November and December 2014

Agenda time allocation for report:	5 minutes

Report of: Vicky Peverelle

Designation: Chief of Corporate Affairs

Report Prepared by: Jon Holliday

Designation:

1.	**SUPPORTING INFORMATION**	
1.1	**Links to the Assurance Framework**	
	This report provides assurance to the Committee for primary care development associated with the Assurance Framework Strategic Objectives 1, 2, 4 & 5 and associated principal risks and sections 2.16 and 2.2a (February 2014 Framework document)	
1.2	**Links to Objectives**	
	To have the highest quality of governance and processes to support its business	X
	To commission high quality health care that meets the needs of individuals and groups	X
	Wherever it makes safe clinical sense to bring care closer to home	X
	To support a safe and sustainable local hospital, supporting them to transform the way they provide services so that they are as efficient and effective as possible for the people of Barnsley	
	To develop services through real partnerships with mutual accountability and strong governance that improve health and health care and effectively use the Barnsley £.	X
1.3	**Governance Arrangements Checklist**	**Has the area been considered (yes / no / not relevant)?**
	Financial Implications	Not relevant
	Contracting Implications	Not relevant
	Quality	Not relevant
	Consultation / Engagement	Not relevant
	Equality and Diversity	Not relevant
	Information Governance	Not relevant
	Environmental Sustainability	Not relevant
	Human Resources	Not relevant

Code	Practice	CQC Score
C85008	Hoyland First PMS Practice	Good Across the Board
C85009	The Kakoty Practice (PMS)	NA
C85010	Hill Brow Surgery PMS Practice Mapplewell (Hill Brow Partnership)	Good Across the Board
C85012	Great Houghton Medical Centre	NA
C85013	Chapelfield Medical Centre	NA
C85014	The Rose Tree PMS Practice	Good Across the Board
C85015	Rotherham Road Medical Centre PMS Practice	NA
C85016	Woodgrove Surgery PMS Practice (linked to Lakeside Surgery)	NA
C85017	Park Grove Surgery	NA
C85018	Grimethorpe Surgey	Good Across the Board
C85019	The Grove Medical Practice	NA
C85020	Huddersfield Road Practice	Good Across the Board
C85022	Hoyland Medical Practice	NA
C85023	Hollygreen Practice	Good Across the Board
C85024	High Street Practice	NA
C85026	Apollo Court Medical Centre PMS Practice	
C85028	Lundwood Medical Centre PMS Practice	NA
C85030	Wombwell Medical Centre Practice	Issues Identified
C85033	Victoria Medical Centre PMS Practice	Good and Outstanding
C85614	Darton Health Centre Practice	NA
C85617	Furlong Road Surgery (Gopinath)	NA
C85619	St George's Medical Centre PMS Practice	Good Across the Board
C85622	Monk Bretton Health Centre PMS Practice	NA
C85623	Kingswell Surgery PMS Practice	NA
C85624	Cope Street Surgery	NA
Y04660	Brierley Medical Centre	NA
C85628	Caxton House Surgery	Report in Draft - Issues Identified
Y00411	Dearne Valley Group Practice	NA
Y02644	HBP Surgery Lundwood	Good Across the Board
Y02815	Highgate Surgery Grimethorpe (HBP)	NA
Y02850	Lakeside Surgery (linked to Woodgrove Surgery)	NA

C85001	Goldthorpe Medical Centre PMS Practice (Sen)	NA
C85003	Ashville Medical Practice PMS Practice	Awaiting Report
C85004	Penistone Group PMS Practice	Awaiting Report
	Dove Valley Practice	Issues Identified
C85005	Royston Group Practice	Good and Outstanding
C85006	Dodworth Road Practice	

NHS
Barnsley Clinical Commissioning Group
Putting Barnsley People First

PRIMARY CARE COMMISSIONING COMMITTEE

30 April 2015

Premises Approval Process

1.	**PURPOSE OF THE REPORT**
	Under delegated commissioning the CCG will need to undertake decisions on capital developments. There are Directions associated with premises development and associated costs (Appendix A).
2.	**EXECUTIVE SUMMARY**
	These Directions cover both capital investment and associated revenue cost consequences and on-going revenue costs associated with GP premises such as notional rent. To supplement these Directions NHS England has produced guidance by means of a Frequently Asked Questions which can be found on the following link: https://www.england.nhs.uk/commissioning/primary-care-comm/infrastructure-fund/qa/#q15 The Committee will need to manage the local developments following the launch of the Primary Care Infrastructure Fund the £1billion, four-year fund for practices which will help to improve their premises to benefit both patients and professionals working in primary care – either through making improvements to existing buildings or through the creation of new ones. It will also help practices to harness technology and give practices the space to offer more appointments and improved care for the frail elderly in the community – essential in supporting the reduction of hospital admissions. To support the Committee to fulfil its responsibilities a Premises Approval Process will be developed and presented to its next meeting.
3.	**THE COMMITTEE IS ASKED TO:** • Note the delegated arrangements for primary care premises and the associated Directions and guidance and that a Premises Approval Process will be developed and presented to its next meeting.

Agenda time allocation for report:	10 minutes.

Report of:	Vicky Peverelle
Designation:	Chief of Corporate Affairs
Report Prepared by:	Jon Holliday
Designation:	Lead Service Development Manager

1.	**SUPPORTING INFORMATION**	
1.1	**Links to the Assurance Framework**	
	This report provides assurance to the Committee for primary care development associated with the Assurance Framework Strategic Objectives 1, 2, 4 & 5 and associated principal risks and sections 2.16 and 2.2a (February 2014 Framework document)	
1.2	**Links to Objectives**	
	To have the highest quality of governance and processes to support its business	X
	To commission high quality health care that meets the needs of individuals and groups	X
	Wherever it makes safe clinical sense to bring care closer to home	X
	To support a safe and sustainable local hospital, supporting them to transform the way they provide services so that they are as efficient and effective as possible for the people of Barnsley	
	To develop services through real partnerships with mutual accountability and strong governance that improve health and health care and effectively use the Barnsley £.	X
1.3	**Governance Arrangements Checklist**	
	Financial Implications	Not relevant
	Contracting Implications	Not relevant
	Quality	Not relevant
	Consultation / Engagement	Not relevant
	Equality and Diversity	Not relevant
	Information Governance	Not relevant
	Environmental Sustainability	Not relevant
	Human Resources	Not relevant

NATIONAL HEALTH SERVICE, ENGLAND

The National Health Service (General Medical Services – Premises Costs) Directions 2013

CONTENTS

PART 5
RECURRING PREMISES COSTS

PART 6
MISCELLANEOUS PROVISIONS

PART 7

TRANSITIONAL, REVOCATION AND SAVINGS PROVISIONS

The Secretary of State, in exercise of the powers conferred by sections 98A, 272(7) and (8) and 273(1) of the National Health Service Act 2006(a), gives the following Directions:

PART 1

GENERAL

Citation, commencement and application

1.—(1) These Directions may be cited as the National Health Service (General Medical Services–Premises Costs) Directions 2013 and shall come into force on 1st April 2013.

(2) These Directions are given to the Board.

Interpretation

2. In these Directions—

"the 2006 Act" means the National Health Service Act 2006;

"the Board" means the National Health Service Commissioning Board(b);

(a) 2006 c.41; section 98A was inserted by section 49(1) of the Health and Social Care Act 2012 ("the 2012 Act"). By virtue of section 271(1) of the 2006 Act the powers conferred by these sections are exercisable by the Secretary of State only in relation to England.

(b) The National Health Service Commissioning Board was established by section 1H of the 2006 Act; section 1H was inserted by section 9 of the 2012 Act.

"contractor", unless the context otherwise requires, means a person entering into, or who has entered into, a GMS contract with the Board or a person who is party to a GMS contract with the Board as a consequence of a property transfer scheme made under section 300 of the Health and Social Care Act 2012(**a**) (transfer schemes);

"District Valuer Service" means the District Valuer Service of the Valuation Office Agency(**b**), and "District Valuer" is to be construed accordingly;"

"estates strategy for investment prioritisation" means the strategy by which the Board determines how it will prioritise its programme of investment in practice premises, having regard to—

(a) its general duties under Part 2 of the 2006 Act (health service bodies); and

(b) its duty to secure the provision of primary medical services under Part 4 of the 2006 Act (medical services);

the "family member" of a person (P) means—

(c) P's husband, wife or civil partner;

(d) a person who, not being married to P or P's civil partner, has a relationship with P which shares the characteristics of marriage or civil partnership;

(e) a person who, in relation to P, formerly fell within paragraphs (a) or (b);

(f) P's grandparent, parent, step-parent, child, step-child, or grandchild;

(g) P's brother, step-brother, sister, step-sister, aunt, uncle, nephew, niece or first cousin; and

(h) the husband, wife or civil partner of any family member falling within paragraph (d) or (e);

"GMS contract" means a general medical services contract under section 84 of the 2006 Act(**c**) (general medical services contracts: introductory);

"Local Medical Committee" means a committee recognised under section 97 of the 2006 Act(**d**) (local medical committees);

"practice premises" means the premises specified in a GMS contract as the premises at which services are to be provided under the contract; and

"registered provider of social housing" has the meaning given by section 80(2) and (3) of the Housing and Regeneration Act 2008(**e**) (provider of social housing) and includes a private registered provider of social housing.

Payments in relation to which these Directions apply

3. These Directions apply in relation to the payments made to contractors—

(a) in respect of premises developments or improvements;

(b) in respect of professional fees, and related costs, incurred in occupying new or significantly refurbished premises under Part 3 of these Directions;

(c) relating to the relocation of, or re-mortgaging by, the contractor; or

(d) in respect of recurring premises costs.

Payments in relation to which these Directions do not apply

4. These Directions do not apply in relation to payments made to contractors under a GMS contract in respect of a plan drawn up in accordance with regulation 18(3) of the National Health Service (General Medical Services Contracts) Regulations 2004(**a**) (services generally).

(**a**) 2012 c.7.
(**b**) The Valuation Office Agency is an executive agency of HM Revenue and Customs.
(**c**) Section 84 of the 2006 Act was amended by paragraph 31 of Schedule 4 to the 2012 Act.
(**d**) Section 97 of the 2006 Act was amended by paragraph 41 of Schedule 4 to the 2012 Act.
(**e**) 2008 c.17. Section 80 was amended by S.I. 2010/844.

General duties of the Board under these Directions

5.—(1) Before the Board makes a payment to a contractor under these Directions, it must—

(a) enquire of the contractor whether the contractor is registered for Value Added Tax purposes and if so obtain the contractor's VAT registration number; and

(b) enquire of the contractor whether the contractor intends to claim a tax refund or allowance in respect of any element of the costs to which an application for financial assistance relates.

(2) Where the Board makes a payment to a contractor under these Directions, it must—

(a) only make the payment in the circumstances specified in these Directions;

(b) ensure that the payment is made under the terms of the contractor's GMS contract; and

(c) ensure that any conditions to which the payment is subject are included as terms of the GMS contract.

(3) In exercising any of its functions under these Directions, the Board must have regard to any relevant standards or guidance, including guidance as to best practice, issued by or on behalf of the Secretary of State.

Financial assistance in circumstances not contemplated in these Directions

6. These Directions do not prevent the Board from providing such financial assistance as it thinks fit in order to pay, or contribute towards, the premises costs of a contractor in circumstances that are not contemplated by the payment arrangements set out in these Directions, such as where—

(a) the contractor is providing services under a temporary GMS contract;

(b) an emergency need for financial assistance in respect of premises costs arises in circumstances that could not reasonably have been foreseen;

(c) the contractor needs temporary accommodation (whether in the form of portable premises or an existing building) while new practice premises are being built or existing practice premises refurbished; or

(d) the financial assistance relates to contractual arrangements for the provision of primary medical services under section 83(2) of the 2006 Act(**b**) (primary medical services).

PART 2

PREMISES DEVELOPMENT AND IMPROVEMENT

Premises development proposals

7.—(1) Where a contractor has a proposal for–

(a) the building of new premises to be used for providing primary medical services;

(b) the purchase of premises to be used for providing primary medical services;

(c) the development of premises which are used or are to be used for providing primary medical services (or for significant changes to existing development proposals);

(d) the sale and lease back of premises used for providing primary medical services;

(a) S.I. 2004/291, amending instruments are S.I. 2004/2694, 2005/893, 3315, 3491 and 3315, 2006/1501, 2007/3491, 2008/528 and 1700, 2009/2205 and 2230, 2010/22, 231, 234, 478, 578 and 1621, 2012/970, 1479, 1909 and 1916, and 2013/363.

(b) Section 83(2) was substituted by paragraph 30 of Schedule 4 to the 2012 Act.

(e) the increase of the existing floor area of premises used for providing primary medical services which would lead to an increase of a payment made to the contractor under these Directions; or

(f) premises improvements, which are to be the subject of a premises improvement grant application,

and it puts that proposal to the Board as part of an application for financial assistance in respect of the proposal the Board must consider that application.

(2) Subject to direction 32(4), the Board must not agree to fund any proposal under paragraph (1) where—

(a) a contract has been entered into, or

(b) work has been commenced,

and that contract or work has not been subject to prior agreement with the Board.

Projects that may be funded with premises improvement grants

8. The types of premises improvement projects that may be the subject of a premises improvement grant include—

(a) improvements to practice premises in the form of building an extension to the premises, bringing into use rooms not previously used to support delivery of primary medical services or the enlargement of existing rooms;

(b) improving physical access to and within practice premises, and alterations or additions made necessary by the Equality Act 2010(**a**);

(c) improving lighting, ventilation and heating installations (including replacement of other forms of heating by central heating) of practice premises;

(d) the reasonable extension of telephone facilities within practice premises (but not the initial purchase or replacement of telephone systems);

(e) the provision of car parking required for patient and staff use, subject to the number of parking spaces being agreed by the Board (access to and egress from each parking space must be undertaken without the need to move other vehicles);

(f) the provision of suitable accommodation at the practice premises to meet the needs of children and elderly or infirm people;

(g) fabric improvements to practice premises such as double glazing, security systems and work required for fire precautions and other statutory building requirements;

(h) refurbishment of a building not previously used for the provision of primary medical services but which is to be used as practice premises on a temporary basis;

(i) improvements which are necessary in connection with emergency planning, such as the provision of electronic storage facilities at a location remote from the practice premises or the installation of a connection for an emergency generator;

(j) improvements which are necessary to meet infection control or decontamination requirements at practice premises, including the installation of specialist floor covering in areas used for the treatment of patients; and

(k) the installation of a water meter.

Projects that must not be funded with premises improvement grants

9. The Board must not agree to fund the following expenditure with a premises improvement grant—

(a) any cost elements in respect of which a tax allowance is being claimed;

(a) 2010 c.15.

(b) the cost of acquiring land, existing buildings or constructing new buildings;

(c) the repair or maintenance of premises, or the purchase, repair or maintenance of furniture, furnishings, floor covering (with the exception of the specialist floor covering referred to in direction 8(j)) and equipment;

(d) restoration work in respect of structural damage or deterioration;

(e) any work in connection with the domestic quarters or the residential accommodation of practitioners, caretakers or practice staff, whether or not it is a direct consequence of work on surgery accommodation;

(f) any extension not attached to the main building by at least a covered passage way;

(g) improvements designed solely to reduce the environmental impact of premises, such as the installation of solar energy systems, air conditioning, or replacement windows, doors or facades; and

(h) any work made necessary as a result of fair wear and tear.

Initial consideration of premises development or improvement proposals

10.—(1) Before determining whether a proposal from a contractor for premises development or improvement of a type mentioned in direction 7 should be included in the Board's estates strategy for investment prioritisation the Board must—

(a) consult the Local Medical Committee (if any), for the area in which the development or improvement is to take place, about the proposal;

(b) satisfy itself that the proposal—

(i) is required to support, and will support, the delivery of the services that the contractor has agreed to provide under its GMS contract, and

(ii) will provide a safe and secure environment for the delivery of those services;

(c) satisfy itself, where appropriate in consultation with the District Valuer Service, that the proposal represents value for money;

(d) if the premises are held on a lease or a licence—

(i) satisfy itself that the contractor has adequate security of tenure and, for premises held on a lease, the unexpired portion of the lease is at least as long as the period of guaranteed use (see direction 12(4)(d)(i) and (ii)), and

(ii) satisfy itself that a contractor intends to occupy the premises for at least as long as the period of guaranteed use (see direction 12(4)(d)(i) and (ii)) and will enjoy protection under Part 2 of the Landlord & Tenant Act 1954(a) (security of tenure for business, professional and other tenants) for that period;

(e) have regard to any relevant standards issued by or on behalf of the Secretary of State and, where a contractor is proposing to depart from those standards, satisfy itself that—

(i) the departure is reasonable in the circumstances, and

(ii) the premises will nevertheless meet the minimum standards in Schedule 1.

Documentation required in respect of premises developments or improvements

11. The Board must refuse an application for financial assistance in respect of a premises development or improvement proposal from a contractor unless—

(a) 1954 c.56. In Part 2 of the Landlord and Tenant Act 1954, sections 24A to 24D, 31A and 41A were inserted by section 3 of the Law of Property Act 1969 (c.59) and amended by S.I. 2003/3096; sections 29A, 29B and 37A were inserted by S.I. 2003/3096; sections 29 and 40 were substituted by S.I. 2003/3096; and section 43A was inserted by section 3 of the Law of Property Act 1969.

(a) where the nature of the work is such that, in the opinion of the Board, it requires architect's plans for the development or improvement to be drawn up, the contractor supplies the Board with such plans;

(b) where the nature of the work requires building work, the contractor—

(i) carries out a tendering process for a building contractor to undertake the work, resulting in at least three written quotes, and

(ii) agrees with the Board which of those written quotes represents best value for money;

(c) the contractor supplies to the Board copies of any necessary planning and building regulations consents; and

(d) where the premises development or improvement is to premises that are held on a lease or a licence, the contractor supplies the Board with a copy of the written consent to the development or improvement of the landlord or licensor, as appropriate.

Priority funding projects and conditions attached to payments

12.—(1) Where the Board determines that a proposal from a contractor for premises development or improvement of a type mentioned in direction 7 is to be included in the Board's estates strategy for investment prioritisation, and is to be one of its priority funding projects, the Board must seek to finalise a project plan with the contractor.

(2) Where the financial assistance is by way of a premises improvement grant, the Board must not commit itself to covering less than 33% or more than 66% of the total cost of the premises improvement, plus any Value Added Tax for which the contractor cannot claim a refund.

(3) The Board must only agree to a finalised project plan with the contractor where the requirements specified in paragraph (4) are met.

(4) The specified requirements are that the project plan includes—

(a) a payment schedule ("the project payment schedule") setting out the financial assistance to which the Board has committed itself in respect of the project and that project payment schedule is included in any payment schedule in the contractor's GMS contract;

(b) a condition which has the effect of making payments to the contractor under that payment schedule subject to a requirement that the contractor adheres both to the specifications for the project which are set out in the finalised project plan and to any standards to be met during the development or improvement work which are set out in the finalised project plan;

(c) a condition which has the effect of making payments to the contractor under that payment schedule subject to a requirement that the contractor, when carrying out the development or improvement work, does not depart significantly, in the Board's view, from the version of the project in the finalised project plan (which may be varied with the consent of both parties);

(d) a condition (unless such a condition is unreasonable in the circumstances) that has the effect of making the payments to the contractor under that payment schedule subject to a requirement that the contractor guarantees that the premises will, once the development or improvement work has been completed, remain in use for the delivery of NHS services—

(i) for projects costing up to £100,000 plus Value Added Tax for at least 5 years,

(ii) for projects costing between £100,000 and £250,000 plus Value Added Tax, for at least 10 years; and

(iii) for projects costing over £250,000 plus Value Added Tax, for at least 15 years;

(e) where the development or improvement work is in respect of premises held on a lease or under a licence by the contractor, a condition (unless such a condition is unreasonable in the circumstances) that has the effect of committing the contractor to repaying a proportion of the grant ("the repayable amount") should the premises cease to be used to

provide NHS services before the 5, 10 or, as the case may be, 15 year period of guaranteed use has expired.

(5) In paragraph (4)(e), the repayable amount is to be calculated by multiplying the amount the Board has paid by the fraction produced by dividing the amount of time (expressed in whole and part years) left before the 5, 10 or, as the case may be, 15 year period of guaranteed use has expired, by 5, 10 or, as the case may be, 15 years.

PART 3

PROFESSIONAL FEES AND RELATED COSTS INCURRED IN OCCUPYING NEW OR SIGNIFICANTLY REFURBISHED PREMISES

Reimbursement of legal and other professional costs incurred in occupying new or significantly refurbished premises

13. Where—

(a) a contractor has procured newly built practice premises or refurbished existing practice premises;

(b) actual or notional rent payments are to be paid to the contractor in respect of those premises by the Board pursuant to these Directions on completion of the building or refurbishment work; and

(c) the contractor makes an application to the Board for reimbursement in respect of the professional expenses referred to in direction 14,

the Board must consider that application for financial assistance and, in appropriate cases (having regard, amongst other matters, to the budgetary targets it has set for itself), grant that application.

Types of professional expenses that may be reimbursed

14. In the case where—

(a) notional rent payments are to be paid in respect of newly built or refurbished practice premises, the reimbursable professional expenses are—

(i) the reasonable costs of engaging a project manager to oversee the interests of and give advice to the contractor, up to the maximum reimbursable amount, which is 1% of the total reasonable contract sum relating to the construction or refurbishment work;

(ii) reasonable surveyors', architects' and engineers' fees, which, taken together, may be paid up to a maximum reimbursable amount, which is 12% of the total reasonable contract sum relating to the construction or refurbishment work; and

(iii) reasonable legal costs in connection with the purchase of a site (where applicable) and the construction or refurbishment work; or

(b) the practice premises are, or are to be, leasehold premises, the reimbursable professional expenses are—

(i) the reasonable costs of engaging a project manager to oversee the interests of and give advice to the contractor, up to the maximum reimbursable amount, which is 1% of the total reasonable contract sum relating to the construction or refurbishment work, and

(ii) the reasonable legal costs incurred by the contractor in connection with agreeing the lease or a contract for the lease.

Value Added Tax on professional expenses

15. Where—

(a) the Board decides to grant an application for reimbursement in respect of the professional expenses mentioned in direction 14; and

(b) Value Added Tax has been properly charged in respect of the amount that the Board has decided to reimburse,

the Board must provide the contractor with financial assistance, under its GMS contract, to cover the cost to the contractor of that Value Added Tax (but excluding any Value Added Tax for which a refund can be claimed by the contractor).

PART 4

GRANTS RELATING TO RELOCATION OF OR RE-MORTGAGING BY A CONTRACTOR

Repayment mortgage redemption or deficit grants

16.—(1) Where a contractor—

(a) agrees to relocate to leasehold premises approved by the Board in its estates strategy for investment prioritisation; and

(b) makes an application in writing to the Board for a mortgage redemption or deficit grant in respect of a repayment mortgage to cover all or a proportion of the following—

(i) a mortgage deficit which arises, after owner-occupied practice premises are sold, because the actual sale price of the premises was not sufficient to clear the outstanding mortgage on the property, or

(ii) mortgage redemption fees that the contractor may incur as a result of the sale or re-mortgage of such premises; and

(c) includes in that application all reasonable information required of it by the Board to determine the application, including details of the amount of the outstanding mortgage that was used to build or improve the property,

the Board must consider that application for financial assistance and, in appropriate cases (having regard, amongst other matters, to the budgetary targets it has set itself), grant that application.

(2) Where a contractor re-mortgages practice premises and—

(a) the contractor is in receipt of financial assistance under direction 36 in respect of those premises;

(b) the existing mortgage is a repayment mortgage at a fixed rate of interest;

(c) the new mortgage is a repayment mortgage at a lower rate of interest than the existing mortgage, and for no more than the amount outstanding under the existing mortgage;

(d) the contractor makes an application in writing to the Board for a mortgage redemption grant to cover all or a proportion of mortgage redemption fees that the contractor may incur as a result of the re-mortgage; and

(e) includes in that application all reasonable information required of it by the Board to determine the application, including details of the existing mortgage and the new mortgage,

the Board must consider that application for financial assistance and in appropriate cases, (having regard, amongst other matters, to the budgetary targets it has set itself, and to the likely savings to be made in the level of financial assistance given under direction 36 as a result of the re-mortgage), grant that application.

Costs that may not be funded with mortgage redemption or deficit grants

17. The Board must not agree to cover the following costs or liabilities of a contractor with a mortgage redemption or deficit grant—

(a) any proportion of a mortgage deficit that has arisen through—

(i) arrangements entered into by the contractor which result in mortgage repayments not being made for any period ("payment holidays"), or

(ii) reduced loan repayments not reflected in the amount the Board pays in respect of borrowing costs under direction 39;

(b) any borrowings or redemption charges not connected with the original purchase of land, building works or subsequent improvements to the premises (for example furnishings, fittings and equipment, including IT and telephone systems).

Matters that must be considered before determining mortgage redemption or deficit grant applications

18. Before determining an application for a mortgage redemption or deficit grant from a contractor, the Board must obtain professional advice and be satisfied that—

(a) negotiations with the lender have limited the extent of any deficit or redemption charges;

(b) options for change of use for the property have been considered and where appropriate, outline planning permission sought or obtained;

(c) a proper process has been undertaken to identify a suitable third party developer and a site for the new leasehold premises;

(d) the timing of the grant is appropriate to maximising the opportunity for a sale which will coincide with completion and occupation of the new leasehold premises; and

(e) the sale of the premises is adequately advertised and the best price obtained,

and the Board must deduct from any amount that it would otherwise be prepared to pay by way of a mortgage redemption or deficit grant the surrender value of any endowment policy cover linked to the mortgage on the premises.

Conditions attached to mortgage redemption or deficit grants

19. Although, for accounting purposes, a mortgage redemption or deficit grant is to be treated as a payment to the contractor, the Board must ensure that payment of the grant is made subject to the following conditions—

(a) the contractor must consent to the Board sending the grant directly to the lender;

(b) the contractor must provide the Board with sufficient details to enable it to do so;

(c) the contractor must provide the Board with the information it needs from the lender to determine whether any endowment policy cover is linked to the mortgage on the premises, and if so, its surrender value; and

(d) the contractor must not be in receipt of financial assistance under direction 20 in respect of the same mortgage.

Borrowing costs relating to mortgage redemption or deficit costs

20.—(1) Where a contractor, which is not in receipt of a mortgage redemption or deficit grant—

(a) agrees to relocate to leasehold premises approved by the Board in its estates strategy for investment prioritisation;

(b) takes out a loan to cover—

(i) a mortgage deficit which arises, after owner-occupied practice premises are sold, because the actual sale price of the premises was not sufficient to clear the outstanding mortgage on the property, or

(ii) mortgage redemption fees that the contractor may incur as a result of the sale or re-mortgage of such premises, or a third party takes out a loan to cover those costs or

fees on its behalf and the contractor is obliged to meet the third party's liabilities in respect of the repayment of that loan;

(c) makes an application in writing to the Board for financial assistance towards meeting its, or the third party's, regular payments to repay the loan; and

(d) includes in that application all reasonable information required of it by the Board to determine the application, including details of the amount of the outstanding mortgage that was used to build or improve the property,

the Board must consider that application for financial assistance and, in appropriate cases (having regard, amongst other matters, to the budgetary targets it has set itself), grant that application.

(2) Where a contractor re-mortgages practice premises and—

(a) the contractor is in receipt of financial assistance under direction 36 in respect of those premises;

(b) the existing mortgage is a repayment mortgage at a fixed rate of interest;

(c) the new mortgage is a repayment mortgage at a lower rate of interest than the existing mortgage, and for no more than the amount outstanding under the existing mortgage;

(d) the contractor takes out a loan to cover mortgage redemption fees that the contractor may incur as a result of the re-mortgage of the premises, or a third party takes out a loan to cover those fees on its behalf and the contractor is obliged to meet the third party's liabilities in respect of the repayment of that loan;

(e) the contractor makes an application in writing to the Board for financial assistance towards meeting its, or the third party's, regular payments to repay the loan; and

(f) includes in that application all reasonable information required of it by the Board to determine the application, including details of the existing mortgage and the new mortgage,

the Board must consider that application for financial assistance and in appropriate cases (having regard, amongst other matters, to the budgetary targets it has set itself, and to the likely savings to be made in the level of financial assistance given under direction 36 as a result of the re-mortgage), grant that application.

Costs that must not be funded under direction 20

21. The Board must refuse an application of a type mentioned in direction 20 if the loan covers—

(a) any proportion of a mortgage deficit that has arisen through—

(i) arrangements entered into by the contractor which result in mortgage repayments not being made for any period ("payment holidays"), or

(ii) reduced loan repayments not reflected in the cost rent reimbursement;

(b) any borrowings or redemption charges not connected with the original purchase of land, building works or subsequent improvements to the premises (for example furnishings, fittings and equipment, including IT or telephone systems).

Matters that must be considered before determining applications under direction 20

22. Before determining an application of the type mentioned in direction 20, the Board must obtain professional advice and be satisfied that—

(a) negotiations with the lender have limited the extent of any deficit or redemption charges;

(b) options for change of use for the property have been considered and where appropriate, outline planning permission sought or obtained;

(c) a proper process has been undertaken to identify a suitable third party developer and a site for the new leasehold premises;

(d) the timing of the loan is appropriate to maximising the opportunity for a sale which will coincide with completion and occupation of the new leasehold premises; and

(e) the sale of the premises is adequately advertised and the best price obtained,

and the Board must deduct from any regular payments that it would otherwise be prepared to pay, in granting the application, a regular and appropriate proportion of the surrender value of any endowment policy cover linked to the mortgage on the premises.

Conditions attached to payments under direction 20

23. Although, for accounting purposes, regular payments that the Board makes on granting an application of the type mentioned in direction 20 are to be treated as a payment to the contractor, the Board must ensure that the payments are made subject to the following conditions—

(a) the contractor must consent to the Board sending the payments directly to the lender;

(b) the contractor must provide the Board with sufficient details to enable it to do so;

(c) the contractor must provide the Board with the information it needs from the lender to determine whether any endowment policy cover is linked to the mortgage on the premises, and if so, its surrender value; and

(d) the contractor must not be in receipt of a mortgage redemption or deficit grant from the Board in respect of the same mortgage.

Guaranteed minimum sale price payments

24. Where—

(a) a contractor agrees with the Board to relocate to leasehold premises approved by the Board in its estates strategy for investment prioritisation;

(b) the relocation will, in the opinion of the Board, result in an improvement in the range and quality of services to be provided to patients by the contractor;

(c) the Board and the contractor have agreed a guaranteed minimum sale price for owner-occupied practice premises that are being sold ("the previous premises");

(d) the Board is satisfied that the previous premises were placed on the open market with active marketing to sell them at the maximum price achievable on a date to coincide with the contractor's move to new premises;

(e) the Board is satisfied, having taken the advice of the District Valuer Service, that an increased offer (being an offer that was better than the one that was in fact accepted for the previous premises) could not reasonably have been achieved;

(f) the Board is satisfied that the previous premises have not been sold to—

(i) the contractor or, where the contractor is an individual, a family member of the contractor,

(ii) a present or former partner in, shareholder in or employee of the contractor,

(iii) a family member of a present or former partner in, shareholder in or employee of the contractor, or

(iv) the employer of a family member of a present or former partner in or shareholder in or employee of the contractor; and

(g) in appropriate circumstances (such as where the future planning use of the property is unclear)—

(i) the agreement for sale of the previous premises includes a clawback arrangement, and

(ii) the contractor has agreed with the Board an enforceable undertaking in the form of a condition in its GMS contract that it will use any clawback monies to repay all or a proportionate part (as is appropriate) of any payment from the Board pursuant to this direction,

if the sale price for the previous premises is less than the agreed guaranteed minimum sale price for the premises, the Board must provide to the contractor under its GMS contract financial assistance in the form of a payment equal to the difference between those two prices.

Agreement of a guaranteed minimum sale price

25. If the Board is considering agreeing a guaranteed minimum sale price with a contractor, it must—

(a) seek the advice of the District Valuer Service on the actual sale price of the premises to be sold; and

(b) only agree a guaranteed minimum sale price with the contractor—

(i) on the basis of the advice about the actual sale price of the property that it has received, and

(ii) having taken into account the options for change of use of the premises.

Grants relating to the cost of reconverting former residential property

26. Where a contractor has a proposal for reconverting practice premises which were previously the contractor's (or a partner in or shareholder in the contractor's) owner-occupied residential property back to residential use, and—

(a) the property is no longer suitable for the delivery of primary medical services; and

(b) the contractor has agreed to—

(i) move to premises suitable for the delivery of primary medical services,

(ii) rent out the reconverted premises through arrangements made by the contractor directly or through a registered provider of social housing for a minimum period of time, which is to be set by the Board and which the Board must set for a period that is commensurate to the level of grant awarded pursuant to an application of the type mentioned in this direction; and

(iii) the contractor makes an application to the Board for a residential property re-conversion grant towards the cost of the re-conversion,

the Board must consider that application for financial assistance and, in appropriate cases (having regard, amongst other matters, to the budgetary targets that it has set for itself) grant that application.

Circumstances where residential property re-conversion grants are not payable

27. The Board must ensure that payment of a residential property re-conversion grant is made subject to conditions to the following effect—

(a) for the minimum period of time set by the Board in accordance with direction 26(b)(ii), any registered provider of social housing through whom the premises are or will be rented out, and any tenant to whom all or part of the premises are or will be rented out, must not be—

(i) the contractor or, where the contractor is an individual, a family member of the contractor;

(ii) a present or former partner in, shareholder in or employee of the contractor;

(iii) a family member of a present or former partner in, shareholder in or employee of the contractor; or

(iv) the employer of a family member of a present or former partner in, shareholder in or employee of the contractor; and

(b) the contractor must not occupy all or part of the premises during the minimum period of time that has been set by the Board in accordance with direction 26(b)(ii).

Grants towards the cost of surrendering or assigning leases or to meet vacated leasehold premises costs and condition to be attached

28.—(1) Where a contractor which is moving or has moved to premises that are suitable for the delivery of primary medical services makes an application to the Board for a grant towards—

(a) the costs reasonably incurred (including reasonable legal costs) that relate to—

(i) surrendering a lease with no more than five years of its term left to run, or

(ii) assigning a lease where surrender of the lease was not realistically possible,

of leasehold premises that are or were practice premises but are not suitable for the delivery of primary medical services; or

(b) vacated leasehold premises costs, for the 12 month period immediately following the contractor's vacation of the premises, that relate to the contractor's ongoing liabilities (or a partner in or shareholder in the contractor's ongoing liabilities) in respect of practice premises that are being or have been vacated because they are not suitable for the delivery of primary medical services,

the Board must consider that application for financial assistance and, in appropriate cases (having regard, amongst other matters, to the budgetary targets it has set itself) grant that application.

(2) In the case of vacated leasehold premises costs, the Board must ensure that any financial assistance given is subject to a condition to the effect that the contractor must continue to take all reasonable steps to surrender or assign the lease to a third party on reasonable terms.

Circumstances where an application of the type mentioned in direction 28 must be refused

29. The Board must refuse an application of the type mentioned in direction 28 where—

(a) the costs to which the application relates were incurred without the prior approval of the Board;

(b) the leasehold premises are owned by or leased from an NHS trust or Foundation trust, or from NHS Property Services Limited(**a**);

(c) the leasehold premises are wholly or partly owned by, or are leased from—

(i) the contractor or, where the contractor is an individual, a family member of the contractor;

(ii) a present or former partner in, shareholder in or employee of the contractor,

(iii) a family member of a present or former partner in, shareholder in or employee of the contractor, or

(iv) the employer of a family member of a present or former partner in, shareholder in or employee of the contractor;

(d) in the case of costs of assigning a lease, surrender could be agreed with the landlord, unless professional advice has been obtained and the conclusion of that advice is that surrender or assignment is not cost-effective;

(e) in the case of vacated leasehold premises costs—

(i) surrender could be agreed with the landlord, or

(ii) assignment to a third party could be agreed with the landlord and is realistically possible,

unless professional advice has been obtained and the conclusion of that advice is that surrender or assignment is not cost-effective; or

(iii) the costs relating to liabilities in respect of the vacated leasehold premises have not been agreed with the landlord.

(a) NHS Property Services Limited is a company formed under section 223 of the 2006 Act under registration number 07888110. Section 223 was amended by paragraph 117 of Schedule 4 to the 2012 Act and by S.I. 2009/1941.

Stamp Duty Land Tax payable on agreeing a new lease

30. Where—

(a) contractor agrees with the Board to relocate to or additionally occupy leasehold practice premises approved by the Board in the Board's estates strategy for investment prioritisation;

(b) the relocation or additional premises will, in the opinion of the Board, result in an improvement in the range and quality of services to be provided to patients by the contractor; and

(c) the contractor makes an application to the Board for financial assistance to cover the cost of any Stamp Duty Land Tax incurred by the contractor as a consequence of signing a lease to occupy premises,

the Board must consider that application for financial assistance and, in appropriate circumstances (having regard, amongst other matters, to the budgetary targets it has set for itself), grant that application.

PART 5

RECURRING PREMISES COSTS

Leasehold premises rental costs

31. Subject to the following provisions of this Part, where—

(a) a contractor which rents its practice premises makes an application to the Board for financial assistance towards its rental costs; and

(b) the Board is satisfied (before the lease is agreed or varied), where appropriate in consultation with the District Valuer Service, that the terms on which the new or varied lease is to take effect represent value for money,

the Board must consider that application and, in appropriate cases (having regard, amongst other matters, to the budgetary targets it has set for itself), grant that application.

Amount of leasehold premises rental costs payable

32.—(1) Subject to the following provisions of this Part, where the Board grants the application, the amount that it must pay in respect of a contractor's rental costs for its practice premises is—

(a) the current market rent for the premises, plus any Value Added Tax payable by the contractor if this is properly charged to the contractor by the landlord (but excluding any Value Added Tax for which the contractor can claim a refund); or

(b) the actual lease rent for the premises, plus any Value Added Tax payable by the contractor if this is properly charged to the contractor by the landlord (but excluding any Value Added Tax for which the contractor can claim a refund),

whichever is the lower amount.

Current market rents

33.—(1) The Board must determine the amount of the current market rent of leasehold premises in accordance with Parts 1 and 2 of Schedule 2.

(2) Having regard to the fact that current market rent levels in some areas of deprivation may be too low to provide—

(a) sufficient returns to support new capital investment in practice premises; or

(b) sufficient support for existing premises that meet the minimum standards set out in Schedule 1,

the Board may in such circumstances, having taken advice from the District Valuer Service, add an appropriate supplement to the amount it would otherwise pay as the current market rent of practice premises, in order to provide sufficient returns or support.

(3) The Board must reduce payments of the supplement in paragraph (2) in line with any increases in the current market rent until such time as the supplement is extinguished.

Premiums affecting the lower rent rate

34.—(1) Where the actual lease rent for practice premises, plus any properly chargeable Value Added Tax, is only lower than the current market rent for those premises because, in the calculation of the current market rent for the premises, the Board includes the value of a premium paid by the tenant, the amount to be paid by the Board pursuant to direction 32 is the current market rent for the premises rather than the actual lease rent.

(2) In considering the actual lease rent in paragraph (1), the Board must disregard any element of that rent which would not be included in an assessment of current market rent, and must, when adding any properly chargeable Value Added Tax, disregard any part of that Value Added Tax for which the contractor can claim a refund.

Equipment lease costs for leasehold practice premises

35. Where—

(a) a contractor has entered into an agreement (whether as part of an agreement to lease practice premises or otherwise) to lease equipment, furniture or furnishings; and

(b) the nature and level of the costs of leasing the equipment, furniture or furnishings (including any arrangements for increasing the amounts payable), together with the period of time for which these costs are payable, were agreed by the contractor and the Board before the agreement was made, and—

(i) the period of time does not exceed the remaining term of the lease of the practice premises, and

(ii) the Board obtained professional advice before reaching agreement with the contractor; and

(iii) the contractor makes an application to the Board for financial assistance towards those costs,

the Board must consider that application for financial assistance and, in appropriate circumstances (having regard, amongst other matters, to the budgetary targets it has set for itself), grant that application.

Borrowing costs

36. Subject to the following provisions of this Part, where a contractor—

(a) incurs borrowing costs as a result of purchasing, building or significantly refurbishing its practice premises; and

(b) makes an application to the Board for financial assistance towards meeting those costs,

the Board must consider that application and, in appropriate cases (having regard, amongst other matters, to the budgetary targets it has set for itself), grant that application.

Conditions to be met if applications for financial assistance in respect of borrowing costs are to be granted

37.—(1) Where the contractor's borrowing costs relate to new practice premises or the significant refurbishment of an existing building, the Board must only grant an application of the type mentioned in direction 36 if the conditions in paragraph (2) are met.

(2) The conditions referred to in paragraph (1) are—

(a) in respect of the building work, the contractor—

(i) carries out or carried out a tendering process for a firm to undertake the work, resulting in at least three written quotes, and

(ii) agrees or agreed with the Board which of those written quotes represents or represented best value for money;

(b) the amount of financial assistance applied for has been calculated by applying the prescribed percentage to the necessary level of loan incurred (or that would have been incurred had the contractor not wholly or partly funded the project with its, or its partners' or shareholders', own resources) and agreed with the Board, to meet the aggregated cost elements to build, fit-out and equip the premises; and

(c) the loan (being any loan actually taken out by the contractor) is secured by the contractor and is for a term of no more than 25 years.

The prescribed percentage and aggregated cost elements

38. For the purposes of direction 37(2)(b)—

(a) the prescribed percentage is—

(i) if the loan is a fixed interest rate loan (for the duration of loan period), the 20 high year gilt rate issued by the Bank of England(**a**) plus 1.5%;

(ii) if the loan is not a fixed interest rate loan (for the duration of the loan period), the Bank of England Base Interest Rate(**b**) plus 1%; or

(iii) if the contractor is financing the building or refurbishment scheme wholly or mainly from its (or its partners' or shareholders') own resources, that which the Board determines as representing best value for money;

(b) the cost elements that may be aggregated include—

(i) site purchase,

(ii) building works,

(iii) reasonable surveyors', architects' and engineers' fees, and reasonable legal fees arising out of the purchase of the site (where applicable) and the building or refurbishment, which, taken together, may be paid up to a maximum reimbursable amount, which is 12% of the total reasonable contract sum relating to the construction or refurbishment work,

(iv) the reasonable costs of engaging a project manager to oversee the interests of and give advice to the contractor, up to the maximum reimbursable amount, which is 1% of the total reasonable contract sum relating to the construction or refurbishment work,

(v) any rolled-up interest incurred on loans taken out to procure the premises,

(vi) local authority and planning application fees necessarily incurred,

(vii) purchase or lease costs of adequately fitting-out and equipping the new premises, and

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(a) The 20 high year gilt rate may be obtained at the Bank of England's website, http://www.bankofengland.co.uk/boeapps/iadb/newintermed.asp, and entering the code IUMLNPY in the search box.

(b) The Base Interest Rate may be obtained at the Bank of England's website, http://www.bankofengland.co.uk/boeapps/iadb/newintermed.asp, and entering the code IUMBEDR in the search box.

(viii) Value Added Tax and Stamp Duty Land Tax, where properly charged in relation to the above, but excluding any part of the Value Added Tax for which the contractor can claim a refund.

Amounts payable in respect of borrowing costs

39. Where the Board has decided to grant an application from a contractor for financial assistance in respect of borrowing costs pursuant to direction 36, and the Board has calculated the amount of financial assistance in accordance with direction 37(2)(b) ("the annual amount") in respect of the contractor's borrowing costs, the Board must each month provide financial assistance to the contractor in respect of those borrowing costs, based on one twelfth that annual amount, until—

(a) the loan is paid off;

(b) in the case of a loan that is not a fixed interest rate loan (for the duration of the loan period) twelve months have elapsed since the annual amount was last established, at which point a new annual amount is to be established for the next twelve months, based on a re-determined prescribed percentage, which is the Bank of England Base Interest Rate at the time the annual amount is recalculated plus 1%, being applied to the agreed level of borrowing;

(c) alternative borrowing arrangements are entered into by the contractor, and where a contractor changes lender or re-negotiates lower loan costs, the amount payable by the Board shall be recalculated using the appropriate prescribed percentage in force at the time that the changed loan arrangements come into effect; or

(d) the contractor elects not to receive any further payments under these arrangements (for example, in order to receive notional rent payments),

and the monthly amount is to be paid on the last day of the month, unless alternative payment arrangements are agreed between the Board and the contractor.

Condition attached to payments in respect of borrowing costs based on a fixed interest rate loan

40. Where a contractor is to receive payments in respect of borrowing costs under this Part, and those borrowing costs arise as a result of a fixed interest rate loan, the Board must ensure that the making of the payment is subject to a condition to the effect that the contractor must advise the Board of any change of lender or any reduction in the level of interest charged to its loan.

Notional rent payments

41.—(1) Subject to the following provisions of this Part, where a contractor that is an owner-occupier of its practice premises—

(a) either—

(i) has repaid the loans secured on its practice premises, or

(ii) incurs borrowing costs as a result of purchasing, building or significantly refurbishing practice premises (or would have incurred such costs had the contractor not funded the project with its, or its partners' or shareholders', own resources) but elects not to receive any payments from the Board in respect of those borrowing costs; and

(b) makes an application to the Board for notional rent payments,

the Board must consider that application and, in appropriate cases (having regard, amongst other matters, to the budgetary targets it has set for itself), grant that application.

(2) If a contractor has been in receipt of payments in respect of its borrowing costs pursuant to direction 39 but elects not to receive further payments pursuant to that direction and makes an application in accordance with this direction, the Board must grant that application and

make notional rent payments to the contractor under its GMS contract at an appropriate level and frequency.

Amount of notional rent payments

42.—(1) Where the Board grants an application of the type mentioned in direction 41, subject to the following provisions of this Part, the amount that it must pay to a contractor in respect of notional rent is the current market rental value of its practice premises, as determined in accordance with Parts 1 and 3 of Schedule 2.

(2) The Board must review the amount in paragraph (1) as part of a three yearly review of the contractor's notional rent, although this review may be brought forward if—

(i) there is a change to the purposes for which the premises are used; or

(ii) there is further capital investment in the premises, which has been agreed by the Board, and payments are to be made by the Board to the contractor in respect of that investment under its GMS contract.

Abatement of notional rent payments

43.—(1) Where—

(a) capital has contributed to the cost of building or refurbishment work done in respect of the practice premises of a contractor, and

(b) that capital was not borrowed or otherwise provided by the contractor,

on completion of the building or refurbishment work, the amount of the notional rent payable by the Board must be the abated notional rent for those premises, calculated in accordance with Part 1 of Schedule 3, rather than the full notional rent, determined in accordance with direction 42, but after the abatement period the full notional rent again becomes payable.

(2) The abatement period in paragraph (1) is, where the cost of the building or refurbishment work is—

(a) up to £100,000 plus Value Added Tax, a period of 5 years;

(b) between £100,000 and £250,000 plus Value Added Tax, a period of 10 years;

(c) more than £250,000 plus Value Added Tax, a period of 15 years.

Notional rent supplements

44. If a contractor—

(a) is an owner-occupier of its practice premises and is in receipt of payments in respect of its borrowing costs which are paid by the Board pursuant to direction 39, and—

(i) the contractor makes further capital investment in the practice premises and that investment (including the details of the finalised project plan) had the prior approval of the Board but

(ii) the current market rent (and so the notional rent) for the practice premises remains lower than the repayments in respect of borrowing costs being made; or

(b) rents its practice premises and is in receipt of payments in respect of its actual lease rent which are paid by the Board pursuant to direction 32, and

(i) the contractor makes further capital investment in its practice premises, and

(ii) that investment (including the details of the finalised project plan) had the prior approval of the Board,

and the contractor makes an application to the Board for a notional rent supplement, the Board must grant that application and make notional rent supplement payments to the contractor under its GMS contract at an appropriate level and frequency.

Amount of notional rent supplements

45. Where the Board grants an application of the type mentioned in direction 44, the amount that it must pay to the contractor as a notional rent supplement is the value of the enhancement of the current market rent for the premises arising from the further capital investment, which is to be determined (or abated) in accordance with Schedule 2 and Part 1 of Schedule 3.

Payments in respect of running costs

46.—(1) Where—

(a) a contractor is in receipt of payments pursuant to this Part in respect of leasehold rental costs or borrowing costs, or by way of notional rent payments;

(b) the contractor actually and properly incurs the costs which are or relate to—

(i) business rates,

(ii) water and sewage charges,

(iii) charges in respect of the collection and disposal of clinical waste, or

(iv) a utilities and services charge which covers the matters in paragraph (2);

(c) those costs are not covered in the other payments that the contractor is receiving pursuant to these Directions, and

the contractor makes an application to the Board for financial assistance towards meeting any or all of these costs, subject to direction 47, the Board must consider that application and, in appropriate cases (having regard, amongst other matters, to the budgetary targets it has set for itself), grant that application.

(2) The utilities and services charge in paragraph (1)(b)(iv)—

(a) may include a service charge under a lease or a charge levied under separate arrangements made by a contractor which is an owner-occupier,

(b) must cover—

(i) fuel and electricity charges,

(ii) building insurance costs,

(iii) costs of internal or external repairs, and

(iv) plant, building and grounds maintenance costs.

Financial assistance towards service charges

47. The Board must deduct from any amount that it would otherwise be required to pay in respect of a service charge pursuant to an application of the type mentioned in direction 46—

(a) an average (calculated on the basis of the previous year's costs) amount that the contractor paid in respect of—

(i) fuel and electricity charges,

(ii) insurance costs,

(iii) costs of internal or external repairs, and

(iv) plant, building and grounds maintenance costs,

calculated by reference to the same time period as the period in respect of which the service charge is payable; or

(b) if suitable and sufficient information is not (or does not become) available to calculate the average referred to in paragraph (a), 40% of the amount otherwise payable.

Abatements in respect of contributions towards recurring premises costs from third parties

48. Where a contractor's practice premises, or any part thereof, are or form part of premises that are owned or rented by any person other than the contractor, and that person—

(a) is required by any agreement (which includes a licence or a lease) to make or makes any contribution towards any recurring premises costs in respect of which the Board is providing financial assistance to the contractor in accordance with this Part; or

(b) is required by any agreement (which includes a licence or a lease) to pay or pays to the contractor any amount—

(i) by way of rent in respect of the practice premises or any part thereof, or

(ii) in respect of the running costs of the practice premises,

the Board must set off that contribution or that amount, equitably, against the payments made to the contractor pursuant to this Part.

Payments in kind

49.—(1) Where a payment that is to be made pursuant to this Part would be abated, or abated by a greater amount, if instead of receiving money or obtaining a pecuniary advantage a contractor, or a member or employee of a contractor, receives a payment in kind, the Board must take into account the value of the payment in kind in determining the amount of the payment to be made pursuant to this Part.

(2) The Board is to take all reasonable steps to agree with the contractor the value of the payment in kind and must justify the value it does determine.

Minimum standards condition attached to all payments under this Part

50.—(1) If a payment is to be made by the Board pursuant to this Part, the Board must ensure that the making of the payment is subject to a condition to the effect that the practice premises in respect of which the payment is made meet the minimum standards set out in Schedule 1.

(2) If this condition in paragraph (1) is breached but the breach is capable of remedy by refurbishment of the premises—

(a) a remedial notice should not be served in respect of the breach if, pursuant to a plan drawn up in accordance with regulation 18(3) of the National Health Service (General Medical Services Contracts) Regulations 2004(**a**) (services generally), action is already due to be taken which will remedy that breach and the timescale for taking that action under that plan has not yet elapsed;

(b) before serving a remedial notice in respect of the breach, the Board must consult the Local Medical Committee (if any) for the area concerned; and

(c) if a remedial notice is served, the notice period must be no more than 3 months unless in the Board's opinion the breach will require a longer period to rectify.

Accurate information condition attached to all payments under this Part

51. Where the Board grants an application under this Part, it must ensure that the payment is made subject to conditions to the following effect—

(a) the contractor must make available to the Board any information which the Board does not have but needs, and the contractor either has or could reasonably be expected to obtain, in order for the Board to calculate the appropriate amount of financial assistance to be provided; and

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(a) S.I. 2004/291; amending instruments are S.I. 2004/2694, 2005/893, 3315, 3491 and 3315, 2006/1501, 2007/3491, 2008/528 and 1700, 2009/2205 and 2230, 2010/22, 231, 234, 478, 578 and 1621, 2012/970, 1479, 1909 and 1916, and 2013/363.

(b) all information supplied by a contractor to the Board pursuant to or in accordance with the condition set out in paragraph (a) must be accurate.

PART 6

MISCELLANEOUS PROVISIONS

Direct payments to third parties

52.—(1) Where a contractor and the Board agree, the Board must pay any amount that is due to the contractor as financial assistance under these Directions to a third party instead of the contractor, subject to a condition that the contractor ensures that it treats the payment for accounting purposes as a payment to it.

(2) If—

(a) the payment from the Board to the third party is less than the amount that is due from the contractor to the third party; and

(b) the contractor is due other payments from the Board as financial assistance under these Directions which are greater than or equal to the amount of the shortfall,

where the contractor and the Board agree, the Board must pay all or part of those other payments to the third party instead of to the contractor, subject to a condition that the contractor ensures that it treats the payment for accounting purposes as a payment to it.

Time limitation for making applications

53. The Board must only grant an application of a type mentioned in these Directions if the application is made within six years of the premises costs to which the application relates falling due.

PART 7

TRANSITIONAL, REVOCATION AND SAVINGS PROVISIONS

Interpretation

54. In this Part—

"the 2004 Directions" means the National Health Service (General Medical Services – Premises Costs) (England) Directions 2004(**a**); and

"Primary Care Trust" means a Primary Care Trust which was established and which subsisted immediately before the coming into force of section 34 of the 2012 Act (abolition of Primary Care Trusts).

General transitional provision

55. Subject to the following directions in this Part—

(a) any act or omission by, or in relation to, a Primary Care Trust before 1st April 2013 in respect of the exercise of any functions of the Primary Care Trust under the 2004 Directions is deemed to have been an act or omission of, or in relation to, the Board; and

(b) anything which, when these Directions take effect, is in the process of being done by, or in relation to, a Primary Care Trust in respect of, or in connection with the exercise by the

(a) The 2004 Directions were signed on 16th March 2004 and are available to download from the Department of Health website at www.dh.gov.uk.

Primary Care Trust of any of its functions under the 2004 Directions is deemed to have effect as if done by, or in relation to, and may be continued by, or in relation to, the Board.

Transitional provision in respect of payments

56.—(1) Where immediately before 1st April 2013, a Primary Care Trust was making payments to a contractor under Part 4 (grants relating to the relocation of a contractor), 5 (recurring premises costs), or 6 (supplementary provisions) of the 2004 Directions, the Board must continue to make those payments as if the 2004 Directions, as in force immediately before 1st April 2013, continued to apply, and those Directions are to be treated as directions to the Board.

(2) Where a contractor made an application for financial assistance under the 2004 Directions before 1st April 2013 but that application had not been determined by the Primary Care Trust—

(a) where the costs, or any part of them, to which the application relates were incurred before 1st April 2013, the Board must determine the application and make any payments as if the 2004 Directions, as in force immediately before 1st April 2013, continued to apply, and those Directions are to be treated as directions to the Board;

(b) where the costs to which the application relates were all incurred on or after 1st April 2013, the Board must determine the application and make any payments in accordance with these Directions.

Revocation and savings

57.—(1) Subject to the preceding directions in this Part, the 2004 Directions are revoked.

(2) Notwithstanding the revocation provided for in paragraph (1), the 2004 Directions, as in force immediately before 1st April 2013, continue to apply to the extent necessary for the purposes of directions 56 and for the purposes of assessing entitlement to, and any recovery of, payments arising under the 2004 Directions.

(3) For the purposes of paragraph (2) and the resolution of any matter which is pending under the 2004 Directions as at 31st March 2013—

(a) any reference to a Primary Care Trust in the 2004 Directions is to be treated as if it were a reference to the Board;

(b) the Board may do anything or continue to do anything which a Primary Care Trust could have done in relation to the 2004 Directions; and

(c) the transitional provisions in Schedule 1 to the National Health Service (Primary Medical Services) (Miscellaneous Amendments and Transitional Provisions) Regulations 2013(**a**) apply in so far as is necessary.

Signed by authority of the Secretary of State for Health

Ben Dyson

Date

28 March 2013

Name
A member of the Senior Civil Service
Department of Health

(**a**) 2013/363.

SCHEDULE 1

Directions 10, 33 and 50

MINIMUM STANDARDS FOR PRACTICE PREMISES

PART 1

STATUTORY STANDARDS

Health and Safety at Work Act 1974

1. The contractor must comply with any obligations it has under the Health and Safety at Work Act 1974(**a**) (and legislation under that Act) including any applicable requirements regarding adequate standards of ventilation.

Equality Act 2010

2. The contractor must comply with any obligations it has under the Equality Act 2010(**b**) and should carry out any audits as to accessibility of the premises that may be necessary in order to enable it to comply with those obligations. The requirements of the Equality Act 2010 include taking such steps as are reasonable to—

(a) provide for ease of access to the premises and ease of movement within the premises for all users of the premises (including wheelchair users);

(b) provide adequate sound and visual systems for the hearing and visually impaired; and

(c) remove barriers to the employment of disabled people.

Fire precautions

3. There should be adequate fire precautions, including provision for safe exit from the premises, designed in accordance with any requirements of the Building Regulations 2010(**c**) and agreed, where necessary, with the local fire authority.

LOLER and COSHH Regulations

4. The contractor must comply with any applicable requirements of the Lifting Operations and Lifting Equipment Regulations 1998(**d**) ("the LOLER Regulations") or the Control of Substances Hazardous to Health Regulations 2002(**e**) ("the COSHH Regulations") which apply to the premises.

Miscellaneous requirements

5. The contractor must comply with any applicable statutory requirements relating to—

(a) the carrying out of a risk assessment and preparation of a management plan with regards to any risk of Legionella;

(b) the carrying out of a risk assessment and preparation of a management plan with regards to any risk connected with or attributable to the presence of asbestos;

(c) the testing of electrical equipment or appliances; and

(d) the testing of gas appliances or pressure systems (including systems for medical gas).

(a) 1974 c.37.
(b) 2010 c.15.
(c) S.I. 2010/2214.
(d) S.I. 1998/2307, amended by S.I. 2002/2174, 2007/320 and 2008/1597.
(e) S.I. 2002/2677, amended by S.I. 2003/978, 2004/3386, 2006/557, 2007/1894, 2008/960 and 2852, and 2009/716.

PART 2

CONTRACTUAL STANDARDS

General standards

6. The contractor must comply with any requirements in the contractor's GMS contract(**a**) relating to maintaining—

(a) adequate heating and lighting;

(b) adequate facilities for older people and young children, including nappy-changing and feeding facilities;

(c) internal waiting areas, with sufficient and appropriate seating to meet normal requirements;

(d) adequate facilities for patients to communicate confidentially with staff including in person and by telephone;

(e) fixtures and fittings in good repair;

(f) adequate secure storage of drugs, records, prescriptions and statement pads;

(g) adequate security arrangements, including arrangements for the security of the premises and security of the person;

(h) adequate arrangements in consultation or treatment rooms (including rooms for the carrying out of minor surgery or the treatment of minor injuries) to support safe and secure provision of primary medical services, including privacy for consultations and the personal privacy of patients when dressing or undressing; and

(i) adequate procedures for ensuring the continuing safety of practice premises, and the suitability of those premises for delivering primary medical services, including, where necessary, the carrying out of risk assessments of the safety and security of practice premises, and the development of business continuity plans to address any significant disruption to the delivery of primary medical services at the practice premises.

Decontamination and infection control

7. In complying with any requirements regarding decontamination or infection control, the contractor should have regard to the Health and Social Care Act 2008, Code of Practice on the prevention and control of infections and related guidance(**b**), and to the following—

(a) clinical wash hand basins should be connected to running hot and cold water (ideally distributed through elbow, knee or sensor-operated taps);

(b) the premises, fixtures and fittings should be maintained in a clean and hygienic condition;

(c) there should be adequate lavatory and hand hygiene facilities; and

(d) arrangements for the disposal of clinical waste should comply with applicable requirements and take into account applicable guidance.

(**a**) Paragraph 125 of Schedule 6 to the National Health Service (General Medical Services Contracts) Regulations 2004 (S.I. 2004/291; a relevant amendment is S.I. 2013/363) requires a contractor to comply with all relevant legislation and have regard to all relevant guidance issued by the Board, the Secretary of State or Local Authorities in respect of the exercise of their functions under the 2006 Act.

(**b**) Issued by the Secretary of State under section 21 of the Health and Social Care Act 2008 (c.14). The code is available to download from the Department of Health's website at www.dh.gov.uk.

SCHEDULE 2

Directions 33, 42 and 45

CURRENT MARKET RENTS AND NOTIONAL RENT ABATEMENTS

PART 1

FACTORS COMMON TO ALL CURRENT MARKET RENT CALCULATIONS

1. Current market rent calculations for notional rent purposes differ from current market rent calculations for actual leasehold premises pursuant to direction 33.

2. However, in both cases, the District Valuer must consider what might reasonably be expected to be paid by a tenant for the premises at the valuation date. The aim will be to arrive at a rent which can be agreed between the contractor (or his or her representative) and a third party in willing negotiation. For these purposes, it must be assumed that neither party is seeking to take advantage of the fact that—

(a) the contractor's remuneration is so arranged that this rent and any VAT payable is reimbursed separately; and

(b) at any one time only one contractor is permitted to be in the market to use the premises for practice purposes.

3. In determining a figure for any current market rent, the following will also apply—

(a) where the practice accommodation forms part of an owner-occupied residence but does not include areas which are used regularly but not exclusively for practice purposes, the current market rent will be assessed for the practice accommodation only, but as part of the whole premises and not increased or reduced to reflect any advantage or disadvantage there may be in the fact that the practice accommodation is not in separate premises;

(b) where the practice accommodation forms part of a residence owned or rented by a person not connected with the contractor, the current market rent will be assessed in respect of the practice accommodation only and is to reflect any advantage or disadvantage there may be in the fact that it is not in separate premises;

(c) where the practice accommodation forms part of an owner-occupied residence and includes areas which are used regularly but not exclusively for practice purposes, the current market rent will be assessed as at (a) above but with an agreed percentage added of the current market rental value of any area used regularly but not exclusively for practice purposes having regard to the extent and frequency of such use and any modifications made to facilitate that use;

(d) subject to paragraph 4(e), where car parking spaces are provided at the practice accommodation, the number of car parking spaces to be included for the purposes of assessing the current market rent must be limited to the number of spaces agreed by the Board (access to and egress from each parking space must be undertaken without the need to move other vehicles);

(e) where improvements have been made to the practice accommodation and those improvements are designed solely to reduce the environmental impact of the premises, such as the installation of solar panels, air conditioning, or replacement windows or doors, those improvements must be disregarded for the purposes of assessing the current market rent.

PART 2

FACTORS WHICH ONLY APPLY IN RELATION TO LEASEHOLD PREMISES

4. The District Valuer must first have regard to the actual terms of the lease. In the case of the payment provisions—

(a) the amounts payable must be adjusted to take account of appropriate deductions in respect of the following—

(i) any amount referable to residential accommodation, except where this is to be taken into account in accordance with paragraph 3,

(ii) other non-practice accommodation (unless the Board has specifically agreed that no deduction is to be made in respect of it),

(iii) furniture or moveable equipment included in the rent costs,

(iv) services or other facilities included in the rent costs,

(v) the value of any responsibility of the landlord in respect of internal repairs or decoration,

(vi) any amount referable to water rates, where the tenant is responsible for paying the landlord's share and recovers that share from the landlord;

(b) the amounts payable must be adjusted to take account of appropriate additions in respect of the following—

(i) the value of any responsibility of the tenant in respect of external repairs and maintenance, or for insurance of the building,

(ii) any premium paid by the tenant,

(iii) any Value Added Tax paid by the tenant where properly charged to the tenant by the landlord (but excluding any part of that Value Added Tax for which the contractor can claim a refund) and approved by the Board prior to payment by the tenant,

(c) relating to reviewing rental payments, the Board must—

(i) review its assessment of the current market rent for the property when the landlord undertakes a rent review provided for in the lease, unless the landlord's review does not result in a change to the level of rent charged (an assessment on the basis of vacant possession will not be appropriate on a rent review, unless the terms of the lease so provide or the property market can be shown not to distinguish between vacant and tenanted premises);

(ii) review its assessment of the current market rent for the property when the terms and conditions of the lease are varied, even if this variation does not result in any change to the level of rent charged;

(iii) if the rent review is linked to an index, such as the Retail Price Index, adjust the amount it pays in accordance with that index, provided it received a copy of the lease on offer before it was agreed and it agreed to the indexing arrangement, having taken advice from the District Valuer as to its appropriateness; and

(iv) when reviewing its assessment of the current market rent under paragraph (i), require a rent review memorandum, signed by the landlord and the contractor, recording the change in the level of rent charged, and have regard to that change as so recorded (but no other) when carrying out its review;

(d) if the lease rent is inclusive of rates (including water rates), the current market rent must also be inclusive of the rates so included; and

(e) where, in the case of existing leasehold premises, a rental value for car parking spaces has been included in the rent charged by the landlord, this rental value will continue to be included in the assessment of the current market rent until the term of the lease expires or the lease is varied to exclude that rental value from the rent charged.

PART 3

FACTORS WHICH ONLY APPLY IN RELATION TO NOTIONAL RENT CASES

5. If the premises are owner-occupied premises, the following assumptions are to be made by the District Valuer about the nature of the notional lease upon which the notional rent payments are to be based. This notional lease—

(a) is to be for a term of 15 years, with rent reviews every three years (but subject to the assumption that if the rent falls as a result of such a review it does not fall below the level of the rent initially charged);

(b) includes a covenant that the tenant undertakes to bear the cost of internal repairs and decoration and the landlord undertakes to bear the cost of insuring the building and of carrying out external repairs and maintenance;

(c) does not include a service charge, or like payment for such items as upkeep, maintenance (including lift maintenance where appropriate), cleaning and heating of common parts;

(d) is for vacant possession (for the purposes of the initial assessment but not for the purposes of the notional rent review, unless the terms of the lease so provide or the property market can be shown not to distinguish between vacant and tenanted premises);

(e) is exclusive of rates;

(f) includes a right for the tenant to assign or sublet the whole premises, subject to landlords consent which is not to be unreasonably withheld;

(g) allows the premises to be used for practice purposes only.

SCHEDULE 3

Directions 43 and 45

NOTIONAL RENT ABATEMENTS AND NOTIONAL RENT SUPPLEMENTS

PART 1

NOTIONAL RENT ABATEMENTS

1. Where capital has contributed to the cost of building or refurbishment work done in respect of practice premises, and the capital was not borrowed by or provided by the contractor, the notional rent payable in respect of those payments is to be abated (in proportion to the level of the capital contribution) as follows—

(a) determine the current market rent for the premises prior to improvement ***(Pu)***;

(b) determine the current market rent for the whole of the improved premises ***(Pi)***;

(c) subtract one from the other ***(Pi - Pu)***, which will produce the current market rent value of the enhancement ***(I)***;

(d) determine the amount of the capital provided by the contractor as a proportion of the whole cost of the improvement, expressed as a percentage ***(A)***;

(e) ***(A)*** is then to be enhanced by adding 10% to cover normal landlord expenses, which is then applied to ***(I)*** and the resultant is added to ***(Pu).***

2. Accordingly, expressed as a formula, the post-improvement notional rent is—

I ´ (A+10)% + Pu

PART 2

NOTIONAL RENT SUPPLEMENTS

3. Where a notional rent supplement is to be calculated, the amount of that supplement, expressed as a formula, is: $I \times (A+10)\%$.

NHS
Barnsley Clinical Commissioning Group
Putting Barnsley People First

PRIMARY CARE COMMISSIONING COMMITTEE

30 April 2015

Governance Update

1.	**PURPOSE OF THE REPORT**
	To provide the Primary Care Commissioning Committee with the Committee's Terms of Reference, proposed meeting dates, and work plan.
2.	**EXECUTIVE SUMMARY**
	The report covers: • The Primary Care Commissioning Committee's Terms of Reference, which require some minor amendments following receipt of the Delegation Agreement • The proposed frequency and dates of the Committee's meetings • The Primary Care Commissioning Committee Work Plan 2014/15.
3.	**THE COMMITTEE IS ASKED TO:** • Approve the proposed amendments to the Committee Terms of Reference, subject to subsequent Governing Body ratification (Appendix A) • Note and confirm the proposed schedule of dates for the Committee (Appendix B) • Review and approve the draft work programme for the year (Appendix C).

Agenda time allocation for report:	15 minutes

Report of: Vicky Peverelle

Designation: Chief of Corporate Affairs

Report Prepared by: Richard Walker

Designation: Head of Assurance

1.	**SUPPORTING INFORMATION**	
1.1	**Links to the Assurance Framework**	
	The report is especially relevant to the following risks on the Gb Assurance Framework: 2.1 and 5.2.	
1.2	**Links to Objectives**	
	To have the highest quality of governance and processes to support its business	✓
	To commission high quality health care that meets the needs of individuals and groups	
	Wherever it makes safe clinical sense to bring care closer to home	
	To support a safe and sustainable local hospital, supporting them to transform the way they provide services so that they are as efficient and effective as possible for the people of Barnsley	
	To develop services through real partnerships with mutual accountability and strong governance that improve health and health care and effectively use the Barnsley £.	
1.3	**Governance Arrangements Checklist**	**Has the area been considered (yes / no / not relevant)?**
	Financial Implications	Not relevant
	Contracting Implications	Not relevant
	Quality	Not relevant
	Consultation / Engagement	Not relevant
	Equality and Diversity	Not relevant
	Information Governance	Not relevant
	Environmental Sustainability	Not relevant
	Human Resources	Not relevant

2.	**INTRODUCTION/ BACKGROUND INFORMATION**
	In May 2014, Simon Stevens invited CCGs to come forward with proposals to take on an increased role in the commissioning of primary care services. Further guidance issued in November 2014 outlined three broad models for co-commissioning: • greater involvement of CCGs • joint arrangements, or • delegated arrangements. At its meeting on 13 November 2014 the Governing Body decided to pursue option 3 – delegated arrangements. This decision was supported by the Membership Council at its meeting of 17 December 2014. A task and finish working group was established to develop the CCG's application. An extraordinary meeting of the Governing Body was held on 8 January 2015 which reviewed and approved the CCG's application. The Chief of Corporate Affairs submitted the application to NHS England by the required deadline of noon on 9 January 2015. Further to the submission of the CCG's application, and following a regional and national moderation and consistency process, the CCG was informed by NHS England that '…NHS Barnsley CCG has been approved to take on delegated responsibility for NHS England specified general medical care commissioning functions from 1 April 2015, as per the functions set out in the forthcoming delegation agreement.' As part of its successful application, the CCG proposed the creation of this Primary Care Commissioning Committee to function as the corporate decision making body for the management of the delegated functions and the exercise of the delegated powers set out in the delegation agreement.
3.	**DISCUSSION/ISSUES**
	Terms of Reference The Terms of Reference for the Committee, which closely followed a model provided by NHS England, were approved by the Governing Body on 8 January. The Terms of Reference have been reviewed in the light of the Delegation Agreement which was received and signed in March 2015 by the CCG and NHS England. Amended Terms of Reference are attached at Appendix A. The main changes (highlighted via track changes) are: • inclusion of the requirement to produce an Annual Report at paragraph 42 • Reference to the Delegation Agreement at Schedule 1. **Meeting dates** The Terms of Reference state that the Committee will meet monthly, in public. Following consultation with members and attendees it is proposed that the Committee meets on the last Thursday of every month. Proposed dates for the meetings are attached at Appendix B.

	Draft work programme 2015/16 A draft work programme is attached (Appendix C) which is structured around the main areas of responsibility in the Terms of Reference. The Committee should consider whether there are any other items it would like to include on the work plan. The Committee will review the work plan on a regular basis throughout the year.
4.	**IMPLICATIONS**
	Relevant implications are discussed in the other sections of this report.
5.	**RISKS TO THE CLINICAL COMMISSIONING GROUP**
	If the Primary Care Commissioning Committee does not function in accordance with its terms of reference there is a risk that it will not be able to demonstrate to the Governing Body, CCG membership, NHS England, and other stakeholders that it: • has effectively discharged the powers and responsibilities delegated to it in the delegation agreement • has conducted its business transparently and in accordance with CCG policy and statutory guidance in respect of Conflicts of Interest • has ensured the resources delegated to it have used economically, efficiently, and effectively • has contributed to the delivery of the CCG's commissioning priorities • has made arrangements to ensure GP practices in Barnsley have achieved the required standards of quality and patient safety have been achieved in the delivery.
6.	**CONSULTATION**
	The Primary Care Commissioning Committee will ensure that there is full and transparent consideration of all matters in its remit, for example: • Its meetings will be held in public • It will be Chaired by the Lay Member for Patient and Public Engagement • A representative from Healthwatch Barnsley, and a local authority member of the Health and Wellbeing Board, will attend meetings in a non voting capacity • Its minutes will go to the public meetings of the Governing Body • Formal public consultation around specific proposals will be undertaken as necessary.
7.	**APPENDICES TO THE REPORT**
	• Terms of Reference (Appendix A) • Proposed schedule of dates for the Committee (Appendix B) • Work programme for the year (Appendix C
8.	**CONCLUSION**
	The arrangements outlined above will support the Primary Care Commissioning Committee in fulfilling its Terms of Reference and operating effectively and transparently.

NHS
Barnsley Clinical Commissioning Group
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Primary Care Commissioning Committee

Terms of Reference

April 2015

Terms of Reference – NHS Barnsley CCG Primary Care Commissioning Committee

Introduction

1. Simon Stevens, the Chief Executive of NHS England, announced on 1 May 2014 that NHS England was inviting CCGs to expand their role in primary care commissioning and to submit expressions of interest setting out the CCG's preference for how it would like to exercise expanded primary medical care commissioning functions. One option available was that NHS England would delegate the exercise of certain specified primary care commissioning functions to a CCG.

2. In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHS England has delegated the exercise of the functions specified in Schedule 2 to these Terms of Reference to NHS Barnsley CCG. The delegation is set out in Schedule1.

3. The CCG has established the NHS Barnsley CCG Primary Care Commissioning Committee ("Committee"). The Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers.

4. It is a committee comprising representatives of the following organisations:
    - NHS Barnsley CCG;
    - Healthwatch Barnsley (non-voting attendee);
    - Barnsley Metropolitan Borough Council (non-voting attendee).

Statutory Framework

5. NHS England has delegated to the CCG authority to exercise the primary care commissioning functions set out in Schedule 2 in accordance with section 13Z of the NHS Act.
6. Arrangements made under section 13Z may be on such terms and conditions (including terms as to payment) as may be agreed between the Board and the CCG.
7. Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the CCG acknowledges that in

exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:

a) Management of conflicts of interest (section 14O);

b) Duty to promote the NHS Constitution (section 14P);

c) Duty to exercise its functions effectively, efficiently and economically (section 14Q);

d) Duty as to improvement in quality of services (section 14R);

e) Duty in relation to quality of primary medical services (section 14S);

f) Duties as to reducing inequalities (section 14T);

g) Duty to promote the involvement of each patient (section 14U);

h) Duty as to patient choice (section 14V);

i) Duty as to promoting integration (section 14Z1);

j) Public involvement and consultation (section 14Z2).

8. The CCG will also need to specifically, in respect of the delegated functions from NHS England, exercise those set out below:

- Duty to have regard to impact on services in certain areas (section 13O);
- Duty as respects variation in provision of health services (section 13P).

9. The Committee is established as a committee of the Governing Body of NHS Barnsley CCG in accordance with Schedule 1A of the “NHS Act”.

10. The members acknowledge that the Committee is subject to any directions made by NHS England or by the Secretary of State.

Role of the Committee

11. The Committee has been established in accordance with the above statutory provisions to enable the members to make collective decisions on the review, planning and procurement of primary care services in Barnsley, under delegated authority from NHS England.

12. In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and NHS Barnsley CCG, which will sit alongside the delegation and terms of reference.

13. The functions of the Committee are undertaken in the context of a desire to promote increased co-commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers.

14. The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act.

15. This includes the following:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on 'discretionary' payment (e.g., returner/retainer schemes).

16. The CCG will also carry out the following activities:

a) To plan, including needs assessment, primary medical care services in Barnsley;

b) To undertake reviews of primary medical care services in Barnsley;

c) To co-ordinate a common approach to the commissioning of primary care services generally;

d) To manage the delegated allocation for commissioning of primary medical care services in Barnsley

e) To manage other primary care investments in accordance with the CCG's annual Commissioning Plan and supporting Financial Plan

f) To obtain and provide to the Governing Body assurance regarding the quality and safety of primary medical care services in Barnsley

g) Management of complaints regarding primary care medical services in Barnsley.

Geographical Coverage

17. The Committee will comprise the NHS Barnsley CCG.

Membership

18. The Committee shall consist of:

Lay / Executive Members:

- Lay Member for Patient and Public Engagement and Primary Care Commissioning (Chair)
- Lay Member for Governance (Vice Chair)
- Chief Officer
- Chief of Corporate Affairs

Elected Practice Representatives:

- Chair of the Governing Body
- Medical Director
- One other elected member of the Governing Body

(The list of members is included as Schedule 3).

19. In addition to the people stated above, a representative of Healthwatch Barnsley, a Local Authority representative of the Health and Wellbeing Board, and other attendees (as necessary) will be invited to attend meetings and participate in the decision making discussions of the Primary Care Commissioning Committee in a non-voting capacity.

20. The Chair of the Committee shall be the Lay Member for Patient and Public Engagement and Primary Care Commissioning. The holder of this post is appointed for a period of 3 years under a process overseen by the Remuneration Committee in accordance with best guidance.

21. The Vice Chair of the Committee shall be the Lay Member for Governance. The holder of this post is appointed for a period of 3 years under a process overseen by the Remuneration Committee in accordance with best guidance.

22. There will be a standing invitation to a HealthWatch Barnsley representative and a Local Authority representative of the Health and Wellbeing Board to attend the Committee as non-voting attendees.

Meetings and Voting

23. The Committee will operate in accordance with the CCG's Standing Orders. The Secretary to the Committee will be responsible for giving notice of meetings. This will be accompanied by an agenda and supporting papers and sent to each member representative no later than 5 working days before the date of the meeting. When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as s/he shall specify.

24. Each member of the Committee shall have one vote. The Committee shall reach decisions by a simple majority of members present, but with the Chair or Vice Chair having a second and deciding vote, if necessary. However, the aim of the Committee will be to achieve consensus decision-making wherever possible.

Quorum

25. No meeting of the Committee shall be held without a minimum of four members present (excluding non-voting attendees), including either the Chair or Vice Chair, and with the lay and executive majority maintained. The Committee may call on additional lay members or CCG members when required, for example where the Committee would not be quorate because of conflicts of interest.

25. An Officer in attendance but without formal acting up status may not count towards the quorum.

Administration

26. Secretarial support for the Committee will be provided by the CCG's administration function, overseen by the Chief of Corporate Affairs.

Frequency and conduct of meetings

27. The Committee will meet on a monthly basis and more frequently as required, either by circumstances, the Governing Body or the Committee.

28. Meetings of the Committee shall:
    a) be held in public, subject to the application of 28(b);

    b) the Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

29. Members of the Committee have a collective responsibility for the operation of the Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

30. The Committee may delegate tasks to such individuals, sub-committees or individual members as it shall see fit, provided that any such delegations are consistent with the parties' relevant governance arrangements, are recorded in a scheme of delegation, are governed by terms of reference as appropriate and reflect appropriate arrangements for the management of conflicts of interest.

31. The Committee may call additional experts to attend meetings on an ad hoc basis to inform discussions.

32. Members of the Committee shall respect confidentiality requirements as set out in the CCG's Confidentiality Code of Conduct.

33. The Committee will present its minutes to NHS England (North) area team of NHS England and the governing body of NHS Barnsley CCG each month for information, including the minutes of any sub-committees to which responsibilities are delegated under paragraph 30 above.

34. The CCG will also comply with any reporting requirements set out in its constitution.

35. These Terms of Reference will be reviewed annually, reflecting the experience of the Committee in fulfilling its functions. NHS England may also issue revised model terms of reference from time to time.

Accountability of the Committee

36. The Committee will make collective decisions on the review, planning and procurement of primary care services in Barnsley, including functions under delegated authority from NHS England. The Committee will manage the delegated allocation for commissioning of primary care services in Barnsley, together with other primary care investments in accordance with the CCG's annual Commissioning Plan and supporting Financial Plan.

37. The Committee will operate in such a way as to ensure appropriate consultation and engagement takes place with members of the public. For example:
    - The Committee will be Chaired by the Lay Member for Patient and Public Engagement
    - It will be attended by a representative of Healthwatch Barnsley
    - Meetings will be held in public (subject to the application of paragraph 28(b) above)
    - The minutes of every meeting will be taken to a public meeting of the Governing Body of NHS Barnsley CCG except where those minutes record Committee business conducted in private.

Procurement of Agreed Services

38. The CCG will make procurement decisions as relevant to the exercise of its delegated authority and in accordance with the detailed arrangements regarding procurement set out in the delegation agreement. In doing so the CCG will comply with public procurement regulations and with statutory guidance on conflicts of interest.

Decisions

39. The Committee will make decisions within the bounds of its remit.

40. The decisions of the Committee shall be binding on NHS England and NHS Barnsley CCG.

41. The Committee will produce an executive summary report which will be presented to NHS England (North) area team of NHS England and the governing body of NHS Barnsley CCG at least quarterly for information.
42. As soon as practicable after the end of each Financial Year the CCG must provide to NHS England a report on how the CCG has exercised the Delegated Functions during the previous Financial Year.

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~~[Signature provisions]~~

~~[~~Schedule 1 – Delegation~~ to be added when final arrangements confirmed]~~

The CCG and NHS England signed the Delegation Agreement on 26 March 2015. The Agreement became effective on 1 April 2015. The Agreement sets out the arrangements that apply in relation to the exercise of the Delegated Functions by the CCG.

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~~[~~Schedule 2 – Delegated functions~~ to be added when final arrangements confirmed]~~

NHS England has delegated to NHS Barnsley CCG the following functions relating to the commissioning of primary medical services under section 83 of the NHS Act:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on 'discretionary' payment (e.g., returner/retainer schemes).

Delegated commissioning arrangements will exclude individual GP performance management (medical performers' list for GPs, appraisal and revalidation). NHS England will also be responsible for the administration of payments and list management.

~~[~~Schedule 3 - List of Members ~~to be added when confirmed]~~

Lay / executive members:

- Lay Member for Patient and Public Engagement and Primary Care Commissioning (Chair)
- Lay Member for Governance (Vice Chair)
- Chief Officer
- Chief of Corporate Affairs

Elected Governing Body members:

- Chair of the Governing Body
- Medical Director
- One other elected member of the Governing Body

In addition to the people stated above, a representative of Healthwatch Barnsley, a Local Authority representative of the Health and Wellbeing Board, and other attendees (as necessary) will be invited to attend meetings and participate in the decision making discussions of the Primary Care Commissioning Committee in a non-voting capacity.

Primary Care Commissioning Committee meeting dates 2015

The Committee will meet on the last Thursday of the month.

- 30 April 2015 9.30am – 11.30am
- 28 May 2015 1pm – 3pm (falls within Barnsley, Rotherham, Sheffield & Doncaster School holidays)
- 25 June 2015 9.30am – 11.30am
- 30 July 2015 1pm – 3pm (falls within Barnsley, Rotherham, Sheffield & Doncaster School holidays)
- 27 August 2015 1pm – 3pm (falls within Barnsley, Rotherham, Sheffield & Doncaster School holidays)
- 24 September 2015 1pm – 3pm
- 29 October 2015 2.30pm – 4.30pm (falls within Barnsley, Rotherham, Sheffield & Doncaster School holidays)
- 26 November 2015 1pm – 3pm
- 17 December 2015 1pm – 3pm

PRIMARY CARE CO-COMMISSIONING COMMITTEE
ASSURANCE WORK PLAN/AGENDA TIMETABLE 2015/2016

AGENDA ITEMS	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
STANDING AGENDA ITEMS												
Declarations of Interest	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Questions from the Public	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minutes of previous meeting	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Matters Arising Report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
QUALITY, FINANCE, AND PERFORMANCE												
Integrated Finance and Performance Report		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Primary Care Patient Safety and Experience Reports (inc complaints, serious incidents etc)												
Care Quality Commission Update	✓											
STRATEGY, PLANNING, NEEDS ASSESSMENT AND COORDANATION OF PRIMARY CARE												
Transformation Strategy updates (as required)												
Premises approvals process	✓											
Primary medical care service reviews (as required)												

AGENDA ITEMS	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Consultation and engagement exercises (as required)												
CONTRACTING, INVESTMENT AND PROCURMENT DECISIONS												
Contract Monitoring Update		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Equitable Funding in Primary Medical Services	✓											
LES, DES, local incentive schemes (as required)												
Individual practice proposals (eg mergers, boundary changes, GP choice) (as required)	✓											
Review of primary care business cases, investments, and procurements (as required)												
Reprocurement of APMS Practices (as required)												
GOVERNANCE, RISK, AND ASSURANCE												
Assurance Framework and Risk Register	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Terms of Reference	✓											✓
Updating of Work Plan / Agenda Timetable	✓			✓			✓			✓		
Review of Committee's effectiveness						✓						✓

AGENDA ITEMS	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
COMMITTEE REPORTS AND MINUTES												
Primary Care Programme & Transition Board Updates	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minutes of other groups and meetings TBC												
REPORTING THE WORK OF THE COMMITTEE												
Matters for highlights / escalation report to the Governing Body	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Quarterly executive summary report to NHS England				✓			✓			✓		✓
Committee self certification for NHSE assurance process				✓			✓			✓		
Committee Annual Report												✓

KEY	
Cells shaded blue	Documents providing assurance
Cells shaded Red	Documents requiring decision

NHS
Barnsley Clinical Commissioning Group
Putting Barnsley People First

PRIMARY CARE COMMISSIONING COMMITTEE

30 April 2015

Risk Register

1.	**PURPOSE OF THE REPORT**
	To provide the Primary Care Commissioning Committee with a register of its key risks.
2.	**EXECUTIVE SUMMARY**
	In common with all committees of the CCG it is proposed that the Primary Care Commissioning Committee receives and reviews at every meeting extracts of the Corporate Risk Register providing details of the risks allocated to the Committee for monitoring and updating. A register of risks relating to Primary Care Commissioning was prepared and submitted with the CCG's application for delegated responsibility in January 2015. This register identified and scored the risks as they were then perceived and included some which were relevant specifically to the application process. This register has been reviewed and updated so that it now includes the key risks the CCG faces in carrying out its delegated responsibilities going forward (see Appendix A).
3.	**THE COMMITTEE IS ASKED TO:** Review the draft risk register attached and: • Consider whether the risks identified are appropriately described and scored • Consider whether there are other risks which need to be included • Authorise the Chief of Corporate Affairs to incorporate the risks within the CCG's Corporate Risk register.

Agenda time allocation for report:	10 minutes

Report of: Vicky Peverelle

Designation: Chief of Corporate Affairs

Report Prepared by: Richard Walker

Designation: Head of Assurance

1.	**SUPPORTING INFORMATION**	
1.1	**Links to the Assurance Framework**	
	The report is especially relevant to the following risks on the Gb Assurance Framework: 2.1 and 5.2.	
1.2	**Links to Objectives**	
	To have the highest quality of governance and processes to support its business	✓
	To commission high quality health care that meets the needs of individuals and groups	
	Wherever it makes safe clinical sense to bring care closer to home	
	To support a safe and sustainable local hospital, supporting them to transform the way they provide services so that they are as efficient and effective as possible for the people of Barnsley	
	To develop services through real partnerships with mutual accountability and strong governance that improve health and health care and effectively use the Barnsley £.	
1.3	**Governance Arrangements Checklist**	**Has the area been considered (yes / no / not relevant)?**
	Financial Implications	Not relevant
	Contracting Implications	Not relevant
	Quality	Not relevant
	Consultation / Engagement	Not relevant
	Equality and Diversity	Not relevant
	Information Governance	Not relevant
	Environmental Sustainability	Not relevant
	Human Resources	Not relevant

PRIMARY CARE COMMISSIONING COMMITTEE RISK REGISTER

Domains
1. Adverse publicity/ reputation
2. Business Objectives/ Projects
3. Finance including claims
4. Human Resources/ Organisational Development/ Staffing/ Competence
5. Impact on the safety of patients, staff or public (phys/psych)
6. Quality/ Complaints/ Audit
7. Service/Business Interruption/ Environmental Impact
8. Statutory Duties/ Inspections

Likelihood		Consequence		Scoring Description			Current Risk No's	Review
Almost Certain	5	Catastrophic	5	Red	Extreme Risk	(15-25)	4	Monthly
Likely	4	Major	4	Amber	High Risk	(8- 12)	13	3 mthly
Possible	3	Moderate	3	Yellow	Moderate Risk	(4 -6)	15	6 mthly
Unlikely	2	Minor	2	Green	Low Risk	(1-3)	3	Yearly
Rare	1	Negligible	1					
				Total = Likelihood x Consequence				

The initial risk rating is what the risk would score if no mitigation was in place. The residual/current risk score is the likelihood/consequence (impact) of the risk sits when mitigation plans are in place

			Initial Risk Score						Residual Risk Score					
Ref	**Domain**	**Risk Description**	**Likelihood**	**Consequence**	**Score**	**Mitigation/Treatment**	**Lead Owner of the risk**	**Source of Risk**	**Likelihood**	**Consequence**	**Score**	**Date Risk Assessed**	**Progress/ Update**	**Date for re-assessment**
PCC/ 1		If the CCG is unable to secure sufficient operational & strategic capacity to fulfil the delegated functions this may impact on the ability of the CCG to deliver its existing delegated statutory duties, for instance in relation to quality, financial resources and public participation.	**3**	**5**	**15**	CCG considered its strategic capacity & capability as part of the successful application process. The CCG has access to existing primary care commissioning resource within the Area Team under the RASCI agreement. In addition the CCG is recruiting a Head of Quality for Commissioning Primary Medical Services. The CCG is undertaking a review of management capacity including delegated responsibilities.	VP PCCC	Risk Assessment	**2**	**3**	**6**	04/15		10/15

			Initial Risk Score						Residual Risk Score					
Ref	**Domain**	**Risk Description**	**Likelihood**	**Consequence**	**Score**	**Mitigation/Treatment**	**Lead Owner of the risk**	**Source of Risk**	**Likelihood**	**Consequence**	**Score**	**Date Risk Assessed**	**Progress/ Update**	**Date for re-assessment**
PCC/ 2		If the CCG does not effectively discharge its delegated responsibility for contract performance management there is a risk that the CCG's reputation and relationship with its membership could be damaged.	**3**	**4**	**12**	The CCG has access to existing primary care commissioning resource within the Area Team under the RASCI agreement. The CCG will seek to integrate Area team resources to ensure that the role is carried out consistently with the CCG's culture & approach. The CCG is also undertaking a review of management capacity which will incorporate proposed delegated responsibilities. The CCG has an open channel of communication with the Membership Council regarding commissioning and contracting arrangements (eg equalisation).	VP PCCC	Risk Assessment	2	4	**8**	04/15		07/15

			Initial Risk Score						Residual Risk Score					
Ref	**Domain**	**Risk Description**	**Likelihood**	**Consequence**	**Score**	**Mitigation/Treatment**	**Lead Owner of the risk**	**Source of Risk**	**Likelihood**	**Consequence**	**Score**	**Date Risk Assessed**	**Progress/ Update**	**Date for re-assessment**
PCC/ 3		There is a risk that if the CCG does not effectively engage with the public, member practices and other stakeholders on matters relating to the delegated commissioning of primary care (including redesign of service delivery), the CCG's reputation with its key stakeholders could therefore be affected.	**2**	**3**	**6**	The CCG has a well-established and effective PPE function currently commissioned from CSU, as well as robust governance supporting the function. Arrangements going forward are being reviewed. The existing primary care commissioning resource and expertise within the Area Team can be accessed by the CCG. The CCG considered its strategic capacity & capability as part of the successful application process.	VP PCCC	Risk Assessment	1	3	**3**	04/15		04/16

			Initial Risk Score						Residual Risk Score					
Ref	**Domain**	**Risk Description**	**Likelihood**	**Consequence**	**Score**	**Mitigation/Treatment**	**Lead Owner of the risk**	**Source of Risk**	**Likelihood**	**Consequence**	**Score**	**Date Risk Assessed**	**Progress/ Update**	**Date for re-assessment**
PCC/ 4		If the CCG is unable to deliver the delegated responsibilities within the financial allocation provided for this purpose there is a risk to the CCG's ability to make investments during 2015/16 and to the delivery of its statutory financial duties	**5**	**5**	**25**	Assurances were received as to the sufficiency of the financial allocation during the application process. A designated financial representative from the CCG will support ongoing management of the budget. Regular network meetings will be held with NHSE. The financial position will be routinely reported to the PCCC going forward.	VP PCCC	Risk Assessment	**2**	**5**	**10**	04/15		07/15
PCC/ 5		If the CCG does not comply in a fully transparent way with the statutory Conflicts of Interest guidance issued in December 2014 there is a risk of reputational damage to the CCG and of legal challenge to the procurement decisions taken.	**3**	**3**	**9**	Conflicts of Interest Policy updated. Register of Interests extended to incorporate GP practice staff. Declarations of interest to be tabled at start of every meeting to enable updating. PCCC has Lay Chair and Lay & Exec majority.	VP PCCC	Risk Assessment	**2**	**3**	**6**	04/15		10/15

			Initial Risk Score						Residual Risk Score					
Ref	**Domain**	**Risk Description**	**Likelihood**	**Consequence**	**Score**	**Mitigation/Treatment**	**Lead Owner of the risk**	**Source of Risk**	**Likelihood**	**Consequence**	**Score**	**Date Risk Assessed**	**Progress/ Update**	**Date for re-assessment**
						Register of Procurement decisions to be established to record how any conflicts have been managed. Guidance to be provided to minute takers on recording decisions re managing conflicts of interest.								