NHS
Harrogate and Rural District
Clinical Commissioning Group

PROCUREMENT POLICY
FOR HEALTHCARE SERVICES
June 2015

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POLICY AMENDMENTS

Amendments to the Policy will be issued from time to time. A new amendment history will be issued with each change.

New Version Number	Issued by	Nature of Amendment	Approved by and Date	Date on Intranet
1.0		New Policy	HaRD CCG Senior Management Team – 22 June 2015	03 July 2015

CONTENTS

1 Introduction

Since the election of the Coalition government in 2010 and the Health and Social Care Act 2012, the National Health Service is going through its biggest restructure since its creation in 1948. The abolition of Primary Care Trusts on 31 March 2013 and the introduction of Clinical Commissioning Groups (CCGs) on 01 April 2013 transferred the commissioning and procurement responsibility of Healthcare (clinical) services to CCGs.

The National Strategy is to empower CCGs to commission Healthcare services for the local population working in partnership with the Local Authority, the Health and Wellbeing Board, voluntary sector, local health providers and the NHS Commissioning Board to deliver care closer to home, increase patient choice and deliver an improved quality of care whilst maintaining the current levels of expenditure.

The publication of NHS Harrogate and Rural District CCG's (HaRD CCG) (hereafter referred to as the CCG) Strategic Plan (2014/15 to 2018/19)[1] outlines the CCG's vision that by 2020 the population :

- are physically and mentally healthy and are independent for as long as possible, have the support to manage their long term conditions and mental health and receive care when they are ill by the right person at the right time in the right place and return to independence as quickly as possible
- have positive experiences from high quality, safe integrated health and social care services, irrespective of the day or time of the week and access to high quality cost effective elective care
- differences in health outcomes between population groups are minimised
- health and social care resources are sustainable

To achieve these goals the CCG will focus on the following six priority areas :

1. Urgent care
2. Long term conditions
3. Vulnerable people and mental health
4. Elective care
5. Health and Wellbeing
6. Primary care

In order to achieve these goals the CCG will follow the guidance and policy documents below when considering procurement decision making:

- The NHS (Clinical Commissioning Group) Regulation 2012 no. 1631 (2012),
- Securing best value for NHS patients (2012),
- Procurement briefings for Clinical Commissioning Groups (2012),
- Procurement Guide for commissioners of NHS-funded services (2012),
- Health and Social Care Act (2012)
- Social Value Act (2012
- The National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations (2013)

[1] http://www.harrogateandruraldistrictccg.nhs.uk/data/uploads/publications/hard_strat_plan_final_june2014.pdf

- Monitor's Substantive Guidance on the Procurement, Patient Choice and Competition Regulations (2014)
- Managing Conflicts of Interest: Statutory Guidance for CCGs (2014)
- The Public Contracts Regulations (2015); (currently in draft form, to be enacted into UK legislation in 2015)

This Procurement Policy document will also inform, and be informed by :

- NHS Harrogate and Rural District Clinical Commissioning Group Constitution
- NHS Harrogate and Rural District Clinical Commissioning Group Standing Orders
- NHS Harrogate and Rural District Clinical Commissioning Group Prime Financial Policies
- NHS Five Year Forward View (2014)

In the context of the local and national agenda, and recognising significant improvements already made to delivery, service quality and outcomes, a "business as usual" approach to the commissioning of healthcare services will fail to secure better outcomes and value for money. Changes to the roles of hospitals, and a shift to primary care leading and delivering more services in a community based setting, will require the CCG to work closely with all providers, including new providers and the voluntary sector.

In line with the Procurement Guide and The National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations (2013), the CCG will need to decide if a project for a Healthcare (clinical) service should be tendered, taking into consideration the estimated value of the contract, level of market interest and capability, government policy on protected services and if there is a reason that competition is not appropriate in a particular circumstance.

Once the decision is taken to procure by competitive tender the CCG will need to establish an agreed process which sets out the principles, rules and methods the CCG will work to. This policy clearly outlines how and when it is appropriate to seek to introduce contestability and competition as methods to help to define the most beneficial and cost effective modes of delivery.

Generating momentum, delivery of completed projects, and stakeholder engagement are key. Rigorous and transparent processes will deliver affordable services within defined timescales. The CCG will develop the local health economy in Harrogate and the surrounding area by encouraging new providers and supporting local and existing providers so they can participate fully. A vibrant marketplace for healthcare provision will encourage innovation, drive up quality, and allow the CCG to clearly demonstrate value for money.

2 Principles and Practice EU Principles and Criteria

- The EU Treaty and various Directives on procurement require competition as a mechanism by which contracting authorities ensure equality of treatment, transparency and non-discrimination for providers in any given market. Nevertheless, it remains for each contracting authority to decide whether a formal tender is required for healthcare services.
- the CCG will consider the following criteria when deciding whether to procure services by inviting competitive tenders :

- estimated values of contract
- level of market interest and capability (and potential for innovation)
- government policy on protected service
- circumstances under which competition is not appropriate
- quality of service provided by existing providers

3 EU Directive

The EU Directive has two levels of application – a full regime for services designated as Part A where the value of the Part A contract exceeds the relevant threshold and a lighter regime for other services designated as Part B. The table below illustrates how the regulations apply to Part A and Part B services.

The Public Contract Regulations (2015) remove the distinction between Part A and Part B services however the categorisation of Healthcare (clinical) services will fall under the new 'Light Touch' regime. This will come into effect on 18 April 2016 until which time the current Part B guidance should be followed.

Table 1: Requirements

	Part A	Part B
Sufficient degree of advertising to satisfy the principles of transparency, non-discrimination, and equality of treatment	X	X
Tender advertised in the Official Journal of the European Union	X	X
Compliance with specified minimum timescales for providers to respond to adverts, pre-qualification checks and tenders	X	
Competitive dialogue or negotiated procedure allowed only in specified circumstances	X	X
Detailed rules on selection and award criteria; contracts awarded either on the basis of the most economically advantageous offer (but note: award criteria must still be fair and non-discriminatory in the case of Part B contracts)	X	
Provision of feedback to unsuccessful providers and standstill requirement after contract award and prior to contract execution	X	X
Issue of contract award notice to European Commission within 48 days of award	X	X
Collation of relevant statistical data	X	X

To comply with the requirement for transparency, non-discrimination and equality of treatment, the CCG can adopt approaches required for Part A services when tendering for healthcare (clinical) service and should take proportionate and appropriate action to ensure a fair playing field among providers.

4 NHS Principles

The NHS Principles are outlined in National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations (2013) and Monitor's Substantive guidance on the Procurement, Patient Choice and Competition Regulations (2014). The key deliverables are :

(a) securing the needs of the people who use the services,

(b) improving the quality of the services, and

(c) improving efficiency in the provision of the services

Table 2 below highlights the procurement principles for all the CCG's procurement exercises which incorporates both EU treaty and NHS principles.

Table 2 :

Procurement Principles
1. All procurements will comply with the CCG's vision, values and principles, along with the requirements of its Prime Financial Policies and Standing Orders.
2. All procurement processes and outcomes will be affordable, viable and represent value for money, and will result in safe, fair, sustainable, quality, efficient and effective services for patients.
3. All procurements will comply with the requirements of the Public Contract Regulations (2015), where they apply.
4. The CCG will run all projects in line with the following EU treaty principles : a. Transparent – this includes transparency of what is to be competitively tendered, and of the tender process itself, including criteria for evaluation; including the use of sufficient and appropriate advertising of tenders, transparency in making decisions not to tender, and the declaration and separation of conflicts of interest in compliance with 'Managing Conflicts of Interest: Statutory Guidance for CCGs (2014)'. b. Proportional – Competitive tenders and procurement exercises will be scaled and appropriate to the size and complexity of the project. The costs of procurements both for the CCG and potential providers will be minimised wherever possible; making procurement processes proportionate to the value, complexity and risk of the services contracted, and critically not excluding potential providers through overly bureaucratic or burdensome proceedings. c. Objective – decisions to competitively tender will be evidence based where possible, evaluation criteria will be clearly defined, and award of contracts will be based on merit. d. Non-discriminatory – the nature of any procurement will not prevent any provider from participating, and the CCG will ensure a level playing field. All procurements will take full account of the CCG's policies on equality and diversity.
5. The CCG will publish its policies and processes for procurements and will ensure that all procurements are compliant with the principles described within.
6. All procurements will ensure that all providers in all sectors have equal opportunity to compete where appropriate; that financial and due diligence checks apply equally and are proportionate; and that pricing and payment regimes are transparent and fair.

7.	In undertaking a procurement exercise, consideration will be given to the impact on service stability.
8.	Procurements will take into account the needs and views of patients and the public and other stakeholders.
9.	The CCG will adopt an approach to pricing for services that is objective, transparent, and consistent with the PbR Code of Conduct.
10.	Any procurement process managed by, or on behalf of the CCG will include the creation of a register of potential conflicts of interest. All contributors to the process, including specification drafting/input, financial modelling, procurement, project management and commissioning, will be required to sign a declaration of interest form. Any potential, perceived or actual conflict will be referred to the Governing Body.
11.	The CCG will maintain a procurement decision register highlighting • the details of the decision; • who was involved in making the decision (i.e. Governing Body or committee members and others with decision-making responsibility); and • a summary of any conflicts of interest in relation to the decision and how this was managed by the Clinical Commissioning Group. This will be made available on the Clinical Commissioning Group's website and on request at the CCG's headquarters.

5 Deciding whether to use the Competitive Tender Process

The following four criteria should be considered:

Estimated Value of the contract

- The greater the value, the stronger the case for advertising the competitive tender. The process is shown in Diagram 1.

Level of market interest and capability

- The larger the number of potential providers the stronger the case for advertising the tender. This could override considerations based on the value of the contract.

Government Policy on Protected services

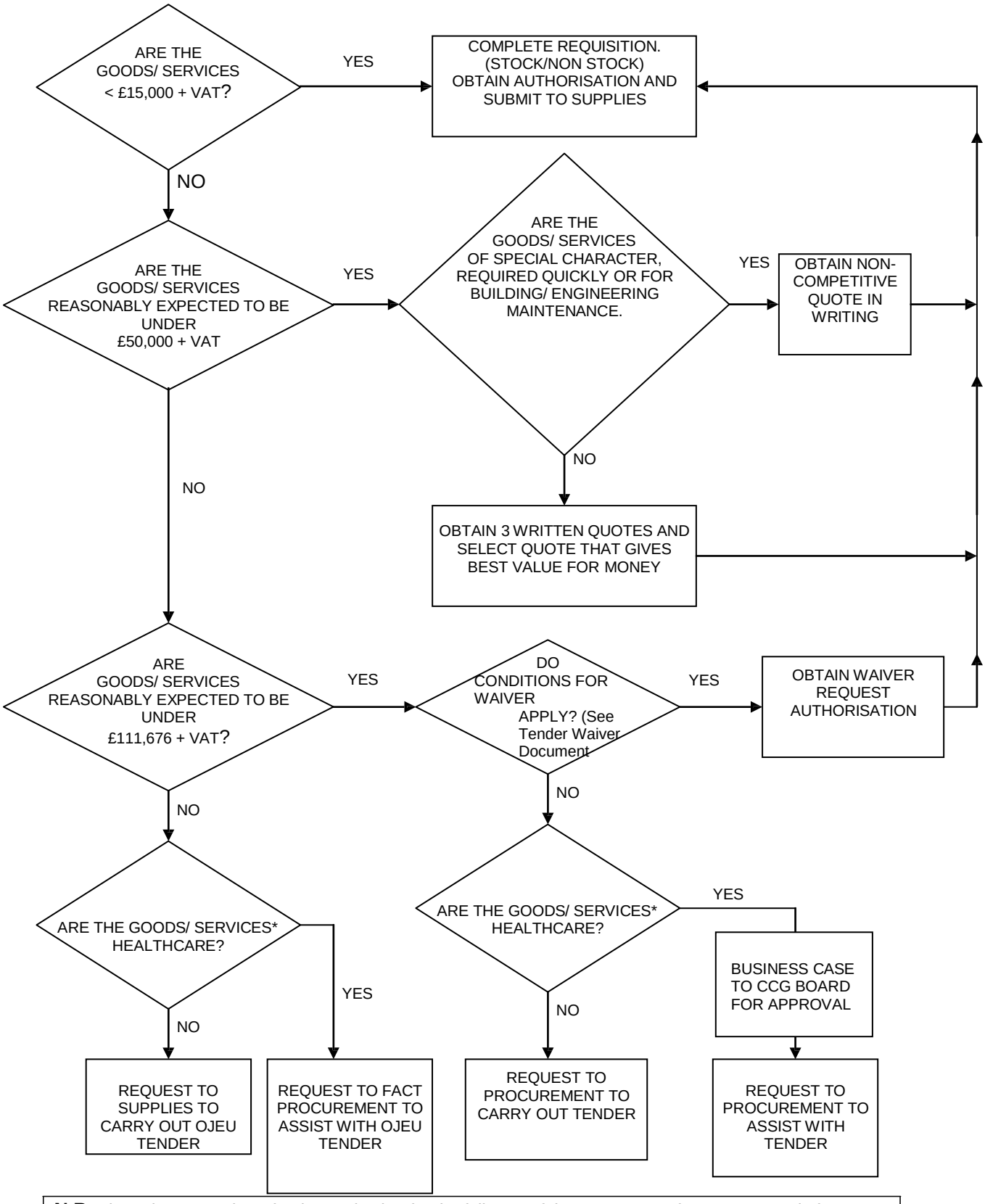
- A tender waiver is possible where the CCG can demonstrate that there is only one provider in the market who can deliver the service specification (this must not be used to protect providers that are not best placed to deliver the needs of their patients and population).

Is competition appropriate?

- Is there only one supplier capable of providing the service due to technical reasons or special or exclusive rights ?
- Do urgency considerations, due to factors beyond the CCG's control, preclude an advertised tender ?
- Are the services protected by monopoly rights in accordance with a legal or administrative instrument ?

The transparency principle imposes an obligation to carry out a sufficient level of advertising, but does not necessarily imply an obligation to conduct a formal tender procedure in full accordance with procurement rules. The CCG will assess local context and each circumstance, and decide whether a formal procurement is desirable on the grounds of demonstrating best value, maintaining some element of competitive tension and complying with the Public Contract Regulations (2015). Use of single tender actions and urgency exemptions will be avoided except where robust reasons can be given.

Diagram 1 - PROCESS TO IDENTIFY APPLICABLE PROCUREMENT ROUTE



N.B. The values stated are for the total value for the full term of the agreement. If an agreement is for more than one term/year and the full term value exceeds the stated value, the relevant process would apply.

* Includes the healthcare provision, services, devices and infrastructure associated with the provision of such. Non-healthcare included facilities, stationery, furniture, IT, telecoms etc.

6 CCG Process for Managing Major Procurements

This section seeks to establish an agreed process for managing service procurements undertaken by the CCG. The process will seek to ensure that there is a clear, consistent, fair and transparent approach to the process of procurement and contract award.

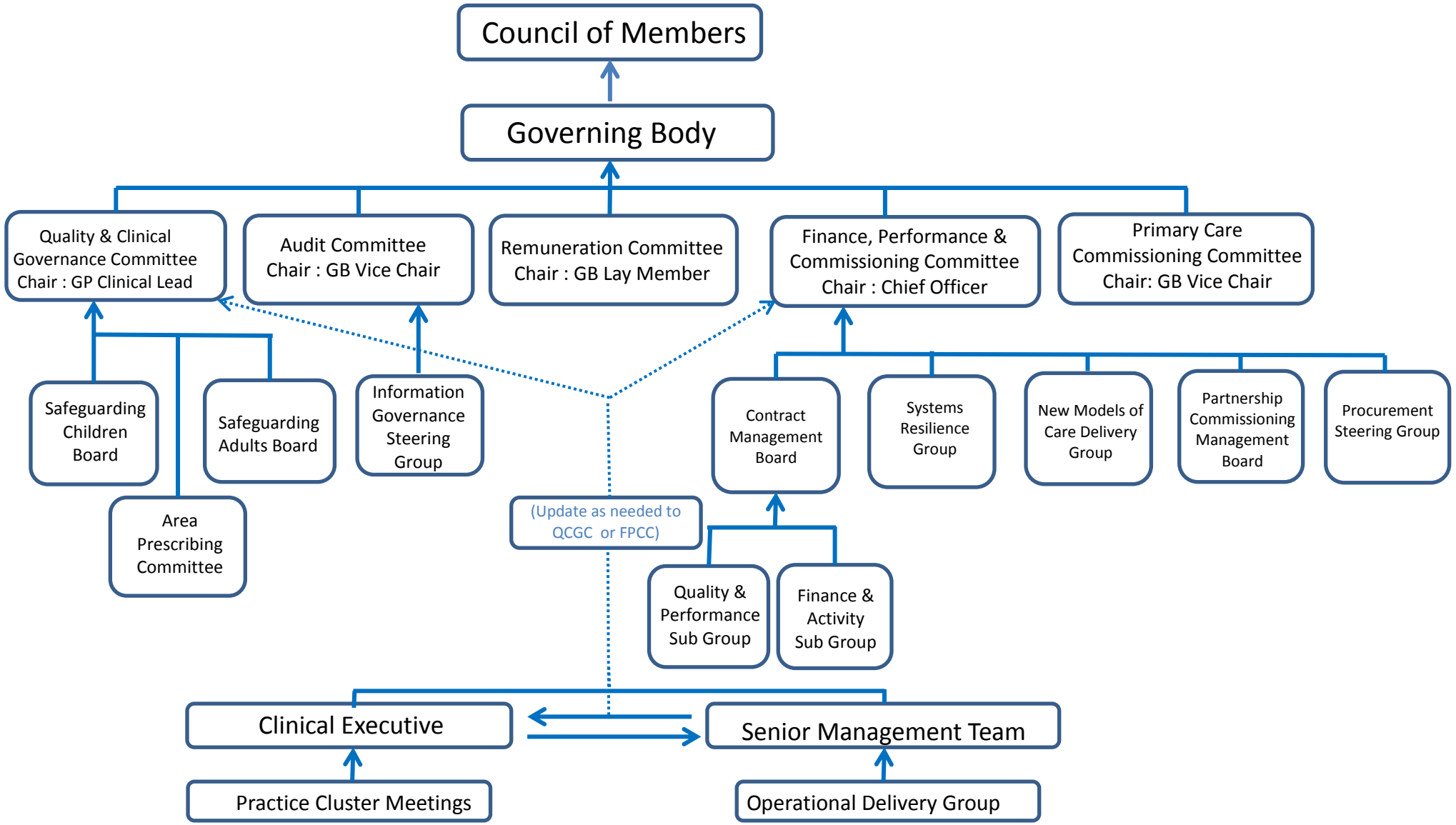
For all developments valued over £111,676 where competitive tendering is employed the following process will be implemented.

The Governance structure will operate at three levels shown in table 3:

Table 3. Governance Structures

Governance Structure		
Authorities : £1m+ - Governing Body £250,000 - £1m – FPCC Up to £250,000 – SMT Unless for Primary Care in which case procurement up to £1m - PCCC		
CCG Governing Body Members (excluding any member who may have a potential Conflict of Interest).	**CCG Governing Body**	Agree business cases over £1m and be informed of business cases approved under £1m. Agree procurement route, Endorse the decision on preferred bidder(s), Give authority to award the contract,
Procurement of Primary care services.	**Primary Care Co Commissioning Committee up to £1m.**	Agree business case, Agree procurement route, Endorse the decision on preferred bidder(s), Give authority to award the contract,
Chaired by the Chief Officer with Finance and Clinical representation. CCG Procurement representation will be available as and when required by the Chief Officer.	**Finance Performance & Commissioning Committee**	1. Monitor and assure work of procurement team 2. Establish: - project team - timeline - budget 3. Sign off: - short list of bidders - evaluation scoring criteria - recommendation to the board to appoint a preferred bidder - award of Contract 4. Assure the Board on the process
CCG Officers and Advisors	**Procurement Team CSU**	1. Manage the procurement, 2. Develop all tender documents, 3. Propose evaluation scoring, 4. Assist with the evaluation assessment and negotiate contract, 5. Prepare update and briefing reports for FPCC and Governing Body.

7 NHS Harrogate and Rural District Clinical Commissioning Group Governance Structure



CCG roles and responsibilities

Establish the strategic direction for service development	SMT
Agree the business case for the development (up to £1m) which will include : • Case of need • Priority outcomes for the scheme • Outline cost • Timescale for the process	FPCC or PCCC
Agree the procurement route for the service	FPCC
Receive recommendations from the project team on the preferred bidder and review the justification and evidence for that decision	FPCC
Award the contract	Contract Team
Receive regular progress reports on the development of the scheme	FPCC or PCCC
Monitor and assure the work of the project team, agreeing a clear timeline and budget for the project reporting regularly to the Governing Body through the Chief Officer	FPCC or PCCC
Approve the tender documentation submitted by the project team	SMT
Assess and approve the evaluation reports from the project team	SMT
Sign off the short list of bidders	FPCC
Receive monthly reports from the project team	SMT
Agree the evaluation scoring proposals for the scheme	SMT
Review the project team's preferred bidder recommendation prior to submission to the Governing Body	SMT➔FPCC or PCCC➔GB
Monitor the scheme progress and taken action to ensure the scheme is delivered on time and within budget	SMT

8 The Procurement Support Team responsibilities

The Procurement Support Team will be responsible for :

- Day to day management and delivery of the process
- Documentation drafting (all letters, tender documents, etc.)
- Communications with potential providers
- Clarifications and responses to bidders questions
- Assistance with the evaluation of proposals and recommendations to the FPCC or PCCC regarding short-listing
- Recommending the Preferred Bidder(s) and contract award(s) for FPCC or PCCC and Governing Body review and approval
- Internal and external communication and delivery

9 Procurement Steering Group

The Procurement Steering Group will consist of :

- Procurement Advisor
- Contract Lead
- Finance Lead
- Commissioning Lead

The Steering Group will be responsible for :

- Developing a Procurement Plan (see section 12 below)
- Developing the Market Development Plan (see section 15 below)
- Reporting to FPCC or PCCC as required

10 Procurement Project Groups

Procurement Project Groups will consist of :

- Project Lead / Manager
- Procurement Advisor
- Commissioning Lead (if not the Project Lead)
- Contract Lead
- Clinical Lead
- Finance Lead
- IM&T Representative
- HR Advisor
- Legal Advisor
- Evaluation Support

(As Required)

The Procurement Project Group will meet periodically (excluding the Legal Advisor, Evaluation Support, IM&T Representative and HR Advisor who would attend as required) and will for each meeting provide and issue the FPCC or PCCC with a summary, including :

- An updated procurement plan,
- Revised action plan,
- List minutes from the meeting,
- Risks and Issues log,
- Project Timeline,
- Short update report monthly to support above documentation.

11 Confidentiality and Conflicts of Interest

All procurement projects must comply with this Policy. To protect the integrity of the process, all stages of the process are to be treated as commercially sensitive/confidential, unless required by statute to disclose at any stage of the process. All members of the CSU Procurement Team, and the CCG's FPCC, PCCC and Governing Body who will be part of any disclosure will be asked to complete a Conflict of Interest Form and that any information they are party to will be treated as confidential and not discussed or disclosed outside of the forum it is disclosed within.

All members of the FPCC and Procurement Team will be either directly employed or subcontracted by the CCG or YHCS. Relevant processes will be established to ensure that there are no breaches of confidentiality

The Managing Conflicts of Interest: Statutory Guidance for CCGs Clinical Commissioning Group Policy on Conflict of Interest applies at all stages of the process.

12 Procurement Planning

A procurement plan will be maintained that will list all current and future procurements. The procurement plan will be reviewed on a regular basis taking into account local and national priorities; the CCG's commissioning intentions; requirements of the annual operating framework, and nationally mandated procurements. In addition it will take into account the impact of completed and ongoing procurements.

The plan will highlight the priority, timescale, risk and resource for each potential procurement. Not every priority on the procurement plan will result in a procurement, but indicates the intention of the CCG to review the service or activity which may result in a procurement.

The plan is a key element to provide communication between the CGG and providers. Through transparent and open processes, the CCG will actively encourage provider engagement at an early stage of any procurement, particularly in the case of review of existing services with existing providers.

The procurement plan will consider the issues in Table 2.

Table 2 - Considerations in Procurement Planning

Assess relevant markets	
What is the need?	Are new services required in terms of new treatments or additional and discrete new provision?
Market Structure	Assess local, regional and national markets in terms of where services are provided along current or desired patient pathways (vertical market structure). Assess the number of local and regional provider organisations and understand current market structure (horizontal market structure).
Competition	Assess behaviours that demonstrate competitive tension and responsiveness to patients and commissioner needs. Is there a case for introducing (more) competition to address choice, quality, efficiency or responsiveness?
Innovation	Assess developments in the market in other regions and international benchmarks.
Interest	Assess market interest in opportunities, transparently and without discrimination, including whether a contract may be of interest to a provider from a member state.
Evaluate existing contracts	
Performance	Analyse current provider's performance – are they meeting expectations and seeking quality improvements? Will a re-tender/new tender have a positive impact on the end user?
Efficiency	Are services being delivered efficiently? Is productivity in line with services delivered elsewhere including internationally?
Demand	Is demand being managed effectively?
Fitness	Are current contracts fit for purpose in light of future need and requirements?
Evaluate procurement options (especially in relation to market structure)	
Outcomes	Review outcomes from previous procurements, particularly of similar services and with regards to the size/structure/number of contracts and contract lots.
Attractiveness	Based on the market assessment and proposed risk-sharing arrangements. Determine the scale and attractiveness of the opportunity to providers (existing providers, existing or potential market).

'lots'	Assess whether the needs of the population would be best served by single or multiple contracts (Separate 'lots' are required in multiple tenders), and approaches to achieving seamless pathways of care.
Multi-source	The (AQP) multi-sourcing approach offers a number of potential benefits including: ▪ providing scope for continuing to exert a degree of competitive pressure between providers; ▪ access to a wider range of resources and approaches than might otherwise be possible, and to pilot or run with different approaches in parallel; and ▪ Continuous improvement.
Single-sources	The potential benefits of a single provider approach include: ▪ flexibility in bringing about business change; ▪ potential for servicing the entire requirement at a lower total cost than with multiple providers, through economies of scale; and ▪ Reduced contract management overheads.
Evaluate procurement routes	
Advice	Seek external advice) for help on the procurement routes.
Other	Determine other routes that are proportionate for the scale, complexity and risk associated with the services to be purchased and the market to be manager.

13 External Support and Advice

HaRD CCG has a contractual arrangement with Yorkshire and Humber Commissioning Support (YHCS) that will provide the Procurement support function and other support for the CCG.

Non-healthcare procurements are subject to the same rules and regulations as detailed in the CCG's Standing Orders and Official Journal of the European Union guidance. YHCS will assist the CCG in some non-healthcare procurement; this will be reviewed along with other service offers throughout the year.

14 Sustainable Procurement

The NHS is a major employer and economic force both in Harrogate and Rural District, and within the wider North of England region.

The CCG recognises the impact of its purchasing and procurement decisions on the regional economy, and the positive contribution it can make to economic and social regeneration of Harrogate and the surrounding area. The CCG is committed to the development of innovative local and regional solutions, and will deliver a range of activities as part of its market development plan to support this commitment.

Wherever it is possible, and does not contradict or contravene the CCG's procurement principles, the CCG will work to develop and support a sustainable local health economy, working with other public sector organisations to deliver innovative projects to the local population whilst developing the local supplier base.

15 Market Development Plan

A market development plan will be produced in conjunction with this Procurement Policy.

16 Public Involvement and Consultation

The CCG will ensure that it fulfils its statutory obligations under the Health and Social Care Act (2006) by :

- publishing it's two year strategic plan on the CCG's website,
- publishing annual commissioning intentions on the CCG's website and taking all reasonable measures to ensure this is published before the start of the financial year,
- publishing the Procurement Policy on the CCG's website,

Section 14Z2 also states that the CCG must:

…make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways) :

(a) in the planning of the commissioning arrangements by the group,

(b) in the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and

(c) in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

Appendix 1

1. Equality Impact Analysis	
Policy / Project / Function:	Procurement Policy for Healthcare Services HaRD 049
Date of Analysis:	02 June 2015
This Equality Impact Analysis was completed by: (Name and Department)	Phil Tolan Head of Procurement NHS Yorkshire and Humber Commissioning Support (YHCS)
What are the aims and intended effects of this policy, project or function?	
Please list any other policies that are related to or referred to as part of this analysis	
Who does the policy, project or function affect? Please Tick ✔	Employees ✓ Service Users ☐ Members of the Public ☐ Other (List Below) ✓ • CCG Members • Governing Body • Council of Members • Committee and sub-committee Members • Individuals contracted to work on behalf of or provide services or facilities to, the CCG.

2. Equality Impact Analysis: Screening

	Could this policy have a positive impact on…		Could this policy have a negative impact on…		Is there any evidence which already exists from previous (e.g. from previous engagement) to evidence this impact
	Yes	No	Yes	No	Considered – no impact
Race	☐	✓	☐	✓	Considered – no impact
Age	☐	✓	☐	✓	Considered – no impact
Sexual Orientation	☐	✓	☐	✓	Considered – no impact
Disabled People	☐	✓	☐	✓	Considered – no impact
Gender	☐	✓	☐	✓	Considered – no impact
Transgender People	☐	✓	☐	✓	Considered – no impact
Pregnancy and Maternity	☐	✓	☐	✓	Considered – no impact
Marital Status	☐	✓	☐	✓	Considered – no impact
Religion and Belief	☐	✓	☐	✓	Considered – no impact
Reasoning	This policy will have neither a positive nor negative impact on the protected characteristics as it relates to standards of business conduct which are applicable to everyone as outlined within the scope of the policy, regardless of status.				

If there is no positive or negative impact on any of the Nine Protected Characteristics go to Section 7

3. Equality Impact Analysis Findings				
Analysis Rating:	□ Red	□ Red / Amber	□ Amber	✓Green
		Actions	**Wording for Policy / Project / Function**	
Red **Stop and remove the policy**	**Red:** As a result of performing the analysis, it is evident that a risk of discrimination exists (direct, indirect, unintentional or otherwise) to one or more of the nine groups of people who share *Protected Characteristics.* It is recommended that the use of the policy be suspended until further work or analysis is performed.	**Remove the policy** Complete the action plan above to identify the areas of discrimination and the work or actions which needs to be carried out to minimise the risk of discrimination.	No wording needed as policy is being removed	
Red Amber **Continue the policy**	As a result of performing the analysis, it is evident that a risk of discrimination exists (direct, indirect, unintentional or otherwise) to one or more of the nine groups of people who share *Protected Characteristics.* However, a genuine determining reason may exist that could legitimise or justify the use of this policy and further professional advice should be taken.	**The policy can be published with the EIA** • List the justification of the discrimination and source the evidence (i.e. clinical need as advised by NICE). • Consider if there are any potential actions which would reduce the risk of discrimination. • Another EIA must be completed if the policy is changed, reviewed or if	As a result of performing the analysis, it is evident that a risk of discrimination exists (direct, indirect, unintentional or otherwise) to one or more of the nine groups of people who share *Protected Characteristics.* However, a genuine determining reason exists which justifies the use of this policy and further professional advice. ***[Insert what the discrimination is and the justification of the discrimination plus any actions which could help what reduce the risk]***	

		further discrimination is identified at a later date.	
Amber **Adjust the Policy**	As a result of performing the analysis, it is evident that a risk of discrimination (as described above) exists and this risk may be removed or reduced by implementing the actions detailed within the *Action Planning s*ection of this document.	**The policy can be published with the EIA** The policy can still be published but the Action Plan must be monitored to ensure that work is being carried out to remove or reduce the discrimination. Any changes identified and made to the service /policy / strategy etc. should be included in the policy. Another EIA must be completed if the policy is changed, reviewed or if further discrimination is identified at a later date.	As a result of performing the analysis, it is evident that a risk of discrimination (as described above) exists and this risk may be removed or reduced by implementing the actions detailed within the *Action Planning* section of this document. ***[Insert what the discrimination is and what work will be carried out to reduce/eliminate the risk]***
Green **No major change**	As a result of performing the analysis, the policy, project or function does not appear to have any adverse effects on people who share *Protected Characteristics* and no further actions are recommended at this stage.	**The policy can be published with the EIA** Another EIA must be completed if the policy is changed, reviewed or if any discrimination is identified at a later date.	As a result of performing the analysis, the policy, project or function does not appear to have any adverse effects on people who share *Protected Characteristics* and no further actions are recommended at this stage.

Brief Summary / Further comments :	Not applicable

Approved By		
Job Title:	Name:	Date:

Appendix 2

SUSTAINABILITY IMPACT ASSESSMENT
PROCUREMENT POLICY FOR HEALTHCARE SERVICES
HaRD 049

Staff preparing a policy, Governing Body (or Sub-Committee) report, service development or project are required to complete a Sustainability Impact Assessment (SIA). The purpose of this SIA is to record any positive or negative impacts that this is likely to have on sustainability.

Title of the document	Procurement Policy for Healthcare Services HaRD 049
What is the main purpose of the document	To provide clarity and guidance on the standards of conduct expected of everyone covered by the scope of the policy, when carrying out their duties on behalf of HaRD CCG.
Date completed	05 May 2015
Completed by	Phil Tolan Head of Procurement NHS Yorkshire and Humber Commissioning Support (YHCS)

Domain	**Objectives**	**Impact of activity** Negative = -1 Neutral = 0 Positive = 1 Unknown = ? Not applicable = n/a	**Brief description of impact**	**If negative, how can it be mitigated?** **If positive, how can it be enhanced?**
Travel	Will it provide / improve / promote alternatives to car based transport? Will it support more efficient use of cars (car sharing, low emission vehicles, environmentally friendly fuels and technologies)? Will it reduce 'care miles' (telecare, care closer) to home? Will it promote active travel (cycling, walking)? Will it improve access to opportunities and facilities for all groups?	0		

Procurement	Will it specify social, economic and environmental outcomes to be accounted for in procurement and delivery? Will it stimulate innovation among providers of services related to the delivery of the organisations' social, economic and environmental objectives? Will it promote ethical purchasing of goods or services? Will it promote greater efficiency of resource use? Will it obtain maximum value from pharmaceuticals and technologies (medicines management, prescribing, and supply chain)? Will it support local or regional supply chains? Will it promote access to local services (care closer to home)? Will it make current activities more efficient or alter service delivery models	0 1 1 0 1 1 1 1		
Facilities Management	Will it reduce the amount of waste produced or increase the amount of waste recycled? Will it reduce water consumption?	0		
Workforce	Will it provide employment opportunities for local people? Will it promote or support equal employment opportunities? Will it promote healthy working lives (including health and safety at work, work-life/home-life balance and family friendly policies)? Will it offer employment opportunities to disadvantaged groups?	0		
Community Engagement	Will it promote health and sustainable development? Have you sought the views of our communities in relation to the impact on sustainable development for this activity?	0		

Buildings	Will it improve the resource efficiency of new or refurbished buildings (water, energy, density, use of existing buildings, designing for a longer lifespan)? Will it increase safety and security in new buildings and developments? Will it reduce greenhouse gas emissions from transport (choice of mode of transport, reducing need to travel)? Will it provide sympathetic and appropriate landscaping around new development? Will it improve access to the built environment?	0		
Adaptation to Climate Change	Will it support the plan for the likely effects of climate change (e.g. identifying vulnerable groups; contingency planning for flood, heat wave and other weather extremes)?	0		
Models of Care	Will it minimising 'care miles' making better use of new technologies such as telecare and telehealth, delivering care in settings closer to people's homes? Will it promote prevention and self-management? Will it provide evidence-based, personalised care that achieves the best possible outcomes with the resources available? Will it deliver integrated care, that co-ordinate different elements of care more effectively and remove duplication and redundancy from care pathways?	0		