NHS
Leeds North
Clinical Commissioning Group

NHS Leeds North Clinical Commissioning Group **Annual Report and Accounts 2016–2017**

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OUR APPROACH TO THIS REPORT

This report is produced in response to the NHS England requirements, as published in the Department of Health Group Accounting Manual 2016-2017.

The structure closely follows that outlined in the guidance, which has been revised this year following national feedback on previous reports.

The new structure simplifies and slims down the report into three core sections:

- **The Performance Report** – including an overview, performance analysis and performance measures
- **The Accountability Report** – including the members report, corporate governance report, annual governance statement, remuneration and staff report
- **Annual Accounts**

PERFORMANCE REPORT

IN THIS SECTION:

1.0 OVERVIEW

Chair and Chief Officer's Foreword

Over the last year the NHS has faced one of the most challenging periods ever both locally and nationally. We have witnessed unprecedented demand on our services and have worked incredibly hard, together with our partners, to respond to this.

So it seems fitting that we should begin our reflection by thanking all our member GP practices, hospitals, local authority colleagues, carers and voluntary sector partners for their sterling efforts over the last year. People are our greatest asset and without their fantastic support and commitment we wouldn't be able to provide the consistently high quality care that we do for our local populations.

Our partnership approach is central to everything we do at NHS Leeds North CCG which is captured in our strapline "Together we're better". It is an ethos that runs through the whole of our organisation and inspires everything that we do.

During 2016/17 we continued to strengthen our working relationships with partner organisations to help make Leeds the best city it can be for health and care services. We want local people to be able to lead active, fulfilling lives with the right support available when and where they need it. That's why our focus this year, as indeed every year, has been resoundingly local, focussed on improving the health and wellbeing of the communities we serve.

The Leeds North footprint is wonderfully diverse... Otley, Roundhay, Harehills, Wetherby, Chapeltown to name but a few. All our areas have a unique character. So we work closely with the individual populations and the doctors, nurses and practice staff who work there to create services that meet their specific needs and help to improve local health outcomes. For example, over the course of the last year we have commissioned a very successful diabetes programme in Chapeltown and a musculoskeletal service for patients in Roundhay and Moortown.

That's not to say we don't get involved in the bigger picture. On a strategic level we have worked closely with our partners on the Leeds Health and Wellbeing Board to develop a refreshed Health and Wellbeing Strategy for the city which provides a clear approach to addressing the health and wellbeing needs of people across the city. This is built on statistical health data, clinical input and feedback from service users, professionals and providers. It establishes clear priorities and outcomes for us all to strive towards and provides an overarching umbrella under which all our work sits.

This is underpinned by the West Yorkshire and Harrogate Sustainability Transformation Plan (STP) which demonstrates how we can work together at a regional level to address the health and care gaps outlined in the NHS Forward View. Working with our neighbouring CCGs means that we can develop better co-ordinated services and provide continuity of care: this means a common response in terms of stroke services, urgent care and cancer treatment. Yet other health areas need a much more local focus, such as diabetes management.

Alongside the West Yorkshire STP we have also developed a Leeds Health and Care Plan that illustrates how we can achieve things at a local level to improve health outcomes, the quality of care people receive and ensure that services are delivered sustainably with the finances available.

All three of the Leeds clinical commissioning groups lead on different strands of health policy. In Leeds North we lead on mental health, urgent care and implementing new technology (informatics), and this year has seen many big achievements in each of these areas of which we are justifiably proud.

We are delighted to report that we have invested significantly in "parity of esteem" for mental health across the city. This means that we place the same value on patients' mental health as we do on their physical health. We now provide mental health worker support for people in Leeds seven days a week, increased access to psychological therapies and, if you need to go to A&E, you won't just receive physical care but mental health support too, if you need it.

On the subject of urgent care, our A&E units and community teams have been busier than ever this year, particularly during our very tough winter period. Our teams have worked tremendously hard to manage this challenging situation, with local GPs and practice nurses working in A&E departments to help ease the pressure and ensure that patients are seen faster.

Our history of partnership working across urgent and emergency care has resulted in us being awarded £3.2 million capital funding from NHS England to deliver rapid improvements to our services and provide urgent acute services in a non-hospital setting, seven days a week. This means more patients will be able to access the right care, in the right place, at the right time, without having to queue in hospital emergency departments.

Leeds' pioneering work in the field of informatics, which we lead on here at Leeds North, is another reason to be exceedingly proud. The development of The Leeds Care Record is enabling health and care professionals across the city to share up-to-date information about all aspects of patient care. This means patients won't have to keep repeating information to different professionals and if they are admitted to hospital we can provide safer, more co-ordinated care as we already have important personal details about them, such as any allergies. Importantly, we are also using this data now to predict people's future healthcare needs. If we know you have certain conditions, or are on a particular risk register, we can be proactive in planning the care you might need for the future, rather than waiting until you become ill.

Working alongside our third sector colleagues we have launched a brand new programme this year, called Connect Well, which lets GPs refer patients to local community groups and support services that can help improve their overall wellbeing. We call this 'social prescribing' and our patients really like it. Sometimes the root cause of people's anxiety is not medical, but brought on by other worries, such as debt or loneliness, so being put in touch with the right support can make a world of difference. The programme is evaluating well and we've been really moved by some of the positive patient stories coming out.

People are an incredibly rich and powerful source of information and it's very important we listen to what they have to tell us about our services. Our organisation places a high emphasis on involving patients in decisions to ensure that we meet the needs of the

local people we are here to help. Over the course of the last year we have undertaken considerable engagement work. This has included the development of our patient champions' programme and our work with Healthwatch Leeds to evaluate and share what makes an effective Patient Participation Group so that we can help our practice groups to play an active role.

The CCG is a membership organisation, run in partnership with our 25 member practices, each represented on our Council of Members. This is where our GPs, nurses and practice managers come together regularly to ensure that the services our patients receive are as strong and effective as they can be. It enables us to drive through improvements in the planning and delivery of Primary Care services and look at the ways in which we can meet our populations' needs nearer to the communities in which they live. This year, for example, we have been working closely with practices to promote NHS Health Checks and diagnosis of atrial fibrillation (a common heart rhythm disorder that can increase a person's risk of stroke), as once we identify a patient's risks we can put preventative treatment in place to help protect them.

We started our foreword by saying what a tough year it has been. NHS commissioners and providers clearly face many challenges at the current time: not just financial, but also in relation to demographics, staffing and the sustainability of our services. However, we hope you can see what a lot of positive work we have achieved this year through the dedication of our staff and partners.

We believe that the key to sustainable improvement is the different elements of the health and care system working together in a more joined up way and involving patients in the planning and management of their own care.

Over the next year you will see the three Leeds CCGs working ever more closely with each other as "One Voice", as well as with the local authority and other providers. As we have long said here at NHS Leeds North, "Together we're better" and we hope that this ethos will enable our communities to enjoy the best possible care now and in the future.

With best wishes

Nigel Gray
Chief Officer

Jason Broch
Chair

2.0 THE NATURE AND PURPOSE OF NHS LEEDS NORTH CLINICAL COMMISSIONING GROUP

2.1 Nature and purpose

NHS Leeds North Clinical Commissioning Group (CCG) was established under the Health and Social Care Act 2012 as a statutory body, with the function of commissioning local health services. We are a membership organisation made up of 25 member GP practices and in 2016/17 we had a budget of £287.8 million covering a population of 214,972.

We are based at Leafield House, King Lane, Moortown, Leeds, which is a former health centre. Our organisation is led by GPs and nurses, supported by other healthcare professionals. We work together with patients, communities and GP practices in North Leeds to make sure that the right NHS services are in place to support people and help improve their health and wellbeing.

The core purpose of Leeds North is to improve the health and wellbeing of people within our area through the commissioning of high quality healthcare and wellbeing services. Our slogan **"Together we're better"** reflects our membership status and embodies our commitment to working in partnership with patients, communities, GP member practices and other stakeholders to improve the health of our population and reduce health inequalities.

We work hard to ensure that people are respected, treated as individuals and are able to achieve equitable outcomes from commissioned services. We will focus on ensuring that people in North Leeds who are the poorest improve their health the fastest.

A commissioning organisation

We are one of three CCGs in Leeds responsible for planning and funding healthcare on behalf of local people. The two other organisations are NHS Leeds South and East CCG and NHS Leeds West CCG.

The three CCGs in Leeds operate a collaborative approach towards commissioning and each lead on different areas of health policy. Here at NHS Leeds North we lead on behalf of the city for the negotiation, performance management and reporting of Informatics, Mental Health, Learning Disabilities and Urgent Care services.

From 1 April 2016 we began co-commissioning GP primary care services with NHS England and our two neighbouring Leeds CCGs. We do not commission other primary care services such dental care, pharmacy or optometry (opticians) which is done by NHS England through their local area team more commonly referred to as NHS England (West Yorkshire). NHS England also has the responsibility for commissioning specialised services such as organ transplant and specialist cardiac services.

Our partners at Leeds City Council have overall responsibility for commissioning public health services including health visiting and drug and alcohol services. Although the Council has overall responsibility, an increasing number of services are jointly commissioned between the three CCGs in the city and the Local Authority. This ultimately benefits the people using services as commissioners can work together to share experience, skills, information and funding to create more joined up services.

We work in partnership with our patients, communities and GP member practices to continually improve quality of care, to address health inequalities and to support people to stay healthier for longer. We are clear about the legislative requirements associated with each of our statutory functions, including any restrictions on the delegation of those functions. Responsibility for each duty and power has been clearly allocated to a lead director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all our statutory duties.

2.2 Our strategic objectives, vision and values

As an organisation, we have a set of strategic objectives which we use to measure how well we are performing in providing the best quality care for our local populations.

We revised these during 2016/17 to ensure that they reflect the needs of our local population and our organisation's priorities going forward.

Our objectives:

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

Our vision:

We share the vision of the Leeds Health and Wellbeing Strategy that the people of North Leeds:

- Are involved in decisions made about them;
- Will live in healthy and sustainable communities;
- Experience a better quality of life;
- Live full, active and independent lives;
- Live longer and have healthier lives – ensuring that people in North Leeds who are the poorest improve their health the fastest.

Our values:

Underpinning these is a set of embedded values which we aim to embody through all our staff and in the way we carry out our business. These are clearly defined and communicated on our intranet site. They are also used to structure staff appraisals.

- Embracing our patients as partners;
- Working together with our local communities;
- Listening to people and valuing their experience;
- Using the available resources wisely and appropriately;
- Being innovative and using best practice to continuously improve the NHS;
- Being a learning organisation and supporting professional development.

2.3 Key issues and risks

Risk management

Following the agreement of new strategic objectives this year, the Board also reviewed the principal risks to delivering those objectives. Some of our biggest risks include:

- System-wide or provider capacity shortfalls, leading to a failure to meet patient needs
- Inability to develop a population health management approach, leading to a failure to shift care out of hospital settings
- Failure to secure the capacity and skills which the CCG needs, leading to an inability to respond quickly and effectively to change
- Failure to work successfully with partners to integrate services leading to duplication, waste and inefficiency

We have taken a wide range of actions to minimise these risks including:

- Working with partners through the new System Resilience Assurance Board to improve the resilience of the Leeds health system
- Redesigning care pathways and piloting new models of care in locality 'test beds'
- Strong partnership working between the CCGs and Leeds City Council, with a number of integrated and city wide posts
- A review of collaborative working across the three CCGs under the 'One Voice' umbrella.

2.4 Our Council of Members

The CCG is a membership organisation run in partnership with our 25 member practices, each represented on our Council of Members.

The Council of Members is our core decision-making body and consists of two representatives from each GP member practice – a clinical and a non- clinical/ management representative.

This union of GP practices ensures that clinical participation is at the heart of everything the CCG does. The member practices make sure that they are representing the best interests of their patients as well as the wider communities in which they are located.

Members attend bi-monthly Council meetings where they take decisions on issues like amendments to the constitution and approval of the CCG's annual plan. Minutes from Council of Members meetings are available to view on our website www.leedsnorthccg.nhs.uk/publications

2.5 Our member practices

We have 25 member practices within Leeds North Clinical Commissioning Group:

Aireborough Family Practice
Allerton Medical Practice
Alwoodley Medical Centre
Bramham Medical Centre
Chapeltown Family Surgery
Chevin Medical Practice
Collingham Church View Surgery
Crossley Street Surgery
Foundry Lane Surgery
Meanwood Group Practice
Newton Surgery
North Leeds Medical Practice
Oakwood Lane Medical Practice
Oakwood Surgery
One Medicare – The Light
Rutland Lodge Medical Practice
Shadwell Medical Centre
Spa Surgery
St Martin's Practice
Street Lane Practice
The Avenue Surgery
Westfield Medical Centre
Westgate Surgery
Wetherby Surgery
Woodhouse Medical Practice

2.6 Working with partners

Our neighbouring CCGs

There are three CCGs in Leeds; NHS Leeds North CCG, NHS Leeds South and East CCG and NHS Leeds West CCG. As well as focusing on areas of local need, the CCGs in Leeds also work collaboratively to ensure equal access to key NHS services, including acute, community-based, mental health and learning disability services.

Working together as one

Discussions have been taking place about how the three CCGs can work together more collaboratively in the future and a project called "One Voice" has been established. As part of this a joint leadership structure/ executive team is being set up, led by one Chief Executive Officer, overseeing all strategic commissioning work, and a Chief Officer for System Integration, whose role it will be to facilitate and drive provider collaboration.

Work is underway to establish citywide committees to cover governance, quality, finance and patient assurance which will replace the current separate structures. The three CCG boards and governing bodies will still have statutory accountability and be governed by each CCG's respective constitutions.

On an operational level, the Leeds CCGs have been looking at key citywide healthcare services set in the context of both national guidance and local plans (the West Yorkshire and Harrogate Sustainability Transformation Plan and the city-focused Leeds Plan).

Primary Care – The Leeds CCGs have taken on joint responsibility (with NHS England) for the co-commissioning of primary care (GP) services. This means that we are working closely with our member GP practices to see how we can improve access and service quality.

In direct response to the NHS GP Five Year Forward View, the three Leeds CCGs have put together a five year plan. We have six ambitions that will help us to deliver this:

- supporting and growing the workforce;
- improving access;
- transforming estates and the use of technology;
- better workload management;
- redesigning care delivery; and
- resourcing primary care.

West Yorkshire and Harrogate Sustainability and Transformation Plan (STP)

The West Yorkshire and Harrogate Sustainability and Transformation Plan (STP), published this year, aims to address local health and wellbeing gaps. It focuses on supporting people to live longer, healthier lives and ensuring an equitable service for all – no matter where people live. It also stresses the importance of better co-ordinated services and improving the quality of care people receive.

It has identified nine priorities for the West Yorkshire and Harrogate area:

- Prevention
- Primary and community services
- Mental health
- Stroke
- Cancer
- Urgent and emergency care
- Specialised services
- Hospitals working together
- Standardisation of commissioning policies

More information about the STP can be found here:
https://www.wakefieldccg.nhs.uk/stp/

The Leeds Plan

Complementing the STP, but also taking forward the vision to make the city *'a healthy and caring city for all ages, where people who are the poorest improve their health the fastest'* is the Leeds Plan. The Plan itself is still under development, led by Leeds City Council and supported by NHS organisations and the third sector.

Its key themes are:

- Prevention
- Self-management, proactive and planned care
- Optimising the use of secondary care resources and facilities
- Urgent and emergency care and rapid response
- Housing and the environment enable all people of Leeds to be healthy;
- A strong economy, with quality, local jobs;
- Get more people, more physically active, more often;
- Maximise the benefits from information and technology;
- A stronger focus on prevention;
- Support self-care, with more people managing their own conditions;
- Promote mental and physical health equally;
- A valued, well trained and supported workforce; and
- The best care, in the right place, at the right time.

Leeds Health and Wellbeing Board

We have a seat on the Leeds Health and Wellbeing Board which has been established as a statutory committee of Leeds City Council. We actively supported the Joint Strategic Needs Assessment (JSNA), which uses a range of local and national statistics to identify the current health and wellbeing needs of our communities and highlights health inequalities between different parts of the city. The findings from the JSNA fed into the Health and Wellbeing Strategy for Leeds 2016-2021: www.leeds.gov.uk/docs/Health%20and%20Wellbeing%202016-2021.pdf

The strategy has 12 ambitions:

- A child friendly city and the best start in life;
- An age friendly city where people age well;
- Strong, engaged and well-connected communities;

Below are some examples of the progress we have made this year:

- We have kept members of the Health and Wellbeing Board informed about our work around the West Yorkshire and Harrogate STP and the Leeds Plan.
- Agreement on the Better Care Fund for 2016/17. Plans include how partners will work together to meet national conditions for social care, a joint approach to assessment and care planning and a local plan to reduce delayed transfers of care.
- Tackling health inequalities and wider issues that can lead to ill health. This included looking at problems such as poverty, air quality and taking action to reduce incidences of domestic abuse. However, the Health and Wellbeing Board noted concerns about the continued funding cuts for public health and the impact this will have on prevention initiatives.

- There are over 250,000 young people in Leeds under the age of 25: 10% of whom are likely to have a mental health issue or need support with their emotional wellbeing. The Health and Wellbeing Board approved the 'Future in Mind Report' to transform how support is offered and how improvements can be made to the emotional and mental health of children and young people in Leeds. This included outline plans on improving the support for children with Special Educational Needs and Disabilities (SEND). A copy of the strategy can be downloaded at: www.leedsnorthccg.nhs.uk/content/uploads/2016/10/Future-in-Mind-Leeds-Strategy-final-Nov-2016.pdf
- We acknowledge that carers play a very valuable role in supporting local health and social care services, often at great personal cost – both financially and emotionally. The Health and Wellbeing Board has signed up to the Leeds Commitment to Carers, which has been developed with insight from carers (gathered by Carers Leeds).

The Health and Wellbeing Board discussed a paper at its meeting on 20 April 2017, which brought together extracts of the draft annual reports from the three Leeds CCGs. These gave examples of partnership working in contributing to the delivery of the city's health and wellbeing strategy.

The Health and Wellbeing Board acknowledged the extent to which the CCGs had contributed to the health and wellbeing strategy. The board asked that in future the CCGs engage with members on our annual reports at an earlier stage. The agenda for the meeting on 20 April (with reference to item 9) can be found by visiting: http://democracy.leeds.gov.uk/ieListDocuments.aspx?CId=965&MId=7729&Ver=4

Scrutiny Board (Adult Social Services, Public Health, NHS)

The Scrutiny Board reviews and scrutinises the performance of Adult Social Services, Public Health and the local NHS. It also reviews and scrutinises decisions taken by the Executive Board relating to Adult Social Care. Throughout 2016/17 we have continued to keep the Scrutiny Board informed of our key decisions and plans to ensure that we meet our duties to consult, as outlined in the NHS Act (2006).

In 2016/17 we also updated the Scrutiny Board on the following areas.

- Work on developing the West Yorkshire and Harrogate STP and associated Leeds Plan.
- Leeds' response to the NHS GP Five Year Forward View.
- The "One Voice" collaborative approach being adopted by the three Leeds CCGs.
- Concern was raised around cancer waiting times in some specialities. However, the Board was informed of the significant progress made in this area and how Leeds has some of the quickest access to diagnostic services in the country.
- Updates were provided throughout the year on how the NHS is responding to local pressures including A&E targets, waiting times for routine procedures and delayed transfers of care.

Our NHS providers

We are pleased to be able to commission services from three NHS trusts in Leeds, as well as service providers. We, at NHS Leeds North, lead on commissioning services from NHS Leeds and York Partnership NHS Foundation Trust; NHS Leeds West CCG leads on commissioning services from Leeds Teaching Hospitals NHS Trust; and NHS Leeds South and East CCG takes the lead with

Leeds Community Healthcare NHS Trust. Our ambulance services and NHS 111 services are provided by Yorkshire Ambulance NHS Trust. We also fund services from a number of neighbouring providers to uphold the rights of our patients to choose where they go for treatment, where it is appropriate to do so.

Leeds City Council

Leeds City Council commissions care and support services which tackle public health challenges such as obesity, smoking, alcohol and drug misuse.

The future direction of travel, as set out in the NHS Five Year Forward View, is towards the closer integration of health and social care services. These services would be delivered at a community or neighbourhood level by health and social care teams working together to get the best outcomes for local people. To do this we have been working closely with a number of partners, including Leeds City Council's Adult Social Care teams. This integrated partnership approach will grow and develop over the coming years (see Section 3.4.4).

We welcomed the publication of the Director of Public Health's Annual Report and acknowledged the key areas that need to be addressed to improve the health of the population. This includes encouraging people to adopt healthier lifestyles and taking part in initiatives to protect their health, such as NHS Health Checks, the flu jab and cancer screening.

We also worked with Leeds City Council and a range of community organisations to launch The Leeds Suicide Prevention Strategy, based on an audit of detailed findings to identify interventions that could help prevent people from taking their own lives. The Leeds Suicide Audit is considered to be the 'gold standard' of best practice and is recommended by Public Health England as a model for other areas to learn from.

Other programmes where we have worked closely with Leeds City Council to deliver key public health messages include: a campaign encouraging patients to dispose of medical waste (e.g. syringes) and a winter wellbeing campaign called "Stay well this winter" http://www.leedsth.nhs.uk/stay-well

Community and voluntary sector organisations

The role of the community and voluntary sector (often referred to as the third sector) is very important, not only for the delivery of services but also for providing opportunities to engage with people who can be hard to reach, sometimes referred to as 'seldom heard groups.'

Over the past 12 months we have been working with lots of local community groups to run engagement events and activities to ensure that the services we develop meet local needs.

Our new social prescribing scheme, **'Connect Well'**, enables GPs to refer patients to local community groups and support services that can help improve their overall wellbeing. Sometimes the root cause of people's anxiety is not medical but due to other root causes, such as debt or loneliness, so being put in touch with the right support can make a world of difference. Our Connect Well project is delivered by a consortium of community and voluntary sector organisations including: Community Links, Feel Good Factor, Age UK Leeds and One Medical Group.

The new MindWell mental health website for Leeds (see Section 3.6.3) was co-produced in conjunction with a range of community groups co-ordinated by Volition, which is a network of third sector, not-for-profit organisations that support people's mental health and wellbeing in Leeds.

We are delighted that our partners, Carers Leeds, have won a prestigious Health Service Journal Award this year for the advocacy work they do on behalf of the city's carers. They won the "Integrated Commissioning for Carers" award, which is illustrated by their work with the NHS and Leeds City Council to develop the Leeds Commitment to Carers.

Healthwatch Leeds

Healthwatch Leeds is represented on the Leeds Health and Wellbeing Board, giving patients and communities a voice in decisions that affect them. Over the last year we have worked with them to gather patient insight on local health services, including an extensive survey and interviews to capture views on the extended access to GP services scheme (see Public and Patient involvement Section 3.8).

Healthwatch Leeds has also undertaken a number of reviews of services and published reports which include:

- A review of sexual health clinics in Leeds
- Home care services for people receiving support in their own home

We will be looking at how we can use the recommendations from these reports to influence how services are provided in the future.

Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England, responsible for monitoring standards of care. It undertakes announced and unannounced inspections of NHS providers both routinely and in response to concerns raised by patients and staff. The Leeds Quality Surveillance Group (which includes representatives from all three CCGs) also includes a representative from the CQC to support the sharing of information on quality and standards.

Leeds Academic Health Partnership

The Leeds Academic Health Partnership is made up of the city's three universities, NHS organisations and Leeds City Council. The partnership has been set up to use innovations, education and research to improve health and care outcomes. One of the areas the partnership has worked on is personalised medicines. This is looking at how health and care professionals can work with patients to provide tailored treatment that is most likely to have the desired health benefits.

Leeds Informatics Board

The Leeds Informatics Board (LIB), led by NHS Leeds North, is responsible for informatics developments in Leeds. LIB is supported by a number of sub-committees, including a cross-city Information Governance Steering Group and City Informatics Clinical Group.

Using technology is central to transforming services and delivering the city's ambitions. There have been a number of key achievements over the last year, under the leadership of LIB, which are outlined below:

- The Leeds Local Digital Roadmap has been produced in conjunction with the West Yorkshire and Harrogate STP and in collaboration with other Local Digital Roadmaps across West Yorkshire. It provides a joined-up view of our plans to become 'paper free at the point of care'.
- Adult social care and community information have now been included in the Leeds Care Record, in addition to existing GP, hospital and mental health data. We have also significantly increased the number of active users from 2,500 to 4,000 over the course of the last year.
- GPs in Leeds have adopted the national electronic prescription service (EPS) which makes prescribing and dispensing medicines far more efficient, safe and convenient. 95% of Leeds practices can

now digitally send prescriptions direct to the patient's preferred pharmacy. Patients can then collect their repeat medication without having to visit the GP practice or worry about losing a paper prescription.

- There is now free WiFi, for both patients and staff, in nearly all Leeds GP surgeries.
- Six care homes in Leeds are involved in a pilot scheme allowing health and care staff to monitor residents remotely, in an effort to reduce unnecessary hospital admissions.
- Leeds is now transferring patients' full and detailed medical records directly, securely and quickly between their old and new practices when they change GPs (using a system called GP2GP).
- Leeds Health Pathways has issued standardised clinical pathways, medication and guidance to all care professionals in the city. It is managed and supported by Leeds Teaching Hospitals NHS Trust and replaces the 'Map of Medicine' which was previously used by primary care.
- The Leeds Intelligence Hub continues to drive change in commissioning by providing system-wide data analysis and insight.

Leeds Institute for Quality Healthcare

We have been working collaboratively with the Leeds Institute for Quality Healthcare (LIQH) to run a Professional Leadership Programme (PLP) focused on urgent care. This was well attended with a mix of people from primary care, commissioners, LYPFT and adult social care.

The programme's title was "Non-elective, non-surgical admissions: What can we do differently?" and its main objective was the methodology of looking at data and quality and how to simplify difficult problems. The outcomes to date have been very positive: participants have enjoyed working with peers from other practices and seeing things from different perspectives. This has supported some of the work we are doing regarding extended hours.

We have also been successful in our bids for £600,000 extra investment in diabetes care in the city this financial year: to improve the uptake of structured diabetes education; to provide diabetes inpatient Specialist Nurses (DISNs); and to reduce amputations by improving the timeliness of referrals from primary care to a multi-disciplinary foot team (MDFT) for people with diabetic foot disease. This is great news for our three LIQH diabetes projects which map directly onto the three funding streams to enable work going forward.

3.0 PERFORMANCE ANALYSIS

3.1 Financial Outlook

In its first four years, the CCG has faced significant risks and uncertainties arising from the fragmentation of the NHS commissioning structure, resulting in both financial allocation and apportionment uncertainties and the new challenges of co-ordinating with multiple commissioners for the same group of health and social care providers. The challenge will continue to be a feature of the CCG's foreseeable future, especially in view of significant financial pressures continuing to be experienced by NHS England in relation to specialist commissioning activity across the country.

The Leeds health and social care economy is one of the largest in the country and the challenges it faces, in financial and service provision terms, reflect that magnitude. We have two aspirant Foundation Trust applicant NHS organisations planning towards Foundation Trust status, one of which (Leeds Teaching Hospitals NHS Trust) is facing significant underlying financial challenges to overcome in that process. Our local city council is also one of the largest in the country, with high demands placed upon both its adult and children's social care services, which interface directly with NHS care.

The **Better Payment Practice Code** requires that all NHS organisations aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. We know how important it is, particularly in the current economic climate, that we pay suppliers of goods and services promptly. The CCG has signed up to the Prompt Payments Code and our performance in paying bills on time is excellent, with over 98% of our bills from trade suppliers being paid on time.

Non NHS trade invoices	Number	Value (£'000)
Total Non NHS trade invoices paid in the year	4,652	61,817
Total Non NHS trade invoices paid within target	4,535	61,288
Percentage of Non NHS trade invoices paid within target time		97.5%
Percentage of Non NHS trade £value invoices paid within target		99.1%

NHS trade invoices	Number	Value (£'000)
Total NHS trade invoices paid in the year	2,779	191,900
Total NHS trade invoices paid within target	2,765	191,776
Percentage of NHS trade invoices paid within target time		99.5%
Percentage of NHS trade £value invoices paid within target		99.9%

3.2 Healthcare performance in Leeds

One of the main duties of the Leeds CCGs is to commission efficient and effective services to meet the needs of people who require NHS care and treatment each year in our city.

The services we commission are monitored locally, regionally and nationally. This is done through a series of performance indicators that include NHS Constitution Standards and more recently a set of benchmark indicators that are published to support the CCG Assurance Framework. These indicators cover many areas from access targets, such as the time a patient has to wait for hospital treatment, to measures of effectiveness of our services e.g. early diagnosis of cancer. We also have quality standards to comply with, such as the rate of healthcare associated infections.

These performance, quality and public health indicators are monitored by NHS England primarily through the local area team, NHS England (West Yorkshire). As a CCG we monitor all the key standards and where appropriate, support our partner organisations (hospitals, ambulance services, community health services and member practices) to help them achieve these aims.

3.2.1 Overview of our 2016/17 performance

This has been an incredibly challenging year for the NHS, both locally and nationally. Demand for emergency services has continued to grow with attendance rates at A&E rising by over 3%, and similar increases in the need for emergency admission. This rise in demand comes at a time when funding for public services is being constrained, which has resulted in demand outstripping capacity in our main providers.

The impact of this imbalance can be seen in our performance against a number of targets, including achievement of the A&E 4 hour wait target, the 18 week referral to treatment (RTT) target and ambulance response times.

However, we have still managed to perform well against many of the key indicators we're measured against. When compared against other CCGs with a similar population, our performance is favourable and often above average.

During the course of 2016/17 the CQC inspected all of our member GP practices and we are very pleased to report that all were rated as 'Good'. At the time of writing we were just waiting on the report for one of our practices.

My NHS

My NHS is a website where organisations, professionals and the public can compare the performance of health and care services over a range of measures at both a local and national level. You can see performance across a range of areas such as health outcomes or how well-led a CCG is by visiting www.nhs.uk/mynhs

Our ratings on My NHS show that we are rated as being well-led and perform well in cancer care, maternity, dementia and in patient experience of GP services. In fact we are classed as a top performing CCG for cancer care.

Areas where our performance needs improvement include mental health and learning disabilities. In this annual report you'll see the steps we've taken over the last year to make progress in these areas and address this.

3.2.2 Areas of achievement

Cancer Waits: The waiting time standard, for receiving an outpatient appointment within 2 weeks of an urgent cancer care referral, continues to be achieved. In fact Leeds is one of the few areas in the country where patients with suspected cancer are consistently given an urgent two week referral to diagnostic services from their GP. In addition we have continued to meet the 62 and 31 day diagnosis to treatment targets.

Referral to Treatment: Whilst the CCG very narrowly missed the 92% target for the percentage of patients remaining on a waiting list and not being seen within 18 weeks, Leeds compares favourably with the national and West Yorkshire overall figures i.e. fewer patients in Leeds wait over 18 weeks compared to the England average.

3.2.3 Where we need to improve

It is clear that there have been a number of performance challenges in 2016/17 and these challenges are expected to continue into 2017/18. While there are a number of targets that we haven't quite met, the CCG remains fully committed to improving the quality of our services and improving health outcomes for patients.

The key priorities for action are outlined below.

Referral to treatment times (RTT)

NHS Leeds North CCG remains committed to meeting the national standard for RTT and was very close to achieving the standard in 2016/17. However, the delivery of this target has been adversely affected by demand outstripping capacity: high emergency admissions over the winter months led to routine surgical operations having to be cancelled.

Achieving the standards in the future depends largely on the degree to which the whole health system can be transformed to reduce demand for urgent care and emergency hospital beds. If emergency demand continues to grow, then capacity for routine elective surgery will be restricted. The specialties where targets have not been met are:

- General surgery
- Plastic surgery
- Trauma and orthopaedics
- Urology
- ENT

Work is currently being undertaken with Leeds Teaching Hospitals NHS Trust (LTHT), through the joint Elective Care Working Group, to ensure that, where possible, risks are being managed and mitigated. Patients are also able to access surgical services from independent sector providers and neighbouring trusts.

Emergency Care Standard (ECS)

The four hour ECS target is, put simply, a measure of how quickly people in A&E are seen and the numbers that leave the department within four hours. The measure is also an indicator of how the whole health and social care system is managing its population, especially how patients flow through the system and access the service(s) they need.

Unfortunately, Leeds as a health system has not delivered the Emergency Care Standard (4 hour target) since September 2015. This is a national problem with very few local health systems now able to consistently meet the standard. Nationally there are various factors that contribute to this underperformance including: increased demand on services, shortages in staff with the right skill mix, delays in discharge and a lack of community health and social care capacity.

The multi-agency, Leeds System Resilience Assurance Board (Local A&E Board), coordinates both provider and commissioner functions to try and improve processes and ensure a system-wide approach to delivering high quality services all year round.

Leeds has an Urgent Care Strategy which (along with the STP and Leeds Plan) sets out a vision for transforming the whole urgent and emergency care system. Initiatives include:

- Simplifying the system to improve access
- Changing the role of ambulance services (see below)
- Developing integrated primary, community and hospital services
- Implementing an integrated discharge service
- Supporting the care home sector
- Redesigning services to meet urgent needs in health and social care

Yorkshire Ambulance Service NHS Trust (YAS)

The implementation of the new ambulance response programme has seen a slight improvement in performance and supports the improvement of 999 services overall.

Yorkshire Ambulance Service (YAS) continues to trial new and innovative ways of improving its operations as part of the West Yorkshire Urgent and Emergency Care Vanguard and Accelerator Zone programmes. This includes:

- Identifying other resources to reduce pressure on the system, such as St John's Ambulance and private providers.
- Working with the fire service to trial new delivery models using the wider emergency services.
- At a Leeds level YAS are now represented on the Leeds A&E Delivery Board to support local developments.
- Future developments in the Leeds Care Record will provide YAS with prompt and easily accessible information to ensure patients are directed to the most appropriate service.

IAPT performance against targets, as at end of quarter three (latest available figures at time of publication of annual report):

Performance above target

- IAPT waiting times – less than 18 weeks, our performance was at 99.5% against a target of 95%
- IAPT waiting times – less than 6 weeks, our performance was at 98.2% against a target of 75%

Performance below target

- Seven day follow up following discharge, our performance was at 94.6% against a target of 95%
- IAPT recovery rate, our performance was 46% against a target of 50%

3.3 CCG improvement and assessment framework

Clinical Commissioning Groups (CCGs) were established on 1 April 2013 and are clinically-led organisations at the heart of the NHS system. NHS England has a statutory duty (under the Health and Social Care Act (2012)) to conduct an annual assessment of every CCG. The assurance process aims to ensure that CCGs are commissioning safe, high quality and cost effective services, to achieve the best possible outcomes for patients.

In 2016/17 NHS England introduced a new CCG Improvement and Assessment Framework to replace both the existing CCG assurance framework and CCG performance dashboard. This new framework provided a greater focus on ensuring that CCGs were focussing on improvement alongside meeting their statutory requirements.

The new framework draws together the NHS Constitution, performance and finance metrics and transformational challenges and underpins the delivery of the Five Year Forward View.

The CCG Improvement and Assessment Framework for 2016/17 set out four domains that reflected the key elements of well-led and effective clinical commissioning groups as listed below.

- **Better Health:** this section looks at how the CCG is contributing towards improving the health and wellbeing of its population.
- **Better Care:** focussed on how CCGs are supporting redesign of care, performance of constitutional standards, and improving health outcomes with a specific focus on six clinical areas: mental health, dementia, learning disabilities, cancer, maternity and diabetes.
- **Sustainability:** how the CCG is remaining in financial balance, and is securing good value for patients and the public from the money it spends.
- **Leadership:** assessment of the quality of the CCG's leadership and strength of its governance, including the quality of its plans and how the CCG works with its partners.

At the time of writing we had not formally received our score for 2016/17. The CCG's Annual Assurance meeting was held with NHS England on 19 April and we are awaiting confirmation of our final rating. These should be available in July and will be published on the My NHS website: www.nhs.uk/mynhs

3.4 Improving quality and safety

The three Leeds CCGs place quality at the core of all their functions, commissioning practice and discussions with providers. We do this by making our expectations clear and measurable, and then monitoring these standards closely.

There are five key elements which drive the work of the Quality team:

- Patient safety
- Patient experience
- Clinical effectiveness
- Responsiveness
- Being well-led

Organisations from which we commission care must meet essential standards of quality and safety, as defined by the Care Quality Commission (CQC). In many cases we set quality standards for our providers that are above these essential requirements. We work closely with our acute, mental health and community services throughout the year to ensure that they meet these standards, providing challenge where the care provided is not as expected.

Our Quality Framework sets out the process and mechanisms by which we assure ourselves of the quality of care that we commission. As commissioning arrangements develop across the three CCGs, the Quality team will ensure that the framework is aligned to the Leeds 'One Voice' Approach.

Our Quality and Safety Committees are working towards a more collaborative approach with regards to monitoring quality across the whole Leeds health economy. Regular quality updates are also provided for the Board, ensuring that quality of care receives attention and scrutiny at the highest level within the CCG.

Key programmes undertaken in 2016/17 include:

- Development of the Leeds multiagency healthcare-associated infections (HCAI) improvement group and Clostridium difficile infection review panel.
- Reviewing how we oversee the quality standards in all key provider organisations. To do this we speak to patients, managers and staff through a scheduled programme of visits.
- Working collaboratively with partners to improve consistency of assessment and reporting of pressure ulcers in Leeds.
- Developing a citywide patient insight working group to review patient experience and identify areas for action.
- Working with partners across the city to improve oversight of care delivery in care homes across the city.
- Developing processes for monitoring incidents reported in primary care (in collaboration with our governance team).

HCAI improvement

The Leeds multiagency, healthcare-associated infection (HCAI) improvement group was established to achieve a consistent and united approach across local community and hospital care organisations. It aims to make improvements, identify concerns relating to HCAI and agree annual priorities to focus the work of the group.

On a quarterly basis the group hosts the CDI review panel. The meeting has representation from CCGs, LTHT, LCH, LYPFT, independent hospitals and Public Health.

The level of Clostridium difficile infection in Leeds teaching Hospitals and community associated Clostridium difficile have both reduced in 2016/17.

Pressure ulcer improvement

A significant amount of work to review category 3 & 4 pressure ulcers has been undertaken this year across the city. Pressure ulcer investigation panels are held to understand the challenges, failings and actions being put in place and the CCG is actively monitoring the progress against this work stream at provider quality meetings. There are early signs of a reduction in the reporting of category 3 & 4 ulcers and an increase in the reporting of category 2 pressure ulcers. This reflects improvements in identifying patients at risk.

Leeds Community Healthcare Trust has also undertaken a comprehensive review of the skills and competencies of all staff in the neighbourhood teams to understand the education, development and training needed to enable safe and effective care delivery.

Patient insight

The Quality and Governance teams work together to ensure that the Patient Insight Working Group reviews and analyses patient experience data. The group:

- Monitors all patient experience activities, ensuring that activity is captured on a dedicated patient experience database
- Identifies trends and themes in patient experience, which are reviewed by the CCG
- Ensures that patient experience feedback is used to improve services and informs the planning and design of new services
- Ensures that links are made between Complaints, PALS and Social Media information and that feedback is used to continuously improve healthcare services
- Escalates patient concerns where identified and as appropriate

Friends and Family test

The Friends and Family Test is now in use across every provider. It was created to help service providers and commissioners understand whether their patients are happy with the service provided and where improvements are needed.

The quality team monitor the response rates and results of all our major providers and address any issues with the relevant trust around levels of response and/or satisfaction.

Complaints

We take complaints seriously as they are very important in helping to improve our services. Outcomes from complaint investigations are used to make changes to systems and processes therefore improving the future experience for everybody. We ensure the six principles of remedy are applied when handling complaints and work closely with our partner organisations to ensure that the appropriate information is obtained in a coordinated and timely manner.

We have a Patient Advice and Liaison Service (PALS) which aims to answer questions, resolve concerns and signpost people to the most appropriate services, as well as providing 'on the spot' non-medical advice to patients.

Incident monitoring

The citywide Quality and Governance teams monitor our partner NHS provider organisations in reporting, investigating and learning from serious incidents that occur.

A panel will review the provider's reports and action plans to gain assurance that a robust investigation has been completed, reasons for the incident occurring have been identified and recommendations have been actioned to prevent something similar from

happening again. We work with our partners to ensure learning and actions from all investigations are embedded in future practice.

We also review incidents reported by GP practices to identify any key themes/ trends and share this learning across the city to reduce the likelihood of similar incidents occurring.

Care home quality monitoring

Concerns about the quality of care in a number of care homes, following CQC inspection visits, prompted a review of processes for reporting and escalating concerns through the CCGs' governance structures.

There are a number of established mechanisms in place for monitoring and overseeing quality in care homes, and good multi-agency working via a number of forums/groups. The quality team works proactively with health and social care partners to ensure that monitoring visits are undertaken and outcomes routinely shared between teams.

Throughout 2017/18 we will be working with partners to develop and strengthen health and social care quality and governance mechanisms, as well as to ensure that there is appropriate oversight at each level of the organisations.

Provider monitoring visits

We carry out an annual programme of visits to our local care providers to observe care delivery. Visits generally take place with the prior agreement and notification of the provider, unless there are significant concerns relating to standards of quality and safety whereupon an unannounced visit may be appropriate. A quality review tool is used to support consistency. If we identify any areas of concern, the provider is asked to respond and provide assurance that these have been addressed. If necessary, repeat visits are arranged to ensure that actions have been implemented.

Where we have concerns about the provider's ability to deliver safe, effective care, the CCG uses the NHS England quality risk profile tool to provide an informed view of the level of risk and intervention required. This may include holding a quality summit.

Commissioning for Quality and Innovation (CQUINs)

CQUINs enable a proportion of healthcare providers' income to be spent on innovative schemes to enhance quality in areas of patient care or service improvement.

In 2016/17 our local CQUIN schemes included:

- Improving respiratory and cardiology pathways
- Developing and embedding Integrated Neighbourhood Teams in Leeds Community Healthcare
- Reducing delays and achieving better care in outpatient follow-ups at Leeds Teaching Hospitals

We worked with partners in the hospital and community care trusts to review the current pathways. This was to make sure that people receive the care that is recommended by expert bodies such as NICE and the teams involved work together to improve patient care and experience.

Public Health Outcomes Framework

The quality team have also reviewed work streams against the Public Health Outcomes Framework 2017, and identified progress against the following metrics.

Metric: Better Care

Cancer patient experience:
The CCG reviewed the National Cancer Patient Experience Survey published in July 2016 as part of the Patient Insight Work Group. Whilst there were areas noted for improvement, the CCG benchmarked well nationally. When asked to rate their care on a scale of zero (very poor) to 10 (very good), respondents gave an average rating of 8.6.

Neonatal mortality and stillbirth:
Quality and safety in local maternity services is closely monitored by the Quality team through regular meetings with members of the hospital teams that provide in-patient and community services. We also monitor patient safety incidents occurring within the service and ensure that we are satisfied these are being thoroughly investigated.

Metric: Better Health

Maternal smoking at delivery:
In order to reduce the number of women smoking whilst pregnant, we developed a CQUIN with colleagues in Leeds Teaching Hospitals Trust. Key components of this work are introducing carbon dioxide monitoring in antenatal appointments and referring to Fresh Air Babies, a service run by specially trained advisors to help pregnant women in Leeds stop smoking. Benefits from stopping smoking include reduced risks of miscarriage, premature birth and low birth weight.

3.5 Improving quality and performance in Primary Care

In April 2016 we accepted formal delegation of functions from NHS England relating to the management of primary care services. This includes responsibility for the commissioning and contracting of general practice services and is in addition to our existing statutory responsibility to improve the quality of our member practices.

This section of the report outlines the important work that has been carried out this year in the areas of primary care and medicines optimisation.

3.5.1 Quality improvement

The Primary Care Team supports Leeds North practices to ensure that quality improvement is embedded in everything they do. Our team is focussed on addressing the issues that are pertinent to each practice and not using a 'one size fits all' approach. This means that as well as ongoing day to day support, we also carry out funded quality improvement initiatives with individual or groups of practices that focus upon their populations' specific needs.

Our quality improvement work this year has included:

Incident prevention:

- We have promoted the use of Datix by our practices: this is web-based incident reporting and risk management software for health and social care organisations.
- Our locality managers have worked closely with the citywide governance team to ensure that quality and safety are central to everything we do.
- Incidents are also a standing agenda item on the monthly Practice Managers' meeting agenda, where learning is discussed and ways of preventing incidents are identified.

3.5.2 Supporting collaboration

- We are trying to ensure better joined up care for patients by supporting increased collaborative working between Practice Nurses and Community Nurses.
- The CCG is working closely with Healthwatch to address how our Patient Participation Groups / Practice Preference Groups (PPGs / PRGs) can work better (see Public and Patient Involvement section 3.7), as listening to and involving patients in decision making is fundamental to improving quality.
- Supporting our practices to initiate new conversations with patients via Collaborative Care and Support Planning (CCSP). This differs from traditional methods of consultation by steering away from the health care professional being the sole decision maker, to a partnership model in which patients play an active role in determining their own care and support. It is particularly beneficial for people with long term conditions to determine their overall goals and support needs. It is early days in adopting this new consultation approach across NHS Leeds North, but lots of evidence suggests that it provides patients with the skills, knowledge and confidence to self-manage their long term conditions and have more productive care planning conversations with their practice team.

3.5.3 NHS Health Checks

The NHS Health Check programme aims is to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia, as well as focusing on reducing health inequalities. Everyone between the ages of 40 and 74 is invited once every five years to have a NHS Health check to assess their risks and will be offered support and advice to help them reduce or manage any risks identified, including referral to healthy living services if appropriate.

We continue to work with our member practices to try and increase patient uptake of health checks, as well as with Leeds City Council, who commission this service, to review if/how the service needs to change.

3.5.4 Developing new models of care

The CCG is actively supporting the development of 'new models of care'. This is about identifying new ways that health and care providers can work together to better meet local population's health and wellbeing needs. The focus of our work this year has been supporting our GP practices to develop new collaborative ways of working, identifying priority needs in the local population and developing relationships with other care providers. These are some examples of the work being developed across our localities.

Diabetes

The Chapeltown group of practices and Leeds Community Healthcare have been working closely together during 2016/17 to develop the skills of practice nurses to manage diabetes care more effectively within practices. Further work in 2017/18 will bring Leeds Teaching Hospitals around the table too to look at how Leeds partners can work together better to manage more diabetes care closer to home and undertake more preventative work.

Mental Health

The Chapeltown locality also identified that new ways of working were needed to support patients with identified and unidentified mental health needs. This included patients who were diagnosed with serious mental illness such as schizophrenia, bipolar or other affective disorders. Data shows that within this locality there is a significantly higher than average number of patients within these groups.

Local GPs felt that many people with mental health needs were 'bouncing' between services because the system wasn't spending enough time trying to understand individual circumstances at the early assessment stage, meaning that people weren't always being signposted to the right help.

The resulting Chapeltown test project aims to deliver wrap-around care for these patients: to support both physical and mental health needs in a holistic way and improve the whole flow of how patients move around the health and care system according to their changing needs. As traditionally many patients, once diagnosed with a mental health condition, can get stuck in a service even though they are stable and don't require the same level of support.

The CCG has supported a model which will be delivered for 18 months from October 2016. It involves multidisciplinary teams, including Mental Health Liaison Workers and Emotional Support Workers working alongside practices to provide assessment, liaison and early intervention. The wrap-around teams will support the work of general practice, provide emotional support to patients within a primary care setting, and provide assessment and referral onto other services where needed. They will also liaise with secondary care mental health services and follow up patients with serious mental illness who have been discharged back into primary care.

It is envisaged that this additional support will help move some patients, who are stable, from the specialist mental health team at Leeds and York Partnership NHS Foundation Trust (LYPFT) back under the management of general practice. And likewise, identify where patients may have been discharged back to primary care inappropriately and direct them back to specialist care.

The pilot project is being overseen by the Mental Health Framework Programme Board and the learning from it will help to inform future commissioning and resource decisions.

Otley Frail Elderly Service

The Otley GPs commissioned Leeds Community Healthcare to provide a nursing service to support frail elderly patients who have complex needs and could be at higher risk of an unplanned hospital admission. The team provides ongoing care and support for patients who are housebound and works directly with the practice team to co-ordinate and deliver proactive care to help prevent patients' health deteriorating.

New physiotherapist role working as part of the practice team

Two of our practices are currently testing the benefits of having a physiotherapist, who specialises in musculoskeletal (MSK) care, working closely within the general practice team. Lots of GP appointments are currently booked by patients with MSK needs and this new model is already providing a faster and more responsive service for patients.

Receptionists have been trained to ask patients, in an appropriate way, if their needs are MSK related. If so, they can book them onto the physiotherapist's list, who will call them back within two working days. During the phone consultation the physiotherapist will identify the patient's needs, give them advice and then email an individual exercise plan (if appropriate). They will then follow up with the patient to monitor improvement. This model helps patients to self-manage their symptoms and provides quicker access to specialist MSK support. To date around 1,000 patients have used the service and satisfaction levels are extremely high, with patients feeling they have received a responsive and professional service.

New practice based pharmacists

We have continued to work with practices to expand the roles of pharmacists within GP practices as part of our new models of care. So far this year we have recruited six new pharmacists to work in GP practices across the Leeds North area. These pharmacists are involved with face to face long-term condition management, medication reviews and dealing with a broad range of queries to enable patients to get the best out of their medication. They also play an important role in helping patients self-manage their conditions and in improving medicine related communication between general practice, hospitals and community pharmacy.

3.5.5 Medicines Optimisation

Throughout the past year, the Medicines Optimisation team at NHS Leeds North CCG has worked to improve quality, efficiency and innovation in the use of medicines by health and care providers in North Leeds.

A summary of the work undertaken by the CCG in the past year is shown below:

Improving the treatment of patients with Diabetes

We have been working with GP practices to improve the care of patients with diabetes. During this year we have been encouraging practices to record a target HbA1c for each patient. At the beginning of the year only 6 practices were recording this information, by the end of the year all practices were recording it, with an increase of 6,000 patients. Practices were also encouraged to ensure patients were prescribed lancets and blood testing strips if they were on medication requiring testing and there are now 30% more patients receiving this equipment than at the beginning of the year.

Improving antimicrobial prescribing

Antimicrobial resistance is one of the biggest threats to people's health and wellbeing, with scientists warning that if more isn't done there is a real risk that antibiotics will no longer be effective.

We've been working with our partners to improve understanding of antimicrobial resistance among healthcare professionals and the wider public within north Leeds and citywide. This includes working with prescribers to reduce the prescribing of antibiotics when they're not needed and developing awareness campaigns to make the public aware of the risks of overuse. We are also promoting linked messages to reduce the spread of infection, such as effective hand washing and spotting the signs of sepsis.

One project has involved working with children at David Lloyd Academy in Seacroft to produce a video aimed at raising awareness in older children around appropriate antibiotics use.

We have also carried out patient engagement around antibiotic prescribing. Of the 800 people that took part in the survey, 91% of respondents believed that coughs, colds and sore throats usually get better on their own, without antibiotics; 87% of respondents wish to avoid antibiotics; and 94% agreed that if antibiotics didn't work in the future this could affect their health.

We have continued to work with practices to reduce antibiotic prescribing and we are achieving positive results: in fact we are one of the best performing CCGs in the country for this. By helping to lower antibiotic resistance we can ensure that patients are treated in safer environments and protected from avoidable harm.

Care home medication reviews helping to avoid admissions

We have been working with GP practices and care homes to review 165 patients over the first six months of 2016/17. This has resulted in 816 interventions and a predicted saving of £18,681 per year. Most of these savings have been due to stopping unnecessary medication and avoiding potential admissions.

Better treatment of Atrial Fibrillation to reduce stroke

We have built on the success of the last 2 years' work by continuing to work with GP practices and secondary care colleagues to improve access to anticoagulant medication. This has enabled more patients' diagnosed with atrial fibrillation (a common heart rhythm disorder) to be treated appropriately and reduce their chance of suffering a stroke. During 2015/16 660 people were reviewed and an additional 200 patients have been reviewed during 2016/17. The volume of anticoagulants prescribed continues to increase, as a result of these reviews, ensuring that more people are protected.

Ensuring cost effective prescribing

We have continued to optimise our prescribing of medicines which has resulted in safer, more effective treatment and at the same time making £400,000 of savings on our prescribing budget by minimising the amount of medicines wasted. This has helped keep NHS Leeds North CCG consistently below the regional and national averages.

We have also introduced computer software into all GP practices to help them implement cost effective prescribing which has produced savings of another £500,000 to date. While another £60,000 has been saved by reducing spend on unlicensed medicines and those which have either limited evidence for their use or are not supported by NICE. The savings from which can be used to prescribe more cost-effective, NICE approved medication.

3.6 Reducing health inequalities

Reducing health inequalities is a key priority for us as a CCG. We know that people living in deprived areas in Leeds experience far poorer health outcomes than those in more affluent neighbourhoods. Within the Leeds North footprint alone there is a life expectancy gap of almost 9 years for men and 12 years for women between the most and the least deprived areas.

Our mission is that through successful and effective partnerships with our communities, patients and partners we will reduce health inequalities and deliver improvements in health for local people within the resources available. Our work in this area links in with the Leeds Health and Wellbeing Strategy, the West Yorkshire and Harrogate STP and the Leeds Plan.

As part of the Internal Audit Plan for 2016/17 a health inequalities audit was conducted. The objective of this was to provide a level of assurance that suitable arrangements were in place to support and evidence how Leeds North CCG is meeting its legal duties to reduce health inequalities. The final audit report evidenced that we do have adequate arrangements in place and made a number of recommendations to strengthen these arrangements, for which we have now agreed actions and timescales.

Steps to achieve our mission

This section of the report provides a summary of the range of activities, programmes and structures that are in place to help reduce health inequalities and deliver improvements in health for all.

As part of the Health and Social Care Act 2012, it is a statutory requirement for all local authorities to provide public health advice, guidance and support to CCGs through the Memorandum of Understanding (MOU). A Public Health Consultant and Health Improvement Principal are firmly embedded at NHS Leeds North CCG to ensure that this requirement is met and there are a range of Public Health staff with citywide roles that are linked to the CCG. In Leeds, the positive contribution made by Public Health and the strong relationships between the CCG and Public Health are recognised.

NHS Leeds North CCG has developed a Health Inequalities Delivery Plan 2015-17 to ensure we achieve our mission. Its specific priorities are to:

- Reduce premature mortality
- Increase opportunities for the population of Leeds North to live longer, healthier lives
- Increase targeted support for vulnerable groups and specific communities
- Increase opportunities to address the wider determinants of health
- Provide population public health advice, evidence of effectiveness and impact on inequalities in relation to healthcare

We have also set up a Health Inequalities and Health Improvement steering group to develop, co-ordinate and drive forward the actions identified in the delivery plan. The group is chaired by the Consultant in Public Health and comprises of representatives from Public Health, Commissioning, Primary care, Medicines Management, a clinical lead and information analyst.

3.6.1 Targeted funding

- In 2015, a recurrent resource of £100,000 of funding was agreed by our Council of Members for all practices where 900 or more of their population lives in deprivation. The funding allocation per practice is weighted according to their numbers. The purpose of the funding is to help these practices identify the key health needs of their population and to develop tailored activity to address these needs. A peer review session is held annually as part of the evaluation process.
- A non-recurrent funding resource has also been provided to deliver a 2 year programme in the health inequalities practices to tackle the culture of non-engagement with primary care. This provides additional administrative capacity to focus specifically on encouraging patients to attend NHS Health Checks, cervical screening and immunisations. This is in addition to the recurrent health inequalities funding that these practices already receive.
- NHS Leeds North provides a funding contribution to Leeds City Council (LCC) contracts for Health Trainers, Forward Leeds and Warmth for Wellbeing. This secures additional local level provision within our area and contributes towards reducing health inequalities.
- We have also provided match funding to LCC to fund a one year Chapeltown Project Development Worker. The aim of this post is to improve links between health, LCC and the community and the outcomes have been very successful. A range of activity has been developed within the centre and with practices. This includes recruiting community health champions and supporting the Connect Well and mental health programmes. As a result LCC and the CCG have agreed to extend the post for another year.
- In addition to this there is a broad range of other work that contributes towards our mission to reduce health inequalities, including developing practice profiles to help practices understand the needs of their populations, direct Public Health support and third sector investment.

3.6.2 Examples of good practice

Bowel Cancer Screening Champions

This programme has been running since September 2015 and targets practices in Leeds North with the lowest bowel cancer screening uptake rates. These practices correspond directly with areas of the greatest deprivation. A champion has been identified within each of these practices whose role it is to carry out targeted work to encourage the uptake of bowel cancer screening. These champions have received training from Bowel Cancer UK and motivational interviewing training. In addition to this, they receive ongoing support through the champion peer support network, Public Health, the CCG's Primary Care Team and Cancer Research UK.

This programme has developed wider community awareness and engaged with specific target groups. For example, Chapeltown Family Surgery has worked with a local mosque to raise awareness around bowel cancer and encourage uptake of screening amongst the Muslim community where uptake rates are traditionally low.

The programme has seen some very positive early outcomes. Bowel cancer screening rates are increasing and NHS Leeds North CCG has achieved both the quality premium target

for bowel cancer screening and the national target of 60%. The gap in uptake between deprived and non-deprived practices has also been closing percentage wise and our CCG has had the highest level of improvement, over the last 12 months of all the West Yorkshire CCGs. Due to this success, a further 2 years funding has been secured and the remit of the champions' role has been extended to include breast screening.

3.6.3 Supporting people with mental health problems

NHS Leeds North leads on mental health commissioning for the city. We understand the importance of ensuring people have access and support when they are experiencing mental ill-health or distress. This year we have undertaken a lot of work to ensure **'Parity of esteem'** for people with mental health needs. 'Parity of esteem' is the principle by which mental health must be given equal priority to physical health that was enshrined in law by the Health and Social Care Act 2012. This has been one of our key priorities and we have increased our investment in this important area.

Our city's Health and Wellbeing Strategy prioritises the mental health of citizens in Leeds and we've continued to invest in services that improve mental health and wellbeing. In 2016/17 we have been working on a number of projects to help people access mental health treatment and advice more quickly.

- Following an extensive co-production process, we have developed a new single point of access website for adult mental health known as MindWell: www.mindwell-leeds.org.uk This is the single 'go to' place for easy to access, up-to-date information about mental health for anyone living or working in Leeds, including GPs and other professionals. Launched on World Mental Health Day in October 2016, MindWell is proving very effective. In fact it has already won the Patient Engagement Award at the Medilink Yorkshire and Humber Healthcare Business Awards 2017 in recognition of its work with services users.
- With funding from NHS England's West Yorkshire Vanguard project, we have commissioned a third sector agency to establish a crisis café. The Well Bean Café run on Saturday, Sunday and Monday evenings from 6pm -12pm in Lincoln Green, near St. James's Hospital, offers a non-clinical alternative to using the A&E department at times of mental health crisis.
- We have a well-established, cross-sector crisis care partnership group that includes: West Yorkshire Police, Yorkshire Ambulance Service, staff working in mental health and A&E, community and voluntary sector organisations. The group has continued to meet throughout the year to work on continual improvements to the mental health crisis pathway with a particular focus on access and quality of care as set out in the national Mental Health Crisis Care Concordat.
- For the last 10 years Leeds has benefitted from an excellent Early Intervention in Psychosis service which was recently rated "outstanding" for access in a CCQI report commissioned by NHS England. In 2016/17 this programme has been extended up to the age of 65.
- We have worked with Leeds and York Partnership NHS Foundation Trust to reduce the number of patients being placed 'out of area' for treatment. Changes in care pathways have seen a significant and consistent reduction in out of area placements since September 2016 with only 90 bed days (8 people) in

total for quarter three, compared to 424 bed days (25 people) for quarter two. Quarter four figures are not available at the time this annual report is published.

- Commissioners have worked collaboratively with clinicians, third sector partners and Adult Social Care (Leeds City Council) to develop a new model for community based services. This was signed off by the CCG Network in October 2016 and is informing service developments and commissioning into 2017/18.
- We're piloting new "liaison" roles in primary care to improve the routes to assessment and brief interventions. There are currently around 10 new practitioners working across the city creating a more multi-disciplinary approach, which also includes pharmacist advice and guidance. The primary purpose is to get the patient to the right place first time and avoid unnecessary referrals to specialist services.
- A public health specialist has been working across the system to refresh the mental health needs assessment. This is due for publication in April 2017.
- Service Users, in partnership with clinicians, have developed a set of "I Statements" which clearly state how they wish to be treated by mental health services. These were signed off by the citywide User Group in September 2016 and adopted by commissioners in all service specifications for 2017/18.

3.6.4 Supporting people with learning disabilities

We have been developing and implementing the Leeds Transforming Care Partnership (TCP) to deliver the national three year plan "Building the Right Support". The purpose of this strategy is to develop more effective community services for people with learning disabilities and/or autism with complex behaviour. This helps to support discharge from and prevent admission to hospital via access to specialised assessment and treatment.

The TCP is a partnership of commissioners and providers working in adult health and social care and children and young people's social care. A three year plan has been published (including an easy read version): www.leedsnorthccg.nhs.uk/news/transformation-care-plan-people-learning-disability-andor-autism

The programme, to be completed by March 2019, seeks to ensure that service users and families are at the heart of all work. Co-production is an essential component of the delivery plan. A scoping workshop was held with service users and families in February 2017 to agree the model and approach. Seven key work streams have now been identified to deliver the strategic objectives of the all age plan which is being overseen by the TCP.

Another new initiative this year to improve the health and wellbeing of people with learning disabilities is 'The Making Time Pharmacy Project'. This supports improved access to local pharmacies for people with learning disabilities by providing 'protected time' with pharmacists to help identify their health needs and develop a personalised health action plan. This project has been recognised nationally and won two awards for innovation.

3.6.5 Dementia Services

NHS Leeds North CCG was judged as "Performing Well" for dementia in NHS England's first publication of the CCG Improvement and Assessment Framework. This was based on the dementia diagnosis rate and the number of people receiving an annual face-to-face review.

Over the course of the year we improved our dementia diagnosis from 1,554 people on GP registers (end March 2016) to 1,600 (end Feb 2017). The diagnosis rate (recorded diagnosis as a proportion of estimated prevalence) increased from 58.6% to 59.4%. However, we believe the CCG will achieve the NHS England ambition for a two-thirds (66.7%) diagnosis rate from April 2017. This is because the current method of calculating the indicator will change to a simpler, more realistic method based on GP register numbers. Under the new methodology, NHS Leeds North CCG would already have a diagnosis rate of 69.6% (based on existing diagnosed numbers).

- A new GP-hosted Memory Clinic opened at Oakwood Lane Surgery in autumn 2016. This is in addition to an existing one at Crossley St Surgery which opened in autumn 2015. Initial feedback is that both these clinics are very popular with patients and clinicians. Missed appointments are much rarer than for traditional services at outpatient locations. The new Memory Clinics see patients from other local surgeries as well as the host practice and travel distances are reduced, especially for patients in the Wetherby area who no longer have to travel to Knaresborough. Oakwood Lane also hosts a Memory Café on the mornings of clinic sessions so patients and carers can benefit from a relaxed and welcoming atmosphere and the opportunity to meet people going through similar experiences.
- The Memory Support Worker service completed its first 12 months in October 2016. It has very quickly established itself as a highly valued and easily accessible service for people and families seeking support before and after diagnosis. Citywide, more than 1,500 people were supported in those first 12 months. In spite of a very challenging financial situation, the service has been funded for a further year and evaluation is in progress. It has been shortlisted for a Health Service Journal award for 'Clinical Value' from a large number of high calibre entries; the winners will be announced on 24th May 2017.
- Patients and carers living with dementia in the Wetherby area can also attend a new weekly Wellbeing/Memory Café, which is run as a partnership between two community organisations, Dementia Forward and Wetherby in Support of Elderly (WiSE). There are fifteen regular attendees and it is continuing to grow. This has been funded by the CCG for its first twelve months and the two charities aim to sustain the café longer-term.
- We continue to work with partners to improve day-to-day support for people and carers living with dementia. We have supported Carers Leeds to continue with hospital-based dementia carer support and Touchstone Leeds to provide help for people from BME communities; although again funding remains short-term and sustaining services remains a challenge. We recognise and applaud local community organisations who are addressing the needs of people with dementia using their independent fundraising and voluntary efforts. These include Black Health Initiative, Leeds Irish Health and Homes and several local churches which hold dementia-friendly services and/or host memory cafes.

3.6.6 Maternity and Children's Services

Ensuring that children enjoy the best possible start in life is a citywide priority, as outlined in the Leeds Health and Wellbeing Strategy.

Maternity

The three CCGs are currently reviewing maternity services as part of an ongoing long-term review, involving a number of key partners: Leeds Maternity Strategy 2015-2020 – www.leedswestccg.nhs.uk/content/uploads/2015/06/Maternity-strategy-for-Leeds-2015-2020.pdf

Working groups have established a new citywide perinatal mental health pathway to help identify and support the emotional and mental health needs of women who are pregnant or have just had a baby. These groups are now meeting to ensure pathways are communicated and embedded. Perinatal information also now features prominently on MindWell – new single point of access website for adult mental health services in Leeds (see Section 3.5.3).

Targeted work has taken place to understand the specific experiences and needs of women with learning difficulties and disabilities in relation to maternity services. As a result of this, various changes have been made, including the introduction of new protocols and accessible information.

Work has continued to move towards more personalised maternity care in Leeds. As part of this, community midwifery teams have been reorganised to better align with children's centres and a 'Leeds definition of personalised care' has been co-produced with women, families, and clinical staff.

The Leeds CCGs have also joint funded (alongside the Department of Health and Leeds City Council) the award winning Best Beginnings "Baby Buddy" app which provides useful support, key health information and details of local services throughout a woman's pregnancy.

Children's services

NHS Leeds South and East CCG leads on commissioning services within the city for children and young people. In December 2016 Ofsted and the CQC inspected Leeds partners on their delivery of responsibilities for children and young people with Special Educational Needs and Disabilities (SEND). The Inspectors noted a number of key strengths, including how children and young people who have SEND are proud to be citizens of Leeds and have a voice in improving services in the city. Partnership was also noted as a key strength. Areas requiring some development were improving the educational achievements of this cohort and ensuring that Education, Health and Care Plans (EHCP) were child centred and outcome focussed.

In addition we continue to work with our neighbouring CCGs to develop and deliver the Local Transformation Plan for children and young people's mental health and wellbeing. This year the Future in Mind: Leeds strategy was launched to improve the social, emotional, mental health and wellbeing of children and young people aged 0–25 years.

Other significant achievements during the year include a reduction in CAMHS waiting times and the establishment of a distinct Community Eating Disorder Service for children and young people. We have also launched the MindMate champions' programme for schools and developed MindMate lessons (linked into the PHSE curriculum for emotional and mental health): these tie in with the launch of the MindMate website which offers dedicated advice, support and signposting information for children and young people, parents/carers and frontline professionals: www.mindmate.org.uk

3.7 Contributing to the Leeds health and wellbeing strategy

We are committed to investing in services and projects which support improvements in health, wellbeing and quality of life, in line with the aims of the Leeds Health and Wellbeing Strategy. This strategy sets out a vision for Leeds to be a healthy and caring city for all ages, where "people who are the poorest improve their health the fastest".

We know that within Leeds North there are almost 50,000 people living within the most deprived areas nationally and that people living in those areas experience significantly poorer health outcomes. NHS Leeds North CCG is committed to addressing these health inequalities and delivering improvements for local people through successful and effective partnerships with our communities, patients and partners.

3.7.1 Third Sector Grants Scheme

The CCG has invested just under £1 million to deliver its Third Sector Health Grant programme, in partnership with the Leeds Community Foundation. This innovative grants scheme aims to improve health and wellbeing, prevent ill health and ultimately enable local people to lead healthier lives.

In 2015 nineteen locally based charities and community organisations were awarded grants by an independent panel to deliver interventions throughout 2016/17. The panel included representatives of patients, clinicians and commissioners.

Grants ranged from smaller grants of £5,000 to larger grants of up to £70,000, all of which were focussed on addressing health and wellbeing in local communities within north Leeds. Projects cover a range of interventions, across a wide range of beneficiaries. These included: carers, adults with long term conditions, disabilities and/or mental health problems, parents (including teenage parents and parents-to-be), children, older people, refugees/asylum seekers and the BAME (Black, Asian and Minority Ethnic) community – therefore meeting many of the identified priorities within the Leeds Health and Wellbeing Strategy.

Many of these projects we funded piloted innovative ways of addressing local needs. Examples of the nineteen projects include:

Dial (Leeds) Limited – Weekly advice sessions at the Moortown Foodbank for disabled people and those living with long term conditions. Volunteer advisers and support workers provide advice, advocacy, negotiations and representations on welfare reform, access to health services, energy advice and budgeting in order to help alleviate poverty, in particular food and fuel poverty.

Solace Surviving Exile & Persecution – Family Therapy based approach to working with asylum seekers and refugees and improving their mental health outcomes.

Carers Leeds – One-to-one health advice and support, group work and training for unpaid carers around healthy lifestyles (food, exercise, reduction in smoking and alcohol) and mental wellbeing.

TCV Hollybush – Developing and evaluating the potential of outdoor practical activity sessions to improve the physical and mental wellbeing of priority groups. This involves conservation volunteers doing outreach work and running sessions at two satellite sites in Leeds North.

Otley Action for Older People – Working with local GP surgeries, community healthcare teams and our new social prescribing scheme, Connect Well, to create a support network and source of advice for older people with long term health conditions. This includes holistic assessments and an outreach home-visiting service to engage with those most in need or at risk. This project, known as 'Healthy Together', is encouraging community involvement, physical activity and self-management of health conditions.

Leeds 14 Trust – Community food research project aimed at improving eating and lifestyle behaviours in this significantly deprived area. The North Seacroft Community Food Hosts provide support and help increase knowledge around diet, exercise and health through the Seacroft Supper Club, Digital Dinners and breakfast clubs. They also run family food and activity days in the park and monthly Saturday morning food events for families. Sports coaches from Street Work Soccer Academy also provide sporting activities for boys, girls and older men.

St Gemma's Hospice – We have been working with Leeds Involving People (LIP) to understand and address the low take up of hospice services by people from BAME communities in LS7 and LS8. We carried out focus groups with harder to reach communities to identify specific end of life care issues and barriers, develop community awareness of the palliative services available and build community relationships to help improve service models.

3.8 Patient and public involvement

We work with patients and the public to ensure that the services we plan and buy on their behalf are tailored to the needs of the population of North Leeds.

Under the Health and Social Care Act we have a legal duty to engage and involve our local population in decisions that affect them. Our published Communications and Engagement Strategy describes how we do this.

Our aims for patient and public involvement are to:

- put patients at the heart of everything we do;
- commission high quality services by consistently involving people in their planning, evaluation and improvement;
- introduce clear and accountable functions for patient and public involvement (PPI);
- support the development of local patient reference groups;
- ensure that involvement is representative of all our communities; and
- share and build on best practice across Leeds.

We recognise that people want to get involved at different levels and in different ways. Many of us lead very busy lives and have a limited amount of time to get involved in decisions that perhaps don't directly or immediately affect us. We therefore communicate with, and involve patients and the public in a variety of ways and use their feedback to help shape our commissioning plans and priorities.

This includes:

- working with the wider public to seek views on our strategy and commissioning plans;
- sharing information with patients, carers and the wider public so that they are aware of service changes and are able to make informed choices;
- asking people for their views about local services through surveys and events;
- involving patient champions in commissioning projects to provide assurance that our engagement is robust; and
- feeding back to local people so that they can see how their experiences and feedback have helped to shape services.

This section of the report outlines the structures and processes we have put in place to support meaningful involvement; how we are working with our partners to ensure that we are reaching diverse and hard to reach groups; and some of the key engagement work we have carried out this year.

Patient Assurance Group (PAG)

The Leeds North Patient Assurance Group (LNPAG) is a local group of volunteers who play an important role in ensuring that patients, carers and the public are involved in decisions made about healthcare services in North Leeds. They look at commissioning plans and proposals and offer feedback on whether we have made sufficient plans to involve and engage patients and the public. We actively look to recruit new members to bring new perspectives to the group. You can find out more about our PAG by visiting: www.leedsnorthccg.nhs.uk/get-involved/join/patient-assurance-group

This year we have worked with our PAG members and commissioners to develop an engagement plan template. This supports commissioners in ensuring that their plans meet our statutory PPI requirements so that services can be developed that closely reflect the needs of local people.

Patient Participation groups (PPGs)

From 1st April 2016 it has been a contractual requirement for all English GP practices to form a Patient Participation Group (PPG). These are made up of a group of volunteer patients, the practice manager and one or more GPs who meet on a regular basis to discuss the services on offer and how improvements can be made for the benefit of patients and the practice.

Over the course of the last year we have worked closely with our PPGs to help them understand their role as patient champions. We want PPG members to look beyond their own experience of using services and consider the needs of the diverse communities we serve.

We provide our PPGs with intelligence that helps them better understand the needs of people who are not represented at the group, including access to the results of the national GP survey and population data in the practice profile. This information helps them to set their plans and priorities based on the needs and preferences of the wider community, especially those potentially excluded and disadvantaged groups.

We have also been working with some of our practices to develop **Virtual Patient Participation Group Networks**, which will complement rather than replace the existing face to face meetings. Through the development of this online resource we hope to strengthen our engagement with communities and develop a broader network that is more representative of the diverse patient population of north Leeds.

Membership is growing and we have held a co-creation workshop with practices to see how we can best capitalise on the opportunities a digital network presents.

Healthwatch Leeds Report

To enable our PPGs to be as effective as possible, we asked Healthwatch Leeds to carry out some independent research to find out what works well in our PPGs and where more support may be helpful for them.

Healthwatch conducted 52 face to face or telephone interviews with staff and patients between August and November 2016. They spoke to 8 staff who coordinate the PPGs in the selected practices; 11 PPG members and 32 patients across these surgeries. The Area Operation Manager of One Medical Group also took part.

Healthwatch produced a report outlining the feedback and recommendations which included that:

- PPGs should have a clear purpose
- Meetings should be accessible
- Practices should demonstrate how they have responded to PPG feedback
- Information should be available to patients who are interested in joining the group
- Support should be available for PPG members across the city
- PPG members should be encouraged and supported to get opinion from the wider public and not rely on feedback from the PPG.

The report acknowledged that much of this work was already happening but that PPG members were often not aware of what was available. We are currently carrying out the follow actions in response to the feedback:

- Sharing details of existing resources with GP practices across the city

- Encouraging all PPG members to sign up to the CCG patient network so that they have access to information on engagement activities
- Encouraging PPG members and staff to attend the CCG patient training on PPGs (these sessions run three times a year)
- Encouraging PPG members to attend the monthly peer support group so that they can support each other and share good practice
- Developing a PPG leaflet that will be available to all GP practices

We will share our progress on all these actions with Healthwatch and our PPG members.

Volunteer away day

In September 2016 we worked with our partners at the other two CCGs in Leeds to hold a citywide volunteer away day. The event was an opportunity to 'Explore how we work together in Leeds to ensure that the voice of patients, carers and the public is heard and acted on when we plan, review and pay for services.' 31 people from the different patient participation groups (PPGs) and PAGs across the city attended the event to learn about healthcare developments in the city and to share good practice with their peers.

Patient champion programme

We recognise the challenges in understanding the needs and preferences of the diverse population of Leeds. Rather than focus on the tokenistic approach of developing 'representative' groups we have worked hard to develop a citywide group of people who, while not representative, do recognise, understand and embrace equality and diversity. We have trained our patient champions to provide assurance throughout the commissioning cycle by asking for evidence that we have engaged thoroughly and are using the feedback to develop our services. We currently have 44 patient champions in the programme, 12 of whom are actively involved in 12 different commissioning steering groups.

The programme trains and supports local people so that they can champion the views of the wider public throughout the commissioning process. This is done through:

- Providing a comprehensive suite of bespoke co-designed training for both patients and staff
- Facilitating a monthly peer support group for patient champions
- Providing individual support
- Providing tools and resources to patient champions and staff

During 2016/17 our co-designed training included sessions on co-production and equality and diversity which supports PPG and PAG members to understand some of the challenges faced by people from 'seldom-heard' communities. The training was co-produced with our commissioning support unit and a member of the deaf community in Leeds. All our training is continuously evaluated and developed using patient feedback.

Peer support

Our citywide peer support group meets monthly. It offers an opportunity for PPG and PAG members to support each other, share good practice and address barriers to effective participation. Between April 2016 and February 2017 88 people have attended the peer support sessions at which a wide range of topics have been discussed. This includes supporting the development of PPGs and developing a citywide approach to engagement and assurance.

The meetings have presented opportunities to improve the way we engage with local people:

- **You said** *'Patient champion training is not accessible to people who work traditional working hours';*
  We did *'We improved the accessibility to the training and now offer eight of the ten sessions at the weekend'.*
- **You said** *'We need a citywide event to meet and share good practice in the city';*
  We did *'We set up our citywide volunteer away day for NHS volunteers that was attended by 31 people'.*

Patient, carer and public network

We have invested in a searchable database which has allowed us to create a network of engaged, local people who are interested in hearing about and contributing to local NHS developments. This has reduced written correspondence, increased participation and enabled us to promote engagement activities in a more co-ordinated and targeted manner based on the demographic and geographic data provided. Our network members also receive a copy of our quarterly magazine and a monthly e-newsletter.

Community Voices

We hold a series of informal public information events throughout the year. These are called "Community Voices" events and they take place at different locations throughout North Leeds. It is a great chance for local residents to come together with members of staff from the NHS in the area to hear about local developments and for members of the public to tell us what is important to them via the various methods of feedback available. Our staff are on hand at these events to listen to any comments, questions or concerns people wish to raise.

Three Things

During 2016 we have been carrying out a listening exercise, asking people in North Leeds to tell us 'three things' about local NHS services. This could be things you like, things you don't like, things which are priorities for you, or things you would like to change. This engagement finished at the end of March 2017. The results will be shared and used to help shape plans in 2017/18.

Working with our partners

We are committed to working with the voluntary, statutory and faith sector to ensure that we hear and respond to the most vulnerable members of our community, as we recognise that the CCG does not have the capacity to work with the wide range of 'hidden' communities in Leeds.

- We have commissioned the voluntary sector to engage with 'easily ignored' groups. Leeds Involving People support us by engaging with the public when we propose changes. Voluntary Action Leeds run an asset based engagement project that allows us to understand the views of the most 'seldom heard' communities in our city.
- We have developed links with key stakeholders in Leeds to ensure that our engagement activities are promoted widely.
- At the end of 2016 we started a partnership with our neighbouring CCGs, Leeds and York Partnership NHS Foundation Trust and Leeds Teaching Hospitals NHS Trust to support involvement in the city. This Engagement Hub brings together patients, professionals and other stakeholders to offer a range of training and peer support. Involving our partners has enabled us to expand the range of training we can offer.

- We also worked closely with Leeds City Council, and other members of the Leeds Health and Wellbeing Board, to capture views prior to developing the refreshed Leeds Health and Wellbeing Strategy 2016-2021.

Urgent Care services

We worked with LIP to carry out patient research on people's experience of urgent care services in Leeds, including the Shakespeare walk-in centre. In total we engaged with 430 patients via GP surgeries, community groups and events, local libraries and supermarkets. We also carried out focus groups with hard to reach groups, such as BAME communities. This provided really useful insight for the urgent care team as they propose future models of Urgent Care delivery as part of the Leeds Plan.

Engagement plans for 2016/17

- We will continue to work with and support our PPGs and PAG
- We will work with the other CCGs in the city to develop a citywide database that allows us to share relevant information in a consistent way
- We will continue to hold regular training and peer support to empower our patient champions
- We will work with the voluntary sector to ensure that potentially excluded and disadvantaged groups are getting the opportunity to influence our plans and priorities.

3.9 Safeguarding

We have a legal responsibility to ensure that the needs of children and adults at risk of abuse, or suffering abuse, are addressed in all the work that we undertake and commission on behalf of the people of Leeds. Our Accountable Officer has overall responsibility for safeguarding. The Director of Nursing and Quality is the executive lead for safeguarding.

The citywide safeguarding team comprises of a Head of Safeguarding/Senior Designated Nurse for Safeguarding Children and Adults at Risk, supported by a Deputy Head/ Designated Nurse for Safeguarding Children and Adults at Risk.

In addition, the team has a Deputy Designated Nurse for Safeguarding Children and Adults at Risk/ Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS) Lead, two named nurses for Safeguarding Children and Adults at Risk and a named GP for Safeguarding Children. The Head of Safeguarding/Senior Designated Nurse provides strategic leadership for safeguarding and advice across the health agencies. The named GP provides leadership and support within primary care. This model fully integrates and reflects the 'Think Family, Work Family' approach adopted by all partners in Leeds.

The CCG Safeguarding Children and Adults at Risk Committee meets bi-monthly. Its membership includes commissioners, heads of quality, designated nurses, designated doctors and the directors of nursing and quality. The Safeguarding Committee works on behalf of all three CCGs according to an agreed action and audit programme. It reports into each CCG's individual governance structure.

Key highlights for 2016/17 include:

- A revised CCG Strategy and Training Programme to reflect the NHS England Safeguarding Adults: Roles and Competences for Health Care Staff – Intercollegiate Document which was published in February 2016.
- An increase in the numbers of health staff accessing Prevent training. This training helps practitioners to safeguard vulnerable people from being radicalised into supporting terrorism or becoming terrorists themselves.
- Strong commitment to improving GP engagement with the child protection process, including the development of an electronic child protection conference report template. This template is compatible with both EMIS and SystmOne – the two IT systems used by GP practices in Leeds.
- Continued commitment to working closely with primary care and the safeguarding lead GPs, facilitating quarterly peer support meetings which meet level 3 competences (Royal College of Paediatrics and Child Health 2014).
- Developing a SystmOne and EMIS compatible template to allow health and care staff to flag patients' electronic records. This provides an alert if the patient is an adult at risk, a victim of, or at risk of domestic violence/abuse (DVA) and records the outcome of the routine enquiry.
- Additional investment in the CCG safeguarding team to increase its capacity and resources in order to respond to the co-commissioning of primary care.
- Strong commitment to the development of the Front Door Safeguarding Hub. This acts as a contact centre for health and

care practitioners to identify appropriate responses where there are concerns about the welfare or safety of a child or young person. The Hub also offers a co-ordinated and consistent response to domestic violence cases.

- Partnership and support of the Leeds Safeguarding Children Board and Leeds Safeguarding Adults Board. This includes working on awareness campaigns to raise the profile of the work of these safeguarding boards.
- Continued commitment to raising the profile of: safeguarding adults; Mental Capacity Act (MCA); Deprivation of Liberty Safeguards (DoLS); Prevent; and domestic violence and abuse in primary care.
- Improved working between our MCA/DoLS lead and the lead/DoLS manager within Leeds Adult Social Care to identify patients who receive care in their own homes, are funded through continuing healthcare and require a Court of Protection Order.

Challenges for 2017/18 include:

- To continue to support health's contribution to the Front Door Safeguarding Hub and ensure integration between health and social care.
- To continue supporting and managing the expanding field of safeguarding including the Prevent agenda, human trafficking, child sexual exploitation, forced marriage and female genital mutilation.
- Working with GPs to improve the quality of child protection reports, the response to requests for child protection reports and attendance at child protection conferences.
- To continue to support the 'Break the Cycle' project to reduce the risk of children entering care.
- To continue to embed learning into practice from national and local safeguarding reviews.
- To further develop the 'early help' approach within General Practice. 'Early help' is the term used by agencies in Leeds to describe our support for potentially vulnerable children, young people and families as soon as problems start or when there is a strong likelihood that problems will emerge in the future.
- CCGs and other NHS providers are preparing for the publication of The Independent Inquiry into Child Sexual Abuse. However, there is currently very little guidance available from central government on this.
- The Wood review of local safeguarding children boards (May 2016) will invariably pose a challenge to the Leeds Safeguarding Children Board and all partner agencies.
- The impending Law Commission Review of DoLS is also likely to have significant implications for CCGs. The safeguarding team and MCA lead will continue to work with colleagues in Leeds City Council to address and embed any changes which impact upon us.

3.10 Equality and Diversity 2016/17

The Equality Act 2010 introduced a Public Sector Equality Duty, which means we have to ensure we give due regard to eliminate discrimination, harassment and victimisation; advance equality of opportunity; and foster good relations between people with one or more protected characteristics, both in relation to our commissioning responsibilities and our workforce. In addition we have to publish equality information annually, demonstrating how we have met the general public sector equality duty with regard to both our workforce (organisations with 150+ staff) and the population; and prepare and publish one or more equality objectives at least every four years.

We recognise the diversity of our communities, both citywide and within our CCG's geographical area. We are committed to eliminating unlawful discrimination and promoting equality of opportunity in the way we commission healthcare services and in creating a workforce that is broadly representative of the population we serve. We value and respect our staff and aspire to be an inclusive employer of choice.

We make sure that equality and diversity is a priority when designing, planning and commissioning local healthcare and respect the voices of the diverse communities we serve.

NHS Equality Delivery System

The NHS Equality Delivery System (EDS) is a performance framework that helps NHS organisations to improve the services they commission or provide for their local communities, consider health inequalities in their locality and provide better working environments, free of discrimination, for those who work in the NHS.

The aim of the EDS is to improve equality performance and embed equality into mainstream business planning processes. We use the EDS to support our commissioning role to deliver better health outcomes for all our communities and improve access and experience for our local population. As an employer we use the EDS to help create a working environment for staff which is personal, fair and diverse, and supported by an inclusive leadership approach at all levels.

NHS organisations are required to assess and grade their equality progress using the NHS EDS. The involvement of key stakeholders, representing the interests of our diverse communities, is an essential element of this. Following initial self-assessment, the role of stakeholders is to agree, through constructive discussion, one of four grades for each outcome and to identify key areas for improvement.

We continue to work in partnership across all NHS organisations in Leeds and have developed a new approach to the EDS engagement and assessment process. Our first citywide engagement and assessment workshop for Goal One "Better Health Outcomes for all" was held in September 2016; the second workshop for Goal Two "Improved Patient Access and Experience" was held in November 2016; with a third workshop for Goal Three "Empowered, engaged and well-supported staff" and Goal Four "Inclusive Leadership at all Levels" being held in February 2017.

All workshops were attended by representatives from each of the NHS organisations, as well as representatives from Voluntary Action Leeds, Leeds Involving People, Forum Central, Healthwatch Leeds and Leeds City Council. The events were very successful and a number of key areas for improvement were identified. The Equality Leads, together with colleagues

from each of the NHS organisations and our key stakeholders, will continue to work in partnership with the aim of improving performance in relation to EDS during 2017/18.

Further information is available on our website: www.leedsnorthccg.nhs.uk/about/equality-and-diversity

Equality Objectives

In 2013 we agreed to sign up to the citywide NHS equality objectives and continue to work with all NHS organisations in Leeds to improve performance. These are:

- To improve the collection, analysis and use of equality data and monitoring for protected groups.
- To support the development of leadership at all levels within the NHS economy in Leeds that values and promotes equality, diversity and inclusion.
- To ensure on-going involvement and engagement of protected groups and "local interests" including patients, carers, staff, third sector and local authority.
- To improve access to NHS services for protected groups

Each year we provide a performance update on our progress in relation to these objectives and identify priorities for the following year. Our performance update for the equality objectives is included in our Public Sector Equality Duty Report 2016.

Over the next few months we will review the citywide NHS equality objectives and develop new objectives, using the evidence gathered for our 2016/17 EDS assessment and engagement with our panel of key stakeholders.

Our last Public Sector Equality Duty Report is available on our website: www.leedsnorthccg.nhs.uk/content/uploads/2016/07/Public-Sector-Equality-Duty-Report-2015.pdf

NHS Workforce Race Equality Standard

An NHS Workforce Race Equality Standard (WRES) was developed and introduced in 2015. NHS organisations are required to review and report against nine indicators: a mix of NHS workforce data, staff survey data and a specific indicator to address low levels of BME representation at Board level.

The WRES became mandatory in April 2015. It is expected that year on year all NHS organisations will improve workforce race equality and that these improvements will be measured and demonstrated through the annual publication of data for each of the WRES indicators.

Our WRES report 2016 showed that for each of the nine indicators there were no major concerns in relation to disparities between White and BME staff. Appropriate actions have been identified to improve performance against the indicators for 2017. Progress against the WRES action plan will be monitored by our Workforce Review Group.

Our WRES report 2016 is available on our website: www.leedsnorthccg.nhs.uk/content/uploads/2016/07/LNCCG_WRES_2016.pdf

Monitoring NHS Provider Organisations

As a commissioner of healthcare, we have a duty to ensure that all our local service providers are meeting their statutory duties under the Equality Act 2010 Public Sector Equality Duty. As well as regular monitoring of performance, patient experience and service access, we work with them to consider their progress on their equality objectives. This includes the NHS

Equality Delivery System (EDS), the NHS Workforce Race Equality Standard (WRES) and the implementation of the Accessible Information Standard. Each provider organisation is subject to the specific duty and has published its own data.

We have included the requirement for provider trusts to evidence their compliance within their contracts and have developed and agreed systems to monitor their equality performance. In particular we expect to see information on their performance relating to the Public Sector Equality Duty, the NHS EDS, the WRES and the implementation of the Accessible Information Standard.

When procuring new services, we ensure that service specifications include the requirement to have robust policies in place to ensure that the needs of the nine protected characteristics and other vulnerable groups are adopted. These policies are examined and approved by procurement teams and our equality lead prior to any contract being awarded.

Examples of work during 2016/17:

- We continue to be members of the Leeds NHS Equality Leads Forum. We work with NHS organisations in Leeds to reduce health inequalities for our communities when commissioning or providing healthcare. We also look to improve equality of opportunity in respect of our workforce.
- We continue to chair the Leeds equality network which brings together public sector and third sector organisations across Leeds to collectively identify and address inequalities that exist in Leeds. Throughout 2016/17 network members have continued to organise attendance at the Leeds Migrant Community Network meetings. Other key topics/ areas of work have included; Leeds research network; BME hub health event; veterans of the armed forces and mental health; and the co-ordination of key equality related events across all organisations.
- We developed and implemented the new Leeds approach in relation to the NHS Equality Delivery System engagement and assessment process and have taken part in four successful citywide workshops.
- We have continued to hold bi-monthly Equality and Diversity Steering Group meetings. These provide an opportunity for all members to share their current knowledge of the equality agenda; discuss ideas for sharing good practice; consider future development opportunities and potential challenges within each CCG.
- We have reviewed and revised our training session "Knowing your communities" for our patient champions programme. Training sessions will continue to run throughout 2017.
- We continue to be active members of the Leeds CCGs Accessible Information Standard working group. The aim of the group is to ensure there is a consistent approach across all healthcare providers in relation to compliance with the standard.

3.11 Sustainable development

We recognise that we must offer services that meet local demands in a way that maximises wider positive impacts. Adding social, economic and environmental value will benefit our workforce, our providers, our local communities, the Leeds economy and the natural environment.

Following the adoption of the Social Value Charter for Leeds in 2015-16 we have, this year, developed a joint framework for the evaluation of social value alongside our partners in Leeds West CCG and Leeds South and East CCG. Our framework enables us to quantify and embed social value in our commissioning processes.

A telehealth pilot programme, run by Street Lane and Leeds North GP practices, has provided an opportunity for us to appraise the environmental sustainability of the musculoskeletal care pathway. By comparing the pathway with and without the use of telehealth, we have been able to establish estimates of the environmental benefits of telehealth in a GP practice setting.

Our Sustainable Development Management Plan (SDMP) underpins how we will continue to increase the sustainability of our organisation. For the past two years, this document has been produced in partnership with Leeds West and Leeds South and East CCGs. This joint approach increases efficiency and knowledge sharing, helping us to meet our sustainability ambitions.

Reducing our Carbon Footprint

We continue to monitor our CO2 emissions and focus our efforts on reducing our impacts. Overall, our CO2 emissions have decreased by 27% on our baseline year of 2013-14. We have experienced a minor increase in CO2 emissions on 2015-16 of 4% (1.72 tonnes CO2). This can be attributed to a 27% increase in business travel by car mileage and a 29% increase in general waste tonnage output. Whilst these are significant increases within the emission category, waste and travel form a comparatively small component of our carbon profile.

In shaping our SDMP for next year, we shall address these increases in emissions through reducing business mileage by car (e.g. increased teleconferencing) and implementing more effective controls to reduce, reuse and recycle our waste.

Item	Unit	Consumption				CO2 Emissions (tonnes CO2e)			
		2013-14	2014-15	2015-16	2016-17	2013-14	2014-15	2015-16*	2016-17
Electricity use	kWh	38,789	40,260	43,467	41,000	21.72	24.93	21.59	20.35
Gas use	kWh	151,849	95,580	94,410	97,695	32.21	20.05	19.31	19.93
Travel by car	Miles	14,903	14,081	17,352	22,683	5.51	5.17	5.33	7.00
Travel by rail	Miles	9,906	18,802	28,767	15,560	0.92	1.70	1.29	0.70
General waste	Tonnes	5.80	2.50	2.70	3.80	3.25	0.34	0.80	1.60
Recyclable waste	Tonnes	0.50	2.00	2.20	2.90	0.00	0.14	0.15	0.61
					Total CO2 Emissions (t CO2e)	63.61	52.33	48.47	50.19
					Change on Previous Year (%)	N/A	-18%	-7%	+4%

*CO2 emissions for 2016-17 have been calculated using the 2016 DEFRA carbon factors which are available here: http://www.ukconversionfactorscarbonsmart.co.uk/. These factors are revised each year in line with the carbon intensity of power, fuel and prevailing waste management practices. The use of these government conversion factors explains why, in some cases, our consumption has increased while our carbon emissions have decreased.

3.12 Requests for information / data loss

The CCG is committed to being open and transparent. This includes meeting the statutory requirements of the Freedom of Information (FOI) Act. The FOI requires every public body to produce and regularly maintain a publication scheme. We have adopted the Information Commissioners Office's model publication scheme for health bodies Our aim is to increase openness and transparency about what we do, what we spend, our priorities, decisions and policies.

We also aim to make it easier for members of the public to find the information they require without having to make a written request. Our publication scheme can be found here: https://www.leedsnorthccg.nhs.uk/foi/publication-scheme/

In 2016/17 we received 208 requests under the Freedom of Information Act – compared to 223 in 2015/16. We responded to all of these requests within the mandatory 20 working days, except 3 requests which were withdrawn:

	FOI requests received	Requests responded to within 20 days
April	29	29
May	20	20
June	17	17
July	13	13
August	16	16
September	15	14
October	12	12
November	17	17
December	13	13
January	19	17
February	17	17
March	20	20
Totals	208	205

Data Loss

In the last financial year there have been no serious incidents within the CCG relating to data loss or security.

"I can confirm that I have not been made aware of any incidents that have been determined to be externally reportable at any of the Leeds CCGs from 1 April 2016 to date." – Alastair Cartwright, Director of Informatics at the Leeds CCGs.

3.13 Emergency preparedness

We certify that the Clinical Commissioning Group has business continuity plans in place to comply with NHS England's emergency preparedness requirements. We submit an annual emergency preparedness self assessment to NHS England. In addition, as commissioners we require that all our providers have in place robust emergency preparedness, business continuity and major incident plans. These are reported to the contracts management board for our main providers.

The CCG also engages with other partners and supports the local authority emergency preparedness and resilience planning in Leeds. We also engage on a West Yorkshire level in key meetings as required.

Philomena Corrigan
Accountable Officer

24 May 2017

ACCOUNTABILITY REPORT

IN THIS SECTION:

4.0 CORPORATE GOVERNANCE

4.1 Members Report

This section of the corporate governance report summarises the decision-making structure of the CCG. More detail is provided in the Annual Governance Statement section of the report (see Section 4.3).

Member practices

The CCG is a membership organisation comprised of 25 GP member practices across North Leeds. The CCG is formed around a Council of Members as its core decision-making body. The Council consists of representatives from each of its member GP practices. It meets formally every two months to enable practices to discuss and agree how to tackle health issues affecting their local patients and communities.

This union of GP practices ensures that participation is at the heart of everything NHS Leeds North CCG does. Matters reserved for the Council include amendments to the constitution and approval of the CCG's annual plan.

The CCG's member practices in 2016/17 were:

Aireborough Family Practice
Allerton Medical Centre
Alwoodley Medical Centre
Bramham Medical Centre
Chapeltown Family Surgery
Chevin Medical Practice
Collingham Church View Surgery
Crossley Street Surgery
Foundry Lane Surgery
Meanwood Group Practice
Newton Surgery
North Leeds Medical Practice
Oakwood Surgery
Oakwood Lane Medical Practice
One Medicare (The Light)
Rutland Lodge Medical Centre
Shadwell Medical Centre
Spa Surgery
St Martin's Practice
Street Lane Practice
The Avenue Surgery
Westfield Medical Centre
Westgate Surgery
Wetherby Surgery
Woodhouse Medical Practice

4.1.1 Composition of Governing Body

The CCG Board is responsible for ensuring that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the group's principles of good governance. The members of the Board in 2016/17 were:

- Clinical Chair – Dr Jason Broch
- Chief Officer – Nigel Gray
- GP Non-Executive Director – Dr Nick Ibbotson
- Lay Member (Governance) – Peter Myers
- Lay Member (Public & Patient Involvement) – Graham Prestwich
- Chief Financial Officer – Martin Wright
- Clinical Director – Dr Manjit Purewal
- Practice Manager Representative – Petra Morgan
- Secondary Care Consultant – Dr Mark Freeman
- Public Health Consultant – Lucy Jackson
- Non-Executive Board Nurse – Diane Hampshire
- GP Non-Executive Director – Dr Simon Robinson (to January 2017)
- Director of Commissioning (Primary Care and New Models of Care) – Gina Davy (to December 2016)
- Director of Nursing & Quality – Clare Linley (from September 2016)
- Director of Commissioning & Strategic Development – Sue Robins (from January 2017)

The profiles of our Board members can be viewed here: www.leedsnorthccg.nhs.uk/about/board/team

Committees, including Audit Committee

The CCG has established a Primary Care Commissioning Committee, which is responsible for making decisions on the review, planning and procurement of primary care services in the CCG's area, under delegated authority from NHS England.

The Board has established several formal Committees to which it has delegated some of its responsibilities. These are:

- Audit Committee
- Remuneration Committee
- Governance, Performance & Risk Committee
- Quality & Safety Committee (joint with Leeds South and East CCG from June 2016)

The members of the Audit Committee during 2016/17 were:

- Lay Member Governance – Peter Myers (Chair)
- Lay Member PPI – Graham Prestwich
- GP Non-Executive Director – Dr Nick Ibbotson

The Remuneration Report includes details of the membership of the Remuneration Committee and the Annual Governance Statement includes full details of all of the CCG's committees.

4.1.2 Register of Interests

In line with our Managing Conflicts of Interest policy, the CCG maintains registers of interests for members of the CCG Board and its Committees, CCG staff and member practices. Before each Board and Committee meeting, members are required to declare any conflicts of interests relating to items on the agenda.

The registers can be viewed here: https://www.leedsnorthccg.nhs.uk/results/?for=register+of+interests

Personal data related incidents

There were no Serious Untoward Incidents relating to data security breaches during the year and none were reported to the Information Commissioner.

Statement of Disclosure to Auditors

Each individual who is a member of the CCG at the time the Members' Report is approved confirms:

- so far as the member is aware, there is no relevant audit information of which the CCG's auditor is unaware that would be relevant for the purposes of their audit report
- the member has taken all the steps that they ought to have taken in order to make him or herself aware of any relevant audit information and to establish that the CCG's auditor is aware of it.

Modern Slavery Act

NHS Leeds North CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

4.2 Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England).

The responsibilities of an Accountable Officer are set out under the National Health Service Act 2006 (as amended), Managing Public Money and in the Clinical Commissioning Group Accountable Officer Appointment Letter. They include responsibilities for:

- The propriety and regularity of the public finances for which the Accountable Officer is answerable;
- Keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction);
- Safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities);
- The relevant responsibilities of accounting officers under Managing Public Money;
- Ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the National Health Service Act 2006 (as amended); and
- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group to prepare for each financial year financial statements in the form and on the basis set out in the Accounts Direction. The financial statements are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Clinical Commissioning Group and of its net expenditure, changes in taxpayers' equity and cash flows for the financial year.

In preparing the financial statements, the Accountable Officer is required to comply with the requirements of the Group Accounting Manual issued by the Department of Health and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards, as set out in the Group Accounting Manual issued by the Department of Health, have been followed and disclose and explain any material departures in the financial statements; and,
- Prepare the financial statements on a going concern basis.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out under the National Health Service Act 2006 (as amended), Managing Public Money and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I also confirm that:

- as far as I am aware, there is no relevant audit information of which the CCG's auditors are unaware and that, as Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the CCG's auditors are aware of that information.
- that the annual report and accounts as a whole are fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

Philomena Corrigan
Accountable Officer

24 May 2017

4.3 Governance Statement

NHS Leeds North Clinical Commissioning Group Annual Governance Statement 2016-17

Introduction and context

NHS Leeds North Clinical Commissioning Group (CCG) is a body corporate established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended).

The CCG's statutory functions are set out under the National Health Service Act 2006 (as amended). The CCG's general function is arranging the provision of services for persons for the purposes of the health service in England. The CCG is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population.

As at 1 April 2016, the CCG is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

The CCG currently comprises 25 member practices across North Leeds. The CCG is formed around a Council of Members as its core decision-making body. The Council consists of representatives from each of its member GP practices. It meets formally every two months to enable practices to discuss and agree how to tackle health issues affecting their local patients and communities.

This union of GP practices ensures that participation is at the heart of everything NHS Leeds North CCG does. The member practices reflect the health needs of their patients and the views of their GP practice.

4.3.1 Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the CCG's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I am responsible for ensuring that the CCG is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the CCG as set out in this governance statement.

4.3.2 Governance arrangements and effectiveness

The CCG's Constitution has been formally agreed by our member practices and sets out our arrangements for discharging the CCG's statutory responsibilities for commissioning care on behalf of our population. It sets out our governing principles, rules and procedures that ensure probity and accountability in the day to day running of our CCG, clarifying how decisions are made in an open and transparent way and in the interests of patients and the public.

More specifically, our Constitution includes:

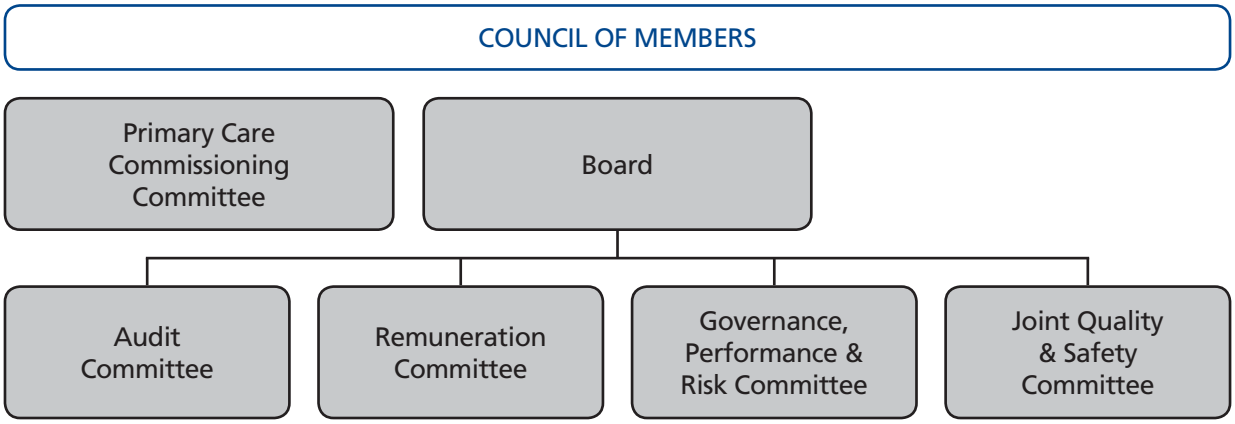
- Our membership
- The geographical area we cover
- The arrangements for the discharge of our functions and those of our Board (including roles and responsibilities of members of the Board)

- The procedures we follow in making decisions and to secure transparency in decision making
- Arrangements for discharging our duties in relation to Registers of Interests and managing Conflicts of Interests.
- Arrangements for securing patient and public involvement

Our Constitution is a living document, which is updated to reflect changes in national guidance, our membership and composition. Any amendments are submitted in line with NHS England guidance, following consultation and approval by our Membership.

In January 2017, the Council of Members agreed amendments to the constitution to enable the establishment of the West Yorkshire and Harrogate Healthy Futures Joint Committee, which will be an important component of the West Yorkshire & Harrogate Sustainability & Transformation Plan ("STP").

Our governance arrangements are shown below.



The Council of Members
The CCG is a membership organisation comprising all of the GP member practices across North Leeds. The Council of Members consists of two representatives from each practice, a clinical and a non- clinical/ management representative, to ensure that the CCG reflects all GP practices in the area. Matters reserved for the Council include amendments to the constitution and approval of the CCG's annual plan.

Members attend bi-monthly meetings, where they reflect the health needs of their population and the views of their GP practice. Council meetings consist of workshop sessions, at which members have the opportunity to discuss key issues affecting their localities and patients, and formal agenda items, when key decisions are made, for example the approval of changes to the constitution. A summary of Council proceedings is submitted to each meeting of the Board and the minutes are available on the CCG website. The effectiveness of Council in engaging with clinicians is shown by consistently high attendance by member practices – over 90% over the year:

Council of Members	Attendance (eligible to attend)
Aireborough Family Practice	6 (6)
Allerton Medical Centre	6 (6)
Alwoodley Medical Centre	6 (6)
Bramham Medical Centre	6 (6)
Chapeltown Family Surgery	6 (6)
Chevin Medical Practice	6 (6)
Collingham Church View Surgery	6 (6)
Crossley Street Surgery	6 (6)
Foundry Lane Surgery	6 (6)
Hilton Road	1 (1)
Meanwood Group Practice	6 (6)
Newton Surgery	4 (6)
North Leeds Medical Practice	6 (6)
Oakwood Surgery	6 (6)
Oakwood Lane Medical Practice	6 (6)
One Medicare (The Light)	6 (6)
Rutland Lodge Medical Centre	6 (6)
Shadwell Medical Centre	2 (6)
Spa Surgery	3 (6)
St Martin's Practice	6 (6)
Street Lane Practice	6 (6)
The Avenue Surgery	6 (6)
Westfield Medical Centre	6 (6)
Westgate Surgery	6 (6)
Wetherby Surgery	6 (6)
Woodhouse Medical Practice	6 (6)

The CCG Board

The Board is responsible for ensuring that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the group's principles of good governance. The Board has established several formal Committees to which it has delegated some of these responsibilities. These are described in the CCG's constitution and consist of:

- Audit Committee
- Remuneration Committee
- Governance, Performance & Risk Committee
- Quality & Safety Committee (joint with Leeds South and East CCG from June 2016)

From 1 April 2016, the CCG had a Primary Care Commissioning Committee to oversee delegated responsibilities for primary care co-commissioning.

The work of each committee is directed by the functions delegated to it by the Board through their terms of reference. During 2016/17, all of the committees reviewed their terms of reference. Any changes to the terms of reference were approved by the CCG Board.

To ensure effective and timely information flows between the Board and its Committees, the Chair of each Committee presents a written summary of the meeting at the subsequent Board meeting. Any issues which Committees consider should be escalated to the Board are highlighted through this mechanism.

To ensure that the Board is sighted on patient and public involvement (PPI), it receives an update on PPI activity at each public Board meeting, together with a summary report from the Patient Assurance Group. Each Board meeting also commences with a 'patient story'.

To ensure that the Board and its Committees are operating effectively, there is a formal 'review of the meeting' item at the close of each meeting. This review has led to changes in how the Board and Committees operate, including improving the format and style of reports.

The Board met 12 times in 2016/17 (6 times in public):

Board	Attendance (eligible to attend)
Clinical Chair (Dr Jason Broch)	8 (12)
Chief Officer (Nigel Gray)	10 (12)
GP Non-Executive Director (Dr Nick Ibbotson)	10 (12)
Lay Member – Governance (Peter Myers)	10 (12)
Lay Member – Public & Patient Involvement (Graham Prestwich)	12 (12)
Chief Financial Officer (Martin Wright)	11 (12)
Clinical Director (Dr Manjit Purewal)	7 (12)
Practice Manager Representative (Petra Morgan)	8 (12)
Secondary Care Consultant (Dr Mark Freeman)	7 (12)
Public Health Consultant (Lucy Jackson)	12 (12)
Non-Executive Board Nurse (Diane Hampshire)	11 (12)
GP Non-Executive Director (Dr Simon Robinson) (to January 2017)	6 (10)
Director of Commissioning – Primary Care and New Models of Care (Gina Davy) (to December 2016)	9 (9)
Director of Nursing & Quality (Clare Linley) (from September 2016)	8 (8)
Director of Commissioning & Strategic Development (Sue Robins) (from January 2017)	3 (3)

During 2016/17, Board workshops reviewed the effectiveness of governance and risk management arrangements and explored a range of strategic issues including:

- A review of the CCG's strategic objectives
- Strategic risks and the Board Assurance Framework
- The West Yorkshire Sustainability and Transformation Plan
- Development of a population health management approach
- The 'One Voice' approach to strategic commissioning and system integration

The Board completed a self-assessment which gave an insight into the effectiveness of the Board. The results of the self-assessment will be explored in a Board workshop in April 2017.

Audit Committee

The Audit Committee critically reviews the CCG's financial reporting and internal control principles and ensures that an appropriate relationship with both internal and external auditors is maintained. It approves a comprehensive system of internal control, including budgetary control, that underpins the effective, efficient and economic operation of the CCG.

The Audit Committee is chaired by the Lay Member for Governance and consists of the Lay Member, Public and Patient Involvement and a GP Non-Executive Director. Each member of the Audit Committee is also a member of the Board. In attendance at each meeting is the CCG Chief Financial Officer together with representatives from internal and external audit.

The work of the Audit Committee has included ensuring there is an effective internal audit function and reviewing the work and findings of the external auditors. It has ensured that the CCG has adequate arrangements in place for countering fraud and during the year approved an updated anti-fraud and bribery policy. The Committee monitors the integrity of the CCG's financial statements. The Committee has placed particular emphasis on ensuring that actions in response to audit findings are implemented in a timely fashion, escalating any issues to the Board where appropriate.

The Committee carried out a self-assessment based on the Healthcare Financial Management Associations' NHS Audit Committee Handbook. At its meeting in April 2017, the Committee will review the issues raised in the self-assessment and agree any plans needed to address them.

The Audit Committee met 5 times in 2016/17:

Audit Committee	Attendance (eligible to attend)
Lay Member Governance (Peter Myers) – Chair	5 (5)
Lay Member PPI (Graham Prestwich)	5 (5)
GP Non-Executive Director (Dr Nick Ibbotson)	5 (5)

Remuneration Committee

The Remuneration Committee's role is to advise and make recommendations to the Board about appropriate remuneration and terms of service for the Chief Officer and other senior managers/officers not on Agenda for Change national terms and conditions.

The Remuneration Committee is chaired by the Lay Member for Governance and consists of the Lay Member, Patient and Public Involvement, a GP Non-Executive Director and the Clinical Chair. Each member of the Remuneration Committee is also a member of the Board.

The Remuneration Committee met twice in 2016/17:

Remuneration Committee	Attendance (eligible to attend)
Lay Member Governance (Peter Myers) – Chair	2 (2)
Lay Member for PPI (Graham Prestwich)	2 (2)
GP Non-Executive Director (Dr Simon Robinson)	1 (1)
GP Non-Executive Director (Dr Nick Ibbotson)	0 (1)
Clinical Chair (Dr Jason Broch)	2 (2)

Governance, Performance & Risk Committee
The Governance, Performance & Risk Committee (GPR), provides assurance to the Board that the CCG has effective systems of internal control in relation to risk management and performance and to ensure effective governance across all commissioned services.

The GPR Committee is chaired by the Chief Officer and consists of a Lay Member, Chief Financial Officer, Clinical Director, Director of Nursing, GP Non-Executive and Director of Commissioning.

The work of the Committee includes monitoring the CCG's risk management systems. In 2016/17, this included overseeing the development of the Board Assurance Framework and regular monitoring of the corporate risk register.

The Committee oversees the development of all CCG policies and approves these on behalf of the Board. Key policies approved in 2016/17 included Managing Conflicts of Interest and Standards of Business Conduct.

The Committee receives and scrutinises performance data covering NHS Constitution and local key performance indicators. Where performance has caused concern, the Committee has called in lead commissioners to outline the improvement plans in place to put performance back on track. During 2016/17, these 'deep dives' have included risks to the delivery of the emergency care standard, child and adolescent mental health services and the Better Care Fund.

The GPR Committee met 6 times in 2016/17:

Governance, Performance and Risk Committee	Attendance (eligible to attend)
Chief Officer (Nigel Gray) – Chair	4 (6)
Lay Member PPI (Graham Prestwich)	5 (6)
Chief Financial Officer (Martin Wright)	6 (6)
Clinical Director (Dr Manjit Purewal)	5 (6)
GP Non-Executive Director (Dr Nick Ibbotson)*	3 (4)
GP Non-Executive Director (Dr Simon Robinson) *	2 (2)
Interim Director of Commissioning – Partnerships and Performance (Rob Goodyear)	4 (6)
Director of Nursing & Quality (Clare Linley)	4 (5)
Interim Director of Commissioning – New Models of Care (Gina Davy) (to	2 (3)
Director of Commissioning (Sue Robins)(from January 2017)	2 (2)

Note: * – GP non Execs alternated attendance

Quality and Safety Committee

The Quality and Safety Committee provides assurance to the Board that commissioned services are being delivered in a high quality and safe manner, ensuring that quality sits at the heart of everything the CCG does. It also ensures that the principles of quality assurance and governance are integral to performance monitoring arrangements for all CCG commissioned services and are embedded within consultation, service development and redesign and the evaluation and decommissioning of services.

From June 2016, the Quality and Safety Committee started meeting jointly with Leeds South and East CCG's Quality Committee. This helped ensure a more consistent and joined-up approach to quality assurance across the 2 CCGs.

The Committee has overseen the development of quality management and assurance reports covering key quality metrics relating to the CCG's providers. As a result of the CCG taking on responsibility for commissioning primary care, these reports now cover primary care providers. Quality reports include metrics such as Healthcare Acquired Infections, the Family and Friends Test and Safer Staffing.

The Committee receives reports on children and adults safeguarding and serious healthcare incidents and complaints. During 2016/17, areas of particular focus for the committee have included care homes, primary care and the impact on quality of increasing pressure on the whole health system.

The Quality & Safety Committee met 6 times in 2016/17, 5 times as a Joint Committee:

Joint Quality & Safety Committee	Attendance (eligible to attend)
Clinical Director (Dr Manjit Purewal) – Chair	5 (6)
Lay Member PPI (Graham Prestwich)	5 (6)
GP Non-Executive Director (Dr Nick Ibbotson)*	0 (1)
GP Non-Executive Director (Dr Simon Robinson) *	5 (5)
Director of Nursing (Clare Linley)	4 (5)
Non-Executive Board Nurse (Diane Hampshire)	5 (6)

Note: * – GP non Execs alternate attendance

Primary Care Commissioning Committee

The Primary Care Commissioning Committee was established in April 2016. It is a committee of the CCG (rather than the Board), and is responsible for making decisions on the review, planning and procurement of primary care services in the CCG's area, under delegated authority from NHS England.

During the year the Committee has received regular updates on quality, performance, finance and risks associated with general practice. It has approved the citywide General Practice Forward View delivery plan, the process for making bids under the Estates Technology Transformation Fund and arrangements for investing PMS monies.

The Committee met 5 times in 2016/17:

Primary Care Commissioning Committee	Attendance (eligible to attend)
Lay Member – Public & Patient Involvement (Graham Prestwich) – Chair	5 (5)
Chief Officer (Nigel Gray)	4 (5)
Lay Member – Governance (Peter Myers)	4 (5)
Chief Financial Officer (Martin Wright)	4 (5)
Secondary Care Consultant (Dr Mark Freeman)	3 (5)
Public Health Consultant (Lucy Jackson)	5 (5)
Non-Executive Board Nurse (Diane Hampshire)	5 (5)
Director of Commissioning – Primary Care and New Models of Care (Gina Davy) (to December 2016)	4 (4)
Director of Nursing & Quality (Clare Linley) (from September 2016)	3 (3)
Director of Commissioning (Sue Robins) (from January 2017)	1 (1)

Patient Assurance Group

The CCG is committed to ensuring that patients and the public are involved in all aspects of its work and that patient feedback is used to inform business planning, and commissioning arrangements and to identify potential service improvements. The Patient Assurance Group (PAG) is an independent public and patient group of volunteers. The PAG provides feedback on how effective and meaningful patient and public involvement has been in the design and delivery of local health and wellbeing services. During 2016/17, the PAG continued to focus its attention on the core commissioning responsibilities of the CCG – Mental Health, Learning Disability and Urgent Care. It also reviewed patient and public engagement on prescribing and explored how practices were engaging with patients through Practice Participation Groups.

A summary of each PAG meeting is reported to the Board.

Leeds Integrated Commissioning Executive

The CCG has a joint meeting with Leeds City Council and NHS England (in relation to its direct commissioning responsibilities), the Leeds Integrated Commissioning Executive (ICE). Leeds ICE has oversight of the joint health and social care commissioning agenda in the city and has responsibility for negotiating opportunities for integrated commissioning of Health and Social Care services in Leeds. Leeds ICE is the Executive arm of the Leeds Health & Wellbeing Board.

Leeds CCG Network

The CCG participates in joint arrangements with NHS Leeds South & East CCG and NHS Leeds West CCG via the Leeds CCG Network. This is not a sub-committee of the CCG, but a cross-city working group. A documented Memorandum of Understanding is in place describing the joint commissioning arrangements within the Leeds health economy including the sharing of local commissioning strategies, the identification of commonalities and the delegation of contracting responsibilities.

Performance and Assessment of Effectiveness

To ensure that the Board and its Committees are operating effectively, there is a formal 'review of the meeting' item at the close of each meeting. This review has led to changes in how the Board and Committees operate, including improving the format and style of reports. The Board and each Committee have also carried out a self-assessment of their own performance and effectiveness throughout the year, which will be reviewed in April 2017.

UK Corporate Governance Code

Whilst the detailed provisions of the UK Corporate Governance Code are not mandatory for NHS bodies, compliance is considered to be good practice. This Governance Statement is intended to demonstrate the CCG's compliance with the relevant principles set out in the Code.

Discharge of Statutory Functions

During establishment, the arrangements put in place by the CCG and explained within the Corporate Governance Framework were developed with extensive expert external legal input, to ensure compliance with all relevant legislation. That legal advice also informed the matters reserved for Membership Body and Board decision and the scheme of delegation.

In light of the Harris Review, the CCG has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the CCG is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the clinical commissioning group's statutory duties.

4.3.3 Risk management arrangements and effectiveness

By working closely together, the Directors and I lead the risk management process, to ensure an integrated and holistic approach to the CCG's risk management activities.

The CCG has adopted a risk management strategy, supported by a risk management process. This aims to:

- ensure structures and processes are in place to support the assessment and management of risk throughout the CCG and across the three CCGs in Leeds;
- achieve a culture that encourages all staff to identify and control risks which may adversely affect the operational ability of the CCG;
- assure the public, patients and their carers and representatives, staff and partner organisations that the CCG is committed to managing risk appropriately.

The strategy sets out the process for identifying, recording, reporting, quantifying, managing and reviewing risks. Risks identified from a broad range of sources including incidents, complaints, internal audit reports and reports by external bodies are recorded on the CCG risk register. Risks that may affect the ability of the CCG to meet its strategic objectives are recorded on the Board Assurance Framework (BAF). The CCG Risk Management Strategy was reviewed and a revised version covering 2015-17 was approved by the Board in May 2015.

Risk management is embedded within the CCG and into wider working. For example, the CCG operates a citywide incident reporting system which facilitates the review of incidents to identify any which are a potential risk to the CCG.

The Board Assurance Framework (BAF)

The BAF sets out how the CCG manages the principal risks to delivering its strategic objectives. The CCG Board owns and determines the content of the BAF, identifying the strategic risks and monitoring progress throughout the year.

At a workshop in June 2016, the Board carried out a comprehensive review to ensure that the BAF captured all strategic risks. The BAF focuses on strategic and reputational risk rather than operational issues, highlighting any gaps in controls and assurances. The BAF provides the Board with confidence that systems and processes are operating safely and effectively.

A Director lead has been assigned to each risk and they have overall responsibility for their risk with support from a manager and the Governance leads. Each risk is regularly reviewed to ensure the controls and assurances remain valid and any identified gaps are mitigated by timely implementation of clearly defined actions. The updates are reported to bi-monthly meetings of the Board, Governance, Performance and Risk Committee and Quality and Safety Committee meetings. The controls, assurances and gaps in controls and assurance are scrutinised along with any actions required to reduce the risks.

Risk Registers

The risk register is a record of all the significant risks faced by the CCG. The register contains a description of the risk, the risk owner, the controls in place and any outstanding actions as well as a risk score. All identified risks have an Executive Director risk owner and an appointed responsible manager to ensure appropriate accountability for managing the risk.

A web-based risk register system, Datix, enables all staff to access and record risks. Staff use a standardised risk assessment form to record risks and the Risk Management Strategy provides a standard risk scoring matrix to ensure consistency. All risks are reviewed and approved by the identified risk owner Director before being accepted as an active risk on the CCG risk register. A number of risk reporting training sessions are held each year for all staff. This ensures that staff understand the risk management system and can openly report and manage risks.

The Strategy documents set levels of risk score that determine which risks are managed at an operational level on the risk register and those that are escalated to the corporate risk register for review by the Board.

The operational risks are managed within directorates with support from the citywide governance team. When risks increase in score, red 15 or above, they are escalated to the corporate risk register. The risks are reviewed and updated on a regular cycle with risk owners and the corporate risk register is reviewed every two months by the Board. Corporate and 'high amber' risks (those scored at 12 or above) are reported every two months to the relevant CCG committee. Responsible managers use various data streams to regularly assess the levels of risk they are managing and update the risks to ensure that an accurate position is presented.

The Datix risk management system enables risks to be captured at a local level as well as citywide. Citywide risks are recorded and reviewed by each CCG prior to acceptance on the risk register. Where risks vary in impact and likelihood across the city these

are managed by the specific CCG to ensure it reflects the local position. The combined citywide and local risks form the risk register. The citywide risk management system supports collaborative working and highlights risks that may affect multiple organisations, but also ensures that local priorities are addressed.

Risk Assessment

The CCG recognises the need for a robust focus on identifying and managing risks and places risk as an integral part of its overall approach to quality.

As Accountable Officer, I have overall responsibility for risk management in the CCG. Risk is assessed in accordance with the CCG Risk Management Strategy 2015-17. This requires managers to identify risks through established reporting streams and assess the likelihood and consequences of the risk occurring. This is done using a measurement matrix included in the strategy. This ensures a consistent approach to risk assessment regardless of the individual performing it. The likelihood and consequence matrix reflects the CCG's agreed risk levels and those at which escalation to senior managers and directors is required.

The risks on the corporate risk register that were escalated for review by the CCG Board as at 31st March 2017 are summarised below:

Risk ID	Risk Title	Risk score
466	**The achievement of the national Ambulance standards:** There is risk to the quality of care provided to all patients requiring the assistance of the Yorkshire Ambulance Service (YAS). This is due to the continued failure of the ambulance service to meet the national performance targets across the city of Leeds. As a result for patients requiring this level of service there is an escalated risk with the potential to impact on their health condition, treatment and recovery	16
286	**Outpatient follow-up waiting list** Failure to be seen in outpatient clinic by the date given by their consultant causing potential risk to patient safety, particularly in colorectal surgery and gastroenterology	16
532	**Commissioner and/or lead provider fails to achieve the operational standard for the 18 week Referral to Treatment Time** Failure to achieve the Referral to Treatment Time standard of no more than 8% of patients waiting more than 18 weeks from Referral To Treatment in each reporting specialty at month end, either as a CCG or within LTHT as lead provider for Leeds residents.	16

The CCG Board Assurance Framework (BAF) describes the CCG's principal risks to achieving its strategic objectives. Each BAF risk has an identified accountable Director and Board Committee to ensure clear responsibility for managing and monitoring the risk. Directors ensure that adequate control measures are identified against each element of risk and that the appropriate assurances are generated.

The 2016/17 BAF describes the CCG's principal risks at 31st March 2017 as:

Summary of 2016/17 Governing Body Assurance Framework

CCG Strategic Objective	Risk Title	Assurances (summary)	Risk score
The people of North Leeds will live independent and healthier lives	Resources are not targeted effectively to areas of most need, leading to failure to improve health in the poorest areas	• CCG inequalities action plan • Memorandum of understanding with Leeds City Council for Public health • Targeted facilitation support • Recurrent health inequalities funding • Social prescribing • Mental health framework • Outcomes framework includes key metrics to measure success in reducing health inequalities • Health and Wellbeing Board • Health and Wellbeing Strategy • Equality and Diversity assessments	6
	Inability to influence behavioural change, leading to failure to improve health and wellbeing	• Programmes to support patients to have more control of their health and wellbeing • Health coaching workforce element in Leeds plan • Citywide self-management action plan and Year of Care programme • Healthy living services • Practice engagement schemes • TeleX work programme • Co-design of pathways and community engagement • Mindwell	8
	Ineffective engagement with patients and the public, leading to commissioning decisions which do not meet the needs of our population	• Communications and Engagement Strategy • Public Participation and Involvement Groups • Patient Assurance Group • Commissioning for Value Group • Communications, Engagement, Equality and Diversity plan • Patient leader programme	9
The people of North Leeds will receive accessible, quality and supportive services	Failure to drive quality improvement, leading to commissioned services not reflecting best practice and improving care	• CCG Quality and Safety Committee • Leeds Institute for Quality Healthcare • Provider management and quality groups • Primary care quality improvement group • Commissioning for Quality and Innovation Scheme	8
	Providers fail to meet quality standards, leading to poor quality and unsafe care	• Provider management and quality assurance groups • West Yorkshire Quality Surveillance Group • CCG Quality Committee • CQC inspection programme • NHS Improvement work • System Resilience Assurance Board • Joint local authority and CCG care home forum • A&E recovery plan	8
	System-wide or provider capacity shortfalls, leading to a failure to meet patient needs	• System Resilience Assurance Board • System Flow Board • Emergency Care Standard action plan • Financial performance and accountability framework • Non-recurrent investment in RTT • Winter contingency fund in place until April 2017 • NHSE area team assurance reviews • Community Bed Strategy • DTOC plan • Acceleration zone for ECS and YAS • Operational resilience group • West Yorkshire Urgent Care Vanguard	16
	Inability to develop a population health management approach, leading to a failure to shift care out of hospital settings	• Population Health Management • Locality Teams supporting practices • GP Forward View and delivery plan • Locality leadership model • Engagement Scheme and Enhanced services • New models of care work	12
	Member practices do not fully engage and participate, leading to decisions which are not clinically led	• Primary care locality team structure • Primary care engagement scheme • Clinical leadership team and GP board members • Council of members	5

The CCG will deliver a well-led and sustainable health and social care system	Failure to achieve financial stability and sustainability, leading to an inability to fund the CCG's strategic objectives	• Citywide and STP plans in place • Financial plan • Provider contracts • Budgetary control system/framework • Detailed financial policies and procedures • Monthly budget reports and audit review	9
	Governance and risk management arrangements are not clear, robust and transparent, leading to poorly informed decisions and reputational harm to the CCG	• Clear governance structure with defined decision making • Governance, Performance and Risk Committee • Risk management strategy • Financial risk sharing • Internal audit programme • Board Assurance framework • Conflicts of interest and freedom to speak up guardians in place • NHSE annual assurance process	6
	Failure to secure the capacity and skills needed to be sufficiently agile, leading to an inability to respond quickly and effectively to change	• Organisational development plan • Investors in Excellence scheme • Resilience programme and lifestyle management support • Objectives and appraisal programme • Collaborative working • Leeds Academic Health Partnership	12
	Failure to work successfully with partners to integrate services, leading to duplication, waste and inefficiency	• Joint Health and Wellbeing strategy • WY STP and Leeds plan • MOU in place for 3 CCGs • MOU with public health • Closer provider working • Population health management group • One Voice CCG review	9

Other sources of assurance

Internal Control Framework

The system of internal control is the set of processes and procedures in place in the CCG to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

Internal and external auditors have been appointed to provide the Board with independent assurance of its process of internal control and to assure itself of the validity of this Governance Statement.

Throughout the year a series of audits have been undertaken to review the effectiveness of governance systems. The reports from these audits are submitted to the Audit Committee. Audit reports generally contain recommendations for improvement and associated action plans. All actions are assigned to an Executive Director with responsibility to complete within a designated timescale. Executive Directors are held to account by the Audit Committee for the completion of all actions. If actions are

not completed within the original timeframe, Executive Directors are required to attend the Committee to explain the reasons. All of the completed Internal Audit Reports for the CCG in 2016/17 were given a rating of significant or full assurance.

The Board Assurance Framework and the Corporate Risk Register are standing agenda items on the Board and Governance Performance and Risk Committee agendas. This allows CCG Board members to cross-check risks with any other significant developments that arise to ensure that risks are appropriately managed.

Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2016) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England has published a template audit framework.

The CCG's internal auditors carried out the audit of conflicts of interest in quarter 4 of 2016/17. The audit resulted in an opinion of significant assurance that the CCG has put in place arrangements to manage conflicts of interest that comply with the statutory guidance issued by NHS England in June 2016 and concluded that "the CCG can demonstrate a positive approach and culture towards the management of conflicts of interest."

Suggested areas for improvement included minor amendments to the CCG's registers of interest, gifts and hospitality and procurement decisions and to increase awareness of the role of the Conflicts of Interest Guardian and the staff that support this role.

Data Quality

The CCG receives a business intelligence service from its commissioning support provider (eMBED) and data is checked by informatics and planning staff within the CCG. The Board and all CCG Committees carried out self-assessments in March 2017 raising no concerns about data quality.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the clinical commissioning group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

The CCG places high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. The CCG takes its Information Governance (IG) responsibilities seriously. The CCG has a suite of approved IG policies and has provided awareness training to staff. It has also reviewed the service specification with its IT supplier which has included additional assurances around data security and more recently assurances around Cyber security. The CCG continues to use a specialist data centre to process any person identifiable data.

The CCG assessed its IG arrangements by completing the Information Governance Toolkit (IGT). This included a review of key factors by our internal auditors. The CCG achieved all the required levels. The CCG

has approved 'consolidated' data sharing agreements in place with NHS Digital to cover national data flows that have been de-identified to the required standard.

The CCG has a Board-level officer responsible for information security and the associated management processes, and this role is known as the Senior Information Risk Owner (SIRO). The CCG has a Board-level clinician responsible for ensuring that all flows of patient information are justified and secure, and this role is known as the Caldicott Guardian. IG training is mandatory for all staff, to ensure that staff are aware of their IG roles and responsibilities. Staff compliance is regularly monitored.

There is an IG Committee which reports to the Governance, Performance & Risk Committee. These are formal meetings with minutes and action tracking. The CCG has bought in an expert IG practitioner and advisory service from eMBED Health Consortium. Any breaches of security are managed within the CCG risk management policy and reported using the Datix risk management system.

Data Security
The CCG has arrangements in place to ensure data security. The CCG has contractual arrangements in place with an accredited IT provider – eMBED Health Consortium and the North East Commissioning Support Unit (NECS). The required Data Processing Agreements are in place. The IT provider has provided the IT facilities required to store the data needed for CCG business. The CCG does not hold 'local' data. NECS were approved by NHS Digital to process confidential data on the CCG's behalf. The CCG also uses national IT systems such as Oracle financials. These are operated under nationally stipulated security arrangements. CCG staff have undertaken the required IG training to handle data securely.

Business Critical Models
The CCG has assessed its predictive business models along with the associated level of criticality. Examples are: Risk Stratification, Activity and Contract plans/ forecasts and cash forecasts. Each business critical area has the required level of professional and management input. Data quality is monitored and there are service level agreements associated with the external provision of models such as Risk Stratification. Some external models such as ONS population forecasting are also classed as business critical, though not provided internally or via an SLA. The CCG has experience of robustly challenging the quality and accuracy of such external models.

Third party assurances
The CCG also seeks assurance for functions it sub-contracts to other service providers:

In 2016/17, eMBED provided the CCG with key services relating to Information Technology (IT), Business Intelligence, Information Governance and Human Resources. The CCG derives assurance on the adequacy of eMBED's key internal controls from reports which detail the control environments which apply to different elements of the service. Detailed service specifications and contractual KPIs are in place for all services and are monitored through regular contract monitoring meetings. Other elements of the control environment include business continuity plans and mandatory training for staff who provide services.

Leeds Teaching Hospitals NHS Trust provides payroll services to the CCG. The Trust has advised that Payroll was not considered by its Internal Auditors as a risk area for 2016/17 and was not subject to an Internal Audit review during this financial year. The Trust has confirmed that no matters relating to the running or performance

of the Payroll Department were brought to its attention which would undermine confidence in assessing controls assurance. It has also confirmed that there was no reason to believe that the Payroll service the CCG receives is not properly controlled, managed and resourced.

Control Issues

The CCG did not identify any control issues in its Month 9 Governance Statement return and no issues have arisen subsequently that require reporting in this Governance Statement.

Review of economy, efficiency & effectiveness of the use of resources

The Board has overarching responsibility for ensuring that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically.

The leadership of the CCG was assessed through the Quality of Leadership indicator of the CCG Improvement and Assessment Framework 2016/17. The year end results for the Quality of The leadership Indicator will be available from July 2017 at www.nhs.uk/service-search/scorecard/results/1175

The Board receives a comprehensive finance and contracts report from the Chief Financial Officer at each of its meetings. The CCG has a programme of internal audits that provides assurance to the Board and Executive Team on the effectiveness of its internal processes. The Audit Committee receives regular reports on financial governance, monitors the internal audit programme and reviews the draft and final annual accounts. The CCG's annual accounts are audited by our external auditors.

The CCG has developed and continues to refine systems and processes to effectively manage financial risks and to secure a stable financial position.

The CCG's 2016/17 financial plan and budgets were signed off by the Board before the start of the financial year. These budgets were subsequently communicated to managers and budget holders. The Chief Financial Officer and their team have worked closely with managers to ensure robust annual budgets were prepared and delivered.

Finance and contracts reports are presented to the Board bi-monthly. Alongside the financial position, performance against statutory duties, risks and actions to mitigate risks are reported to and scrutinised by the Board. The CCG is also required to provide monthly financial information to NHS England.

The CCG makes full use of internal and audit functions to ensure controls are operating effectively and to advise on areas for improvement. Audit reports, action plans and implementation of recommendations are discussed in detail at meetings of the Audit Committee.

The CCG's annual accounts are reviewed by the Audit Committee prior to formal approval by the Board.

The financial austerity which lies ahead is recognised by the CCG and future plans reflect the anticipated lower levels of growth and transfer of resource to the local authority, as part of the Better Care Fund.

The CCG is actively engaged in discussions to ensure resources are prioritised in line with its strategic direction, including opportunities for developing new models of care across the spectrum of Healthcare Providers.

The CCG recognises the need to achieve cost reductions through improved efficiency and productivity and work is ongoing to develop schemes to achieve the QIPP targets and savings from whole system transformation which form part of future financial plans.

Delegation of functions

The CCG has not delegated decision making on any aspect of its expenditure. The CCG does have a risk pooling arrangement in place with Leeds City Council. Governance processes have been clearly outlined in a formal agreement and control of the resources remains with the three CCGs in Leeds who make recommendations in partnership with the Council to the Health and Wellbeing Board for ratification.

Counter fraud arrangements

The CCG has contracted with Audit Yorkshire who provide an Accredited Counter Fraud Specialist (LCFS) to undertake counter fraud work. The LCFS meets regularly with the Chief Finance Officer who is responsible for overseeing and providing strategic management and support for all anti-fraud, bribery and corruption work within the organisation. The LCFS also attends all Audit Committee meetings and provides a progress report on the work undertaken. This includes a report on the outcome of the self-assessment against the NHS Protect Standards for Commissioners. The last assessment was presented in June 2016 with an overall score of 'green'.

4.3.4 Head of Internal Audit Opinion

Following completion of the planned audit work for the financial year for the CCG, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the CCG's system of risk management, governance and internal control. The Head of Internal Audit concluded in May 2017 that:

"Significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently."

During the year, Internal Audit issued the following audit reports:

Area of Audit	Level of Assurance Given
Incident Reporting	Full
Management of Conflicts of Interest	Significant
Primary Care Co-commissioning, Quality and Performance	Significant
Business Intelligence	Significant
Health Inequalities	Significant
System Resilience group	Significant
Information Governance Toolkit	Significant
Clinical Effectiveness	Significant
Budgetary Control and Key Financial Systems	Full
Continuing Healthcare (city wide)	Significant
QIPP (city wide)	Fieldwork Underway

Review of the effectiveness of governance, risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of governance, risk management and internal control within the CCG.

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, Executive Directors and Clinical leads within the CCG, who have responsibility for developing and maintaining the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving its strategic objectives have been reviewed.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Primary Care Commissioning Committee, the Audit Committee, the Governance, Performance & Risk Committee, the Joint Quality and Safety Committee and the Patient Assurance Group. Plans to address weaknesses and ensure continuous improvement of the system are in place.

The Board is responsible for leading and directing the CCG's approach. It has delegated to the Governance, Performance and Risk Committee responsibility for overseeing risk management and to the Audit Committee responsibility for approving a comprehensive system of internal control, including budgetary control, that underpins the effective, efficient and economic operation of the CCG.

The Primary Care Commissioning Committee has ensured close scrutiny of quality, performance, finance and the management of risks associated with primary care.

The Governance, Performance and Risk Committee oversees the CCG's arrangements for managing risk and ensuring sound governance. The Committee's regular review of the Board Assurance Framework and Corporate Risk Register have been critical in ensuring that the CCG focuses on key risks and puts in place appropriate arrangements to manage them.

The Audit Committee provides an independent oversight of internal controls within the CCG, with a particular focus on financial risk management. It reviews all internal and external audits and provides a robust challenge to both CCG managers and audit actions. It undertakes an annual self-assessment of its own performance.

The Quality and Safety Committee provides assurance to the Board that commissioned services are being delivered in a high quality and safe manner. The Committee provides a robust challenge to ensure that patients receive safe and effective care and that they have a positive experience of services.

The Patient Assurance Group challenges the CCG to ensure that patient and public involvement in the design and delivery of local health and care services has been effective and meaningful.

The CCG has assigned both internal and external auditors to provide the Board with independent assurance of its processes of internal control and to assure itself of the validity of this Governance Statement.

Throughout the year a programme of audits has been undertaken to review the effectiveness of governance systems. The reports from these audits are submitted to the Audit Committee. All audit reports contain action plans of work required as a result of the review findings. All actions are assigned to an Executive Director with responsibility to complete within the designated timescales. Directors are held to account by the Audit Committee for completion of all actions.

The CCG also seeks assurance from other areas about some of the services it receives. Annual assurance statements are received from the CCG's Payroll provider in respect of their internal controls.

Conclusion

During 2016/17, the CCG has developed and further strengthened its system of internal control. The Governance Framework is clearly articulated within our constitution and is underpinned by our Information Governance Strategy and Risk Management Strategy. Our refreshed Board Assurance Framework ensures that strategic risks are identified and managed effectively. All internal audit reports issued during the year provided either full or significant assurance that controls were suitably designed, consistently applied and effective. No significant internal control issues have been identified during the year.

The Head of Internal Audit Opinion has provided 'significant assurance' that there is a generally sound system of internal control. I am therefore satisfied that the CCG operates effective and sound systems of internal control.

Philomena Corrigan
Accountable Officer

24 May 2017

5.0 REMUNERATION AND STAFF REPORT

5.1 Remuneration Report

Remuneration Committee

The Remuneration Committee is a formally appointed committee of the Board. Information about its membership, number of meetings during the year and attendance records are provided in the Annual Governance Statement (see Section 4.3).

In November 2016, the CCG Board extended the Remuneration Committee's terms of reference to delegate to the Committee oversight of the remuneration and terms of service for all members of the CCG Board, except those employed on Agenda for Change terms and conditions.

Policy on the remuneration of senior managers

To determine the level of remuneration, both present and future, the Remuneration Committee takes into consideration national guidance issued by NHS England and benchmarking data from other CCGs.

In April 2016 an annual consolidated uplift of 1% was agreed, in line with Agenda for Change, for the Chief Officer, Chief Financial Officer, Clinical Director, GP Clinical Chair and GP Non-Executives. One of the senior managers of the CCG is now paid more than £142,500 per annum pro rata, due to the 1% uplift applied in 2016/17. Having reviewed relevant benchmarking information, the Remuneration Committee was satisfied that the remuneration of all senior managers was appropriate.

The pay and conditions for other senior managers are determined nationally under the Agenda for Change initiative. All Senior Managers have been awarded standard contracts based on a model developed across West Yorkshire by the contracted out Human Resources service, with standard terms and conditions. Standard notice periods are currently 3 months.

Current contracts do not contain any performance related elements which would impact on the remuneration packages. No individuals employed by the CCG have received or are due any kind of award or severance, compensation or early termination payment.

All Executive and Non-Executive Directors are subject to individual performance reviews. This involves setting and agreeing objectives on an annual basis.

Service Contracts of Board Members and Senior Managers:

Name	Title	Tenure	Contract Type	Notice Period
Dr Jason Broch	Clinical Chair	3 years from 17th June 2015	Employee VSM Contract	3 months
	GP Lead	3 years from 17th June 2015	Contract for Service (3 way)	3 months
Nigel Gray	Chief Officer	Permanent	Employee VSM Contract	6 months
Martin Wright	Chief Financial Officer	Permanent	Employee VSM Contract	3 months
Dr Manjit Purewal	Clinical Director	3 years from 21st July 2015	Employee VSM Contract	3 months
Gina Davy	Interim Director of Commissioning – New Models of Care	12 months to 31st December 2016	Employee AfC	12 weeks
Rob Goodyear	Interim Director of Commissioning – Partnerships & Planning	12 months to 31st December 2016	Employee AfC	12 weeks
Sue Robins	Director of Commissioning	From 1st January 2017	Secondment from Leeds West CCG	3 months
Clare Linley	Director of Nursing and Quality	1st November 2015 – 31st May 2016	Secondment from LTHT	3 months
	Director of Nursing and Quality	Permanent from 8th September 2016	Employee VSM Contract	3 months
Peter Myers	Lay Member – Governance	3 years from 1st April 2016	Contract for Service (Individual)	3 months
Graham Prestwich	Lay Member – PPI	3 years from 1st April 2016	Contract for Service (Individual)	3 months
Mark Freeman	Secondary Care Consultant	3 years from 1st April 2016	Contract for Service (Individual)	3 months
Dr Simon Robinson	GP Non Exec Director	3 years from 15th June 2015 (retired 31st January 2017)	Contract for Service (Individual)	3 months
Dr Nick Ibbotson	GP Non Exec Director	3 years from 15th June 2015	Contract for Service (Individual)	3 months
Petra Morgan	Practice Manager Executive	3 years from 15th June 2015	Secondment	3 months
Lucy Jackson	Public Health Consultant Lead	3 years from 1st April 2016	Honorary Contract	Not stated in the honorary contract
Diane Hampshire	Non-Executive Board Nurse	From 25th November 2015	Contract for Service (2 way contract)	3 months

Senior manager remuneration (including salary and pension entitlements)

							2016/17
Name and Title	Salary (bands of £5,000) £000	Expense payments (taxable) to nearest £100 £00	Performance pay and bonuses (bands of £5,000) £000	Long term performance pay and bonuses (bands of £5,000) £000	Total (Bands of £5,000) £000	Other Remuneration (bands of £5000) See Notes 4 & 5	All pension related benefits (bands of £2,500) £000
Nigel Gray (Chief Officer)	120 – 125	3	-	-	125 – 130		27.5 – 30
Martin Wright (Chief Financial Officer)	100 – 105	1	-	-	100 – 105		22.5 – 25
Gina Davy (Director of Commissioning (New Models of Care)) to 31 Dec 16	40 – 45	1	-	-	40 – 45		27.5 – 30
Rob Goodyear ((Director of Commissioning (Partnerships and Performance)) until 28 Feb 17	60 – 65	2	-	-	60 – 65		-
Sue Robbins (Director of Commissioning) From 1 Jan 17 shared with Leeds West CCG	-	-	-	-	-	-	-
Dr Manjit Purewal (GP and Clinical Director)	85 – 90	-	-	-	85 – 90	0 – 5	-
Clare Linley (Director of Nursing) From 1 Apr 16 – 31 May 16. Then from 8 Sep 16.	50 – 55	1	-	-	50 – 55	5 – 10	57.5 – 60
Lucy Jackson (Public Health Consultant Lead)	-	-	-	-	-	-	-
Petra Morgan (Management Executive)	-	-	-	-	-	35 – 40	-
Non-Execs:				-			
Dr Jason Broch (GP and Clinical Chair)	10 – 15	-	-	-	10 – 15	125 – 130	-
Dr Simon Robinson (GP Non-Executive Director) – to 31 Jan 17	10 – 15	-	-	-	10 – 15	-	-
Dr Nick Ibbotson (GP Non-Executive Director)	15 – 20	-	-	-	15 – 20	-	-
Graham Prestwich (Lay Member – Patient and Public Involvement)	10 – 15	-	-	-	10 – 15	-	-
Dr Mark Freeman (Secondary Care Consultant)	5 -10	-	-	-	5 -10	-	-
Diane Hampshire (Nurse Non-Executive Director) from Dec 15	10 – 15	-	-	-	10 – 15	-	-
Peter Myers (Lay Member – Governance)	10 – 15	-	-	-	10 – 15	-	-

1. L Jackson is a Consultant in Public Health at Leeds City Council, who works for the CCG under a Memorandum of Understanding. No remuneration is payable by the CCG.
2. G Davy acted up into the Director of Commissioning role until 31st December 2016
3. R Goodyear acted up into the Director of Commissioning role until 28th February 2017
4. "Other Remuneration" for C Linley relates to payments paid directly to her previous employer for her secondment in April – May 16. She has been employed by Leeds North CCG from 8th September 2016
5. "Other Remuneration" for P Morgan, Dr J Broch and Dr M Purewal relates to payments paid directly to their GP Practice employer to reimburse the practice for the costs of covering their absence whilst they are undertaking CCG roles
6. S Robbins formally undertook the role of Director of Commissioning from 1st January 2017. The role is a shared role with Leeds West CCG. S Robbins is employed by Leeds West CCG. No remuneration is payable by Leeds North CCG
7. "All Pension Related Benefits" is the annual increase in pension entitlement determined in accordance with the method set out in section 229 of the Finance Act 2004
8. S Robinson resigned from the post of Non-Executive Director from 31st January 2017

							2015/16
Name and Title	Salary (bands of £5,000) £000	Expense payments (taxable) to nearest £100 £00	Performance pay and bonuses (bands of £5,000) £000	Long term performance pay and bonuses (bands of £5,000) £000	Total (Bands of £5,000) £000	Other Remuneration (bands of £5000) See Notes 4 & 5	All pension related benefits (bands of £2,500) £000
Nigel Gray (Chief Officer)	120 – 125	2	-	-	125 – 130	-	2.5 – 5
Martin Wright (Chief Financial Officer)	100 – 105	1	-	-	100 – 105	-	5 – 7.5
Liane Langdon (Director of Commissioning & Strategic Development) to Dec 15	60 – 65	1	-	-	60 – 65	0 – 5	7.5 – 10
Gina Davy (Director of Commissioning (New Models of Care)) from Jan 16	10 – 15	-	-	-	10 – 15	-	17.5 – 20
Rob Goodyear ((Director of Commissioning (Partnerships and Performance)) from Jan 16	15 – 20	1	-	-	15 – 20	-	-
Dr Manjit Purewal (GP and Clinical Director)	85 – 90	-	-	-	85 – 90	-	-
Ellie Monkhouse (Director of Nursing and Quality) to Oct 15	20 – 25	1	-	-	20 – 25	-	12.5 – 15
Clare Linley (Director of Nursing) From 1 Nov 15	-	-	-	-	-	10- 15	-
Lucy Jackson (Public Health Consultant Lead)	-	-	-	-	-	-	-
Petra Morgan (Management Executive)	-	-	-	-	-	35 – 40	-
Non-Execs:							
Dr Jason Broch (GP and Clinical Chair)	10 – 15	-	-	-	10 – 15	125 – 130	-
Dr Simon Robinson (GP Non-Executive Director)	15 – 20	-	-	-	15 – 20	-	-
Dr Nick Ibbotson (GP Non-Executive Director)	15 – 20	-	-	-	15 – 20	-	-
Graham Prestwich (Lay Member – Patient and Public Involvement)	10 – 15	-	-	-	10 – 15	5 -10	-
Dr Mark Freeman (Secondary Care Consultant)	5 -10	-	-	-	5 – 10	-	-
Diane Hampshire (Nurse Non-Executive Director) from Dec 15	0 – 5	-	-	-	0 – 5	-	-
Peter Myers (Lay Member – Governance)	10 – 15	-	-	-	10 – 15	-	-

Pension benefits as at 31 March 2017

Name and Title	(a) Real increase in pension at pension age (bands of £2,500) £000	(b) Real increase in pension lump sum at pension age (bands of £2,500) £000	(c) Total accrued pension at pension age at 31 March 2017 (bands of £5,000) £000	(d) Lump sum at pension age related to accrued pension at 31 March 2017 (bands of £5,000 £000	(e) Cash Equivalent Transfer Value at 1 April 2016 £000	(f) Real Increase in Cash Equivalent Transfer Value £000	(g) Cash Equivalent Transfer Value at 31 March 2017 £000	(h) Employers Contribution to partnership pension £000
Nigel Gray (Chief Officer)	0 – 2.5	5 – 7.5	50 – 55	160 – 165	979	56	1,053	-
Martin Wright (Chief Financial Officer)	0 – 2.5	2.5 – 5	30 – 35	100 – 105	608	34	656	-
Gina Davy (Director of Commissioning (New Models of Care) to 31 Dec 16	0 – 2.5	0 – 2.5	10 – 15	25 – 30	116	13	134	-
Clare Linley (Director of Nursing) from 8th September 2016.	2.5 – 5	7.5 – 10	30 – 35	100 – 105	542	61	610	-

1. Reimbursement for P Morgan is paid direct to her employer; Street Lane Practice under a contract of service. The CCG makes no direct pension contributions.
2. Reimbursement for C Linley was paid direct to her employer; Leeds Teaching Hospitals NHS Trust under a contract of service from 1st April 2016 to 31st May 2016, during this time the CCG made no direct pension contributions. From 8th September 2016, C Linley was employed by Leeds North CCG
3. Lay Members do not receive pensionable remuneration, there will be no entries in respect of pensions for Lay Members
4. M Purewal is not a member of the NHS Pension Scheme
5. R Goodyear is not a member of the NHS Pension Scheme

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Pension benefits as at 31 March 2016

Name and Title	(a) Real increase in pension at pension age (bands of £2,500) £000	(b) Real increase in pension lump sum at pension age (bands of £2,500) £000	(c) Total accrued pension at pension age at 31 March 2016 (bands of £5,000) £000	(d) Lump sum at pension age related to accrued pension at 31 March 2016 (bands of £5,000 £000	(e) Cash Equivalent Transfer Value at 1 April 2015 £000	(f) Real Increase in Cash Equivalent Transfer Value £000	(g) Cash Equivalent Transfer Value at 31 March 2016 £000	(h) Employers Contribution to partnership pension £000
Nigel Gray (Chief Officer)	0 – 2.5	2.5 – 5	50 – 55	155 – 160	935	15	979	-
Martin Wright (Chief Financial Officer)	0 – 2.5	2.5 – 5	30 – 35	95 – 100	581	7	608	-
Liane Langdon (Director of Commissioning & Strategic Development) to Dec 15	0 – 2.5	-	10 – 15	35 – 40	174	-	184	-
Gina Davy (Director of Commissioning (New Models of Care)) from Jan 16	0 – 2.5	0 – 2.5	5 – 10	25 – 30	101	7	116	
Ellie Monkhouse (Director of Nursing and Quality) to Oct 15 – shared with LSE CCG	0 – 2.5	2.5 – 5	15 – 20	45 – 50	199	5	222	-

Compensation on early retirement for loss of office – Not applicable.

Payments to past members – Not applicable.

Pay multiples
Reporting bodies are required to disclose the relationship between the remuneration of the highest paid member in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid Director/ Member of NHS Leeds North Clinical Commissioning Group in the financial year 2016/17 was £140k-£145k (2015/16, £140k-145k). This was 4.1 times (2015/16, 4.1 times) the median remuneration of the workforce, which was £35k, (2015/16, £34k).

In 2016/17 (and 2015/16) no employees received remuneration in excess of the highest paid member of the Board. Remuneration ranged from a band of £140k-£145k to £10k-£15k, (2015/16, £140k-£145k to £10k-£15k).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

5.2 Staff Report

Number of senior managers

Pay band	Total
Band 8a	16
Band 8b	4
Band 8c	3
Band 8d	2
Band 9	0
VSM	5
Governing body	7
Any other Spot Salary	0

Staff numbers and costs

Assignment category	Total
Permanent	54
Fixed term	13
Statutory office holders	0
Bank	0
Prof or Non Exec	0

Staff Costs

Employee benefits 2016-17	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other
			Total			Admin			Programme
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Salaries and wages	3,373	2,638	736	2,055	2,012	43	1,318	625	693
Social security costs	258	258	0	204	204	0	54	54	0
Employer Contributions to NHS Pension scheme	307	307	0	227	227	0	80	80	0
Gross employee benefits expenditure	**3,938**	**3,203**	**736**	**2,487**	**2,444**	**43**	**1,452**	**759**	**693**
Less recoveries in respect of employee benefits	(50)	(50)	0	(50)	(50)	0	0	0	0
Total – Net employee benefits	**3,888**	**3,153**	**736**	**2,436**	**2,393**	**43**	**1,452**	**759**	**693**

Employee benefits 2015-16	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other
			Total			Admin			Programme
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Salaries and wages	3,261	2,573	688	1,932	1,914	18	1,330	659	670
Social security costs	195	195	0	158	158	0	38	38	0
Employer Contributions to NHS Pension scheme	288	288	0	218	218	0	70	70	0
Gross employee benefits expenditure	**3,744**	**3,056**	**688**	**2,307**	**2,290**	**18**	**1,437**	**766**	**670**
Less recoveries in respect of employee benefits	0	0	0	0	0	0	0	0	0
Total – Net employee benefits	**3,744**	**3,056**	**688**	**2,307**	**2,290**	**18**	**1,437**	**766**	**670**

Staff composition

Number of senior managers

Gender	Total (Female)	Total (Male)
Governing body	2	5
Band 8a	11	5
Band 8b	2	2
Band 8c	2	1
Band 8d	1	1
Band 9	0	0
VSM	1	4
Any other Spot Salary	0	0
All other employees (including apprentice)	27	3

Sickness absence data

Absence	Total
Average sickness %	4.0%
Total number of FTE days lost	727.9

Expenditure on consultancy

Expenditure on consultancy was £12,000 in 2016/17

Off-payroll engagements

Table 1: Off-payroll engagements longer than 6 months

For all off-payroll engagements as at 31 March 2017, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2017	19
Of which, the number that have existed:	
for less than one year at the time of reporting	5
for between one and two years at the time of reporting	
for between 2 and 3 years at the time of reporting	5
for between 3 and 4 years at the time of reporting	9
for 4 or more years at the time of reporting	

Off payroll engagements are a mix of ongoing part time clinical leads, and some specialist staff.

All existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

Table 2: New off-payroll engagements

For all new off-payroll engagements between 01 April 2016 and 31 March 2017, for more than £220 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017	5
Number of new engagements which include contractual clauses giving Leeds North Clinical Commissioning Group the right to request assurance in relation to income tax and National Insurance obligations	5
Number for whom assurance has been requested	5
Of which:	
assurance has been received	5
assurance has not been received	
engagements terminated as a result of assurance not being received.	

Table 3: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and/ or senior officials with significant financial responsibility, between 01 April 2016 and 31 March 2017.

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	1
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both on payroll and off-payroll engagements.	16

Philomena Corrigan
Accountable Officer

24 May 2017

Parliamentary Accountability and Audit Report

NHS Leeds North CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, fees and charges are included as notes in the Financial Statements of this report. An audit certificate and report is also included.

ANNUAL ACCOUNTS

IN THIS SECTION:

6.0 ANNUAL ACCOUNTS

The accounts for the year ending 31 March 2017 have been prepared as directed by NHS England, in accordance with section 232 (Schedule 15, Paragraph 3) of the National Health Service Act 2006.

The directions issued by NHS England require clinical commissioning groups to comply with the requirements laid out in the Manual for Accounts issued by the Department of Health.

The Manual for Accounts complies with the requirements of the Government Financial Reporting Manual, which the Department of Health Group Accounts are required to comply with.

6.1 Finance Director's Review

During the 2016/17 financial year NHS Leeds North CCG has achieved all statutory and administrative financial duties. Operational costs were contained within the total budget of £287.8m delivering a surplus of £8.5m. Total cash spend was kept below the maximum cash drawdown of £277m.

The CCG received an additional £6.4m growth (2.6%) in 2016/17 with a brought forward surplus of £5.78.

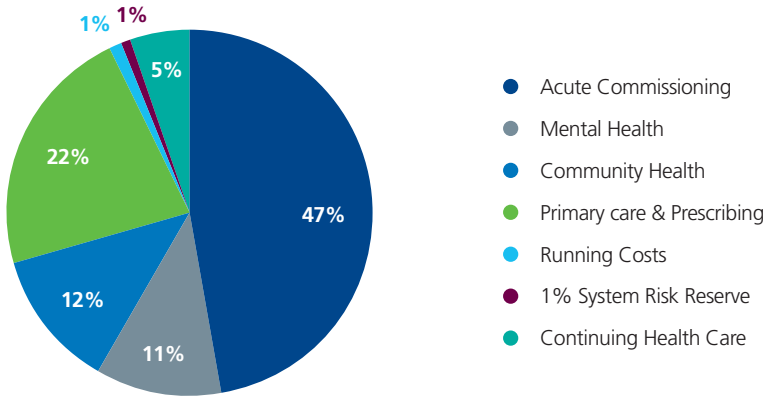
As set out in the 2016/17 NHS Planning Guidance, CCGs were required to hold a 1 percent reserve uncommitted from the start of the year, created by setting aside the monies that CCGs were otherwise required to spend non-recurrently. This was intended to be released for investment in Five Year Forward View transformation priorities, to the extent that evidence emerged of risks not arising or being effectively mitigated through other means.

In the event, the national position across the provider sector has been such that NHS England has been unable to allow CCGs' 1% non-recurrent monies to be spent. Therefore, to comply with this requirement, NHS Leeds North CCG has released its 1% reserve to the bottom line, resulting in an additional surplus for the year of £2.7m. This additional surplus will be carried forward for drawdown in future years. This has therefore increased the CCG's required and actual surplus position from £5.78m to £8.5m in month 12.

At a time when it is more important than ever to make transformational service changes for the benefit of the health and social care system in Leeds, the ability to make those changes was severely hampered by the 2016/17 settlement and business rules.

Quality, innovation, productivity and prevention (QIPP) savings and cost avoidance schemes were identified and delivered £10.4m of savings. £3.7m related to the 2% national efficiency requirement built into provider contracts and the remaining £6.7m was generated via CCG schemes.

NHS Leeds North CCG – Expenditure Chart:



Further details of financial performance are shown in the annual accounts for the financial year ending 31 March 2017.

Performance against the Confederation of British Industry (CBI) Better Payment Practice Code is given in note 6.1 to the accounts.

Details of the treatment of pension liabilities are given in Note 4 to the accounts. There were no exit packages or severance payments agreed in 2016/17.

The Board is responsible for maintaining an effective system of internal control that supports the achievement of our objectives. The annual governance statement which records the stewardship of the organisation is contained within the annual accounts.

The annual accounts have been subject to audit by KPMG, 1 The Embankment, Neville Street, Leeds, LS1 4DW and an unqualified audit opinion received. Details of the audit fees in respect of the statutory audit and associated services can be found in note 5 to the accounts. Internal audit services were provided by the West Yorkshire Audit Consortium. The CCG also has an established counter fraud service provided by West Yorkshire Audit Consortium, with a dedicated local counter fraud specialist and took part in the national fraud initiative.

2017/18 financial plans for the CCG have been developed to deliver the requirements of the planning guidance. The plans demonstrate achievement of 2% in year surplus, 1% recurrent headroom (of which 0.5% is available to be spent non-recurrently and 0.5% of this is to be held uncommitted as a risk reserve) and an additional 0.5% contingency required by NHSE as in previous years.

The CCG has provided NHSE with assurance regarding the ability to meet these requirements in ensuring it has robust deliverable Quality, Improvement, Productivity and Prevention (QIPP) plans in place to deliver the required savings. The GP Five Year Forward View and Mental Health Forward View have also been incorporated in line with national requirements as commissioning intentions.

To ensure that organisational boundaries and perverse financial incentives do not get in the way of transformation, from April 2017 each Sustainable and Transformational Plan (STP), or agreed population/geographical area, will have a financial control total that is the sum of the individual organisational control totals. All organisations will be held accountable for delivering both their individual control total and the overall system control total. It will be possible to flex individual organisational control totals within the system control total, by application to NHS England and NHS Improvement.

Visseh Pejhan-Sykes
Chief Finance Officer

6.2 Independent auditor's report to the members of the governing body of NHS Leeds North CCG

We have audited the financial statements of NHS Leeds North CCG for the year ended 31 March 2017 under the Local Audit and Accountability Act 2014. These financial statements have been prepared under applicable law and the accounting polices directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to the Clinical Commissioning Groups in England. We have also audited the information in the Remuneration and Staff Report (Section 5) that is subject to audit.

This report is made solely to the Members of the Governing Body of NHS Leeds North CCG, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Members of the Governing Body of the CCG, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Members of the Governing Body of the CCG, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of the Accountable Officer and auditor

As explained more fully in the Statement of Accountable Officer's Responsibilities (Section 4.2), the Accountable Officer is responsible for the preparation of financial statements which give a true and fair view and is also responsible for the regularity of expenditure and income. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors. We are also responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General under the Local Audit and Accountability Act 2014 ('the Code of Audit Practice').

As explained in the Annual Governance Statement, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the CCG's resources. We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the CCG's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accountable Officer, and the overall presentation of the financial statements.

In addition we read all the financial and non-financial information in the annual report and accounts to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

In addition, we are required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2016, as to whether the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the CCG had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2017 and of its net operating expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting polices directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to Clinical Commissioning Groups in England.

Opinion on regularity

In our opinion, in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Opinion on other matters

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the accounting polices directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to Clinical Commissioning Groups in England; and
- the other information, published together with the audited financial statements in the Annual Report and Accounts, is consistent with the financial statements.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion, the Governance Statement does not reflect compliance with guidance issued by the NHS Commissioning Board;
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the CCG under section 24 of the Local Audit and Accountability Act 2014; or
- we are not satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

We have nothing to report in respect of the above responsibilities.

Certificate

We certify that we have completed the audit of the accounts of NHS Leeds North CCG in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Rashpal Khangura
for and on behalf of KPMG LLP,
Statutory Auditor
Chartered Accountants
Leeds

26 May 2017

ACCOUNTS CONTENTS

THE PRIMARY STATEMENTS

NOTES TO THE ACCOUNTS

Statement of Comprehensive Net Expenditure for the year ended 31 March 2017

	Note	2016-17 £'000	2015-16 £'000
Income from sale of goods and services	2	(5,714)	(4,720)
Other operating income	2	(82)	(2)
Total operating income		**(5,796)**	**(4,722)**
Staff costs	4	3,938	3,744
Purchase of goods and services	5	280,719	253,001
Depreciation and impairment charges	5	0	0
Provision expense	5	315	(127)
Other Operating Expenditure	5	131	148
Total operating expenditure		**285,103**	**256,766**
Net Operating Expenditure		**279,307**	**252,044**
Finance income			
Finance expense	10	0	0
Net expenditure for the year		**279,307**	**252,044**
Net Gain/(Loss) on Transfer by Absorption		0	0
Total Net Expenditure for the year		**279,307**	**252,044**
Other Comprehensive Expenditure			
Items which will not be reclassified to net operating costs			
Net (gain)/loss on revaluation of PPE		0	0
Net (gain)/loss on revaluation of Intangibles		0	0
Net (gain)/loss on revaluation of Financial Assets		0	0
Actuarial (gain)/loss in pension schemes		0	0
Impairments and reversals taken to Revaluation Reserve		0	0
Items that may be reclassified to Net Operating Costs		0	0
Net gain/loss on revaluation of available for sale financial assets		0	0
Reclassification adjustment on disposal of available for sale financial assets		0	0
Sub total		0	0
Total comprehensive net expenditure for the year		**279,307**	**252,044**

Statement of Financial Position as at 31 March 2017

	Note	Friday, March 31, 2017 £'000	Thursday, March 31, 2016 £'000
Non-current assets:			
Property, plant and equipment	13	0	0
Intangible assets	14	0	0
Investment property	15	0	0
Trade and other receivables	17	0	0
Other financial assets	18	0	0
Total non-current assets		0	0
Current assets:			
Inventories	16	0	0
Trade and other receivables	17	1,643	1,408
Other financial assets	18	0	0
Other current assets	19	0	0
Cash and cash equivalents	20	32	31
Total current assets		**1,675**	1,439
Non-current assets held for sale	21	0	0
Total current assets		**1,675**	1,439
Total assets		**1,675**	1,439
Current liabilities			
Trade and other payables	23	(17,258)	(14,151)
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	(183)	(92)
Total current liabilities		**(17,441)**	(14,243)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(15,766)**	(12,804)
Non-current liabilities			
Trade and other payables	23	0	0
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	(307)	(163)
Total non-current liabilities		**(307)**	(163)
Assets less Liabilities		**(16,073)**	(12,967)
Financed by Taxpayers' Equity			
General fund		(16,073)	(12,967)
Charitable Reserves		0	0
Total taxpayers' equity:		**(16,073)**	(12,967)

The financial statements were approved by the Board on 24 May 2017 and signed on its behalf by:

Philomena Corrigan
Chief Officer

Statement of Changes In Taxpayers Equity for year ended 31 March 2017

	2016-17 General fund £'000	2015-16 General fund £'000
Changes in taxpayers' equity		
Balance at 01 April	(12,967)	**(10,941)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2017	**(12,967)**	**(10,941)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2016-17		
Net operating expenditure for the financial year	(279,307)	(252,044)
Net gain (loss) on available for sale financial assets	0	0
Net gain (loss) on revaluation of assets held for sale	0	0
Impairments and reversals	0	0
Net actuarial gain (loss) on pensions	0	0
Movements in other reserves	0	0
Transfers between reserves	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0
Transfers by absorption to (from) other bodies	0	0
Reserves eliminated on dissolution	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(279,307)**	**(252,044)**
Net funding	276,201	250,018
Balance at 31 March	**(16,073)**	**(12,967)**

The clinical commissioning group has no revaluation or other reserves.

Statement of Cash Flows for the year ended 31 March 2017

	Note	2016-17 £'000	2015-16 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(279,307)	(252,044)
Depreciation and amortisation	5	0	0
Impairments and reversals	5	0	0
Movement due to transfer by Modified Absorption		0	0
Other gains (losses) on foreign exchange		0	0
Donated assets received credited to revenue but non-cash		0	0
Government granted assets received credited to revenue but non-cash		0	0
Interest paid		0	0
Release of PFI deferred credit		0	0
Other Gains & Losses		0	0
Finance Costs		0	0
Unwinding of Discounts		0	0
(Increase)/decrease in inventories		0	0
(Increase)/decrease in trade & other receivables	17	(235)	290
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	23	3,107	1,975
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	30	(80)	(118)
Increase/(decrease) in provisions	30	315	(127)
Net Cash Inflow (Outflow) from Operating Activities		**(276,200)**	(250,024)
Cash Flows from Investing Activities			
Interest received		0	0
Rental revenue		0	0
Net Cash Inflow (Outflow) from Investing Activities		**0**	0
Net Cash Inflow (Outflow) before Financing		**(276,200)**	(250,024)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		276,201	250,018
Net Cash Inflow (Outflow) from Financing Activities		**276,201**	250,018
Net Increase (Decrease) in Cash & Cash Equivalents	20	**1**	(6)
Cash & Cash Equivalents at the Beginning of the Financial Year		**31**	37
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**32**	31

Notes to the Financial Statements

1 Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2016-17 issued by the Department of Health. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on the going concern basis (despite the issue of a report to the Secretary of State for Health under Section 30 of the Local Audit and Accountability Act 2014). Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of Financial Statements. If services will continue to be provided the financial statements are prepared on the going concern basis.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3 Acquisitions & Discontinued Operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.4 Movement of Assets within the Department of Health Group

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Department of Health Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.5 Charitable Funds

Under the provisions of IAS 27: Consolidated & Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entities' accounts.

1.6 Pooled Budgets

Where the clinical commissioning group has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 the clinical commissioning group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

If the clinical commissioning group is in a "jointly controlled operation", the clinical commissioning group recognises:

- The assets the clinical commissioning group controls;
- The liabilities the clinical commissioning group incurs;
- The expenses the clinical commissioning group incurs; and,
- The clinical commissioning group's share of the income from the pooled budget activities.

If the clinical commissioning group is involved in a "jointly controlled assets" arrangement, in addition to the above, the clinical commissioning group recognises:

- The clinical commissioning group's share of the jointly controlled assets (classified according to the nature of the assets);
- The clinical commissioning group's share of any liabilities incurred jointly; and,
- The clinical commissioning group's share of the expenses jointly incurred.

1.7 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

In the application of the clinical commissioning group's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.8 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

1.9 Employee Benefits

1.9.1 Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.9.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the clinical commissioning group of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the clinical commissioning group commits itself to the retirement, regardless of the method of payment.

1.10 Other Expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

Expenses and liabilities in respect of grants are recognised when the clinical commissioning group has a present legal or constructive obligation, which occurs when all of the conditions attached to the payment have been met.

1.11 Property, Plant & Equipment

1.11.1 Recognition

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the clinical commissioning group;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.11.2 Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at valuation.

Land and buildings used for the clinical commissioning group's services or for administrative purposes are stated in the statement of financial position at their re-valued amounts, being the fair value at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.11.3 Subsequent Expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.12 Intangible Assets

1.12.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the clinical commissioning group's business or which arise from contractual or other legal rights. They are recognised only:

- When it is probable that future economic benefits will flow to, or service potential be provided to, the clinical commissioning group;
- Where the cost of the asset can be measured reliably; and,
- Where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised but is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- The technical feasibility of completing the intangible asset so that it will be available for use;
- The intention to complete the intangible asset and use it;
- The ability to sell or use the intangible asset;
- How the intangible asset will generate probable future economic benefits or service potential;
- The availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and,
- The ability to measure reliably the expenditure attributable to the intangible asset during its development.

1.12.2 Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of depreciated replacement cost or the value in use where the asset is income generating . Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.13 Depreciation, Amortisation & Impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the clinical commissioning group checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined

had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.14 Donated Assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.15 Government Grants

The value of assets received by means of a government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.16 Non-current Assets Held For Sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when:

- The sale is highly probable;
- The asset is available for immediate sale in its present condition; and,
- Management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification.

Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Net Expenditure. On disposal, the balance for the asset on the revaluation reserve is transferred to the general reserve.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.17 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.17.1 The Clinical Commissioning Group as Lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the clinical commissioning group's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.17.2 The Clinical Commissioning Group as Lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the clinical commissioning group's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the clinical commissioning group's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in

negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.18 Private Finance Initiative Transactions

HM Treasury has determined that government bodies shall account for infrastructure Private Finance Initiative (PFI) schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The clinical commissioning group therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

- Payment for the fair value of services received;
- Payment for the PFI asset, including finance costs; and,
- Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

1.18.1 Services Received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

1.18.2 PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the clinical commissioning group's approach for each relevant class of asset in accordance with the principles of IAS 16.

1.18.3 PFI Liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'finance costs' within the Statement of Comprehensive Net Expenditure.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Net Expenditure.

1.18.4 Lifecycle Replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the clinical commissioning group's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

1.18.5 Assets Contributed by the Clinical Commissioning Group to the Operator For Use in the Scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the clinical commissioning group's Statement of Financial Position.

1.18.6 Other Assets Contributed by the Clinical Commissioning Group to the Operator

Assets contributed (e.g. cash payments, surplus property) by the clinical commissioning group to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the clinical commissioning group, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.19 Inventories

Inventories are valued at the lower of cost and net realisable value.

1.20 Cash & Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the clinical commissioning group's cash management.

1.21 Provisions

Provisions are recognised when the clinical commissioning group has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:

- Timing of cash flows (0 to 5 years inclusive): Minus 2.70% (previously: minus 1.55%)
- Timing of cash flows (6 to 10 years inclusive): Minus 1.95% (previously: minus 1.%)
- Timing of cash flows (over 10 years): Minus 0.80% (previously: minus 0.80%)

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the clinical commissioning group has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.22 Clinical Negligence Costs

The NHS Litigation Authority operates a risk pooling scheme under which the clinical commissioning group pays an annual contribution to the NHS Litigation Authority which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHS Litigation Authority is administratively responsible for all clinical negligence cases the legal liability remains with the clinical commissioning group.

1.23 Non-clinical Risk Pooling

The clinical commissioning group participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the clinical commissioning group pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership

contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.24 Continuing Healthcare Risk Pooling

In 2014-15 a risk pool scheme was introduced by NHS England for continuing healthcare claims, for claim periods prior to 31 March 2013. Under the scheme, clinical commissioning groups contribute annually to a pooled fund, which is used to settle the claims.

1.25 Carbon Reduction Commitment Scheme

Carbon Reduction Commitment and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the clinical commissioning group makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.26 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.27 Financial Assets

Financial assets are recognised when the clinical commissioning group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:

- Financial assets at fair value through profit and loss;
- Held to maturity investments;
- Available for sale financial assets; and,
- Loans and receivables.

The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

1.27.1 Financial Assets at Fair Value Through Profit and Loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the clinical commissioning group's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

1.27.2 Held to Maturity Assets

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

1.27.3 Available For Sale Financial Assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/deficit on de-recognition.

1.27.4 Loans & Receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the clinical commissioning group assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.28 Financial Liabilities

Financial liabilities are recognised on the statement of financial position when the clinical commissioning group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.28.1 Financial Guarantee Contract Liabilities

Financial guarantee contract liabilities are subsequently measured at the higher of:

- The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and,
- The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

1.28.2 Financial Liabilities at Fair Value Through Profit and Loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the clinical commissioning group's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

1.28.3 Other Financial Liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from the Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.29 Value Added Tax

Most of the activities of the clinical commissioning group are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.30 Foreign Currencies

The clinical commissioning group's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the clinical commissioning group's surplus/deficit in the period in which they arise.

1.31 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the clinical commissioning group has no beneficial interest in them.

1.32 Losses & Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the clinical commissioning group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.33 Subsidiaries

Material entities over which the clinical commissioning group has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the clinical commissioning group or where the subsidiary's accounting date is not co-terminus.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.34 Associates

Material entities over which the clinical commissioning group has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the clinical commissioning group's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the clinical commissioning group's share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the clinical commissioning group from the entity.

Joint ventures that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.35 Joint Ventures

Material entities over which the clinical commissioning group has joint control with one or more other parties so as to obtain economic or other benefits are classified as joint ventures. Joint ventures are accounted for using the equity method.

Joint ventures that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.36 Joint Operations

Joint operations are activities undertaken by the clinical commissioning group in conjunction with one or more other parties but which are not performed through a separate entity. The clinical commissioning group records its share of the income and expenditure; gains and losses; assets and liabilities; and cash flows.

1.37 Research & Development

Research and development expenditure is charged in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Statement of Comprehensive Net Expenditure on a systematic basis over the period expected to benefit from the project. It should be re-valued on the basis of current cost. The amortisation is calculated on the same basis as depreciation.

1.38 Accounting Standards That Have Been Issued But Have Not Yet Been Adopted

The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2016-17, all of which are subject to consultation:

- IFRS 9: Financial Instruments (application from 1 January 2018)
- IFRS 14: Regulatory Deferral Accounts (not applicable to DH groups bodies)
- IFRS 15: Revenue for Contract with Customers (application from 1 January 2018)
- IFRS 16: Leases (application from 1 January 2019)

The application of the Standards as revised would not have a material impact on the accounts for 2016-17, were they applied in that year.

2 Other Operating Revenue

	2016-17 Total £'000	2015-16 Total £'000
Clinical Commissioning Groups	5,412	4,230
NHS England	75	25
NHS Foundation Trusts	0	0
NHS Trusts	33	0
Local Authorities	128	425
Recoveries in respect of employee benefits	50	0
Non-patient care services to other bodies	89	40
Other revenue	9	2
Total other operating revenue	**5,796**	**4,722**

There are three clinical commissioning groups in Leeds and each clinical commissioning group is the lead commissioner in a particular area. Leeds North clinical commissioning group leads on Mental Health and Urgent Care on behalf of the city and revenue received from clinical commissioning groups is in relation to this.

Revenue from NHS England relates to recovery of costs paid for services provided on their behalf by Leeds North clinical commissioning group.

3 Revenue

	2016-17 Total £'000	2015-16 Total £'000
From rendering of services	5,707	4,682
From sale of goods	89	40
Total	**5,796**	**4,722**

4. Employee benefits and staff numbers

4.1.1 Employee benefits

	2016-17		
	Total £'000	Permanent Employees £'000	Other £'000
Employee Benefits			
Salaries and wages	3,373	2,638	736
Social security costs	258	258	0
Employer Contributions to NHS Pension scheme	307	307	0
Other pension costs	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	0	0	0
Gross employee benefits expenditure	**3,938**	**3,203**	**736**
Less recoveries in respect of employee benefits (note 4.1.2)	(50)	(50)	0
Total – Net admin employee benefits including capitalised costs	**3,888**	**3,153**	**736**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**3,888**	**3,153**	**736**

4.1.1 Employee benefits

	2015-16		
	Total £'000	Permanent Employees £'000	Other £'000
Employee Benefits			
Salaries and wages	3,261	2,573	688
Social security costs	195	195	0
Employer Contributions to NHS Pension scheme	288	288	0
Other pension costs	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	0	0	0
Gross employee benefits expenditure	**3,744**	**3,056**	**688**
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0
Total – Net admin employee benefits including capitalised costs	**3,744**	**3,056**	**688**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**3,744**	**3,056**	**688**

4.1.2 Recoveries in respect of employee benefits

	2016-17			2015-16
	Total £'000	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits – Revenue				
Salaries and wages	(40)	(40)	0	0
Social security costs	(4)	(4)	0	0
Employer contributions to the NHS Pension Scheme	(6)	(6)	0	0
Other pension costs	0	0	0	0
Other post-employment benefits	0	0	0	0
Other employment benefits	0	0	0	0
Termination benefits	0	0	0	0
Total recoveries in respect of employee benefits	**(50)**	**(50)**	**0**	**0**

4.2 Average number of people employed

	2016-17			2015-16
	Total Number	Permanently employed Number	Other Number	Total Number
Total	67	55	12	67
Of the above:				
Number of whole time equivalent people engaged on capital projects	0	0	0	0

4.3 Staff sickness absence and ill health retirements

	2016-17 Number	2015-16 Number
Total Days Lost	468	371
Total Staff Years	58	56
Average working Days Lost	8	7

	2016-17 Number	2015-16 Number
Number of persons retired early on ill health grounds	0	0

	£'000	£'000
Total additional Pensions liabilities accrued in the year	0	0

Ill health retirement costs are met by the NHS Pension Scheme

4.4 Exit packages agreed in the financial year

The clinical commissioning group did not agree any exit packages during 2016-17. (nil in 2015-16).

4.5 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/Pensions.

The Scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The Scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, the Scheme is accounted for as if it were a defined contribution scheme: the cost to the clinical commissioning group of participating in the Scheme is taken as equal to the contributions payable to the Scheme for the accounting period.

The Scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

4.5.1 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the Scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2012 and covered the period from 1 April 2008 to that date. Details can be found on the pension scheme website at www.nhsbsa.nhs.uk/pensions.

For 2016-17, employers' contributions of £301,079 (2015-16: £289,017) were payable to the NHS Pension Scheme at the rate of 14.3% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2012. These costs are included in the NHS pension line of note 4.1.

5. Operating expenses

	2016-17 Total £'000	2015-16 Total £'000
Gross employee benefits		
Employee benefits excluding governing body members	3,320	3,146
Executive governing body members	618	598
Total gross employee benefits	**3,938**	**3,744**
Other costs		
Services from other CCGs and NHS England	17,132	17,790
Services from foundation trusts	48,726	49,062
Services from other NHS trusts	123,176	119,485
Services from other WGA bodies	0	0
Services from local authorities	13,226	13,369
Purchase of healthcare from non-NHS bodies	16,439	15,604
Chair and Non Executive Members	99	105
Supplies and services – clinical	26	21
Supplies and services – general	883	789
Consultancy services	12	606
Establishment	833	801
Transport	10	31
Premises	142	108
Impairments and reversals of receivables	0	0
Inventories written down and consumed	0	0
Depreciation	0	0
Amortisation	0	0
Impairments and reversals	0	0
Audit fees	54	54
Other non statutory audit expenditure		
· Internal audit services	0	0
· Other services	1	0
Prescribing costs	32,066	32,504
Pharmaceutical services	0	0
General ophthalmic services	0	0
GPMS/APMS and PCTMS	27,468	1,663
Other professional fees excl. audit	96	87
Grants to Other bodies	31	3
Clinical negligence	0	1
Research and development (excluding staff costs)	0	0
Education and training	103	213
Change in discount rate	0	0
Provisions	315	(127)
Funding to group bodies	0	0
CHC Risk Pool contributions	326	814
Other expenditure	1	39
Total other costs	**281,165**	**253,022**
Total operating expenses	**285,103**	**256,766**

Services from CCGs/NHS England include lead commissioner charges from the other Leeds CCGs for areas that they lead on.

6.1 Better Payment Practice Code

Measure of compliance	2016-17 Number	2016-17 £'000	2015-16 Number	2015-16 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	4,652	61,817	3,724	36,846
Total Non-NHS Trade Invoices paid within target	4,535	61,288	3,623	36,611
Percentage of Non-NHS Trade invoices paid within target	**97.5%**	**99.1%**	**97.3%**	**99.4%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,779	191,900	2,521	186,138
Total NHS Trade Invoices Paid within target	2,765	191,776	2,497	185,913
Percentage of NHS Trade Invoices paid within target	**99.5%**	**99.9%**	**99.0%**	**99.9%**

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

There were no claims made under this legislation.

7 Income Generation Activities

The clinical commissioning group does not undertake any income generation activities.

8 Investment Revenue

Investment revenue is nil.

9 Other Gains and Losses

The clinical commissioning group has no gains or losses to disclose.

10 Finance Costs

The clinical commissioning group has no finance costs.

11 Net Gain/(Loss) on Transfer by Absorption

The clinical commissioning group has no gains or losses on transfer by absorption in 2016-17 (nil in 2015-16).

12. Operating Leases

12.1 As lessee

The CCG occupies property owned and managed by NHS Property Services Ltd. Actual rent was charged in 2015-16 and 2016-17. This is reflected in note 12.1.1. While the arrangements with NHS Property Services Ltd fall within the definition of operating leases, the rental charge for future years has not been agreed. Consequently, this note doesn't include the future minimum lease payments for this arrangement.

12.1.1 Payments recognised as an Expense

	2016-17				2015-16			
	Land £'000	Buildings £'000	Other £'000	Total £'000	Land £'000	Buildings £'000	Other £'000	Total £'000
Payments recognised as an expense								
Minimum lease payments	0	34	2	**36**	0	5	1	**6**
Contingent rents	0	0	0	**0**	0	0	0	**0**
Sub-lease payments	0	0	0	**0**	0	0	0	**0**
Total	**0**	**34**	**2**	**36**	**0**	**5**	**1**	**6**

12.1.2 Future minimum lease payments

	2016-17				2015-16			
	Land £'000	Buildings £'000	Other £'000	Total £'000	Land £'000	Buildings £'000	Other £'000	Total £'000
Payable:								
No later than one year	0	0	1	**1**	0	0	1	**1**
Between one and five years	0	0	0	**0**	0	0	1	**1**
After five years	0	0	0	**0**	0	0	0	**0**
Total	**0**	**0**	**1**	**1**	**0**	**0**	**2**	**2**

12.2 As lessor

The clinical commissioning group currently has no assets to lease as at 31 March 2017 (nil at 31 March 2016).

13 Property, Plant and Equipment

The clinical commissioning group had no property, plant and equipment as at 31 March 2017 (nil at 31 March 2016).

14 Intangible Non-Current Assets

The clinical commissioning group had no Intangible non-current assets as at 31 March 2017 (nil at 31 March 2016).

15 Investment Property

The clinical commissioning group had no investment property as at 31 March 2017 (nil at 31 March 2016).

16 Inventories

The clinical commissioning group had no inventories as at 31 March 2017 (nil at 31 March 2016).

17 Trade and other receivables

	Current Friday, March 31, 2017 £'000	Current Thursday, March 31, 2016 £'000
NHS receivables: Revenue	792	509
NHS receivables: Capital	0	0
NHS prepayments	691	647
NHS accrued income	93	68
Non-NHS and Other WGA receivables: Revenue	0	84
Non-NHS and Other WGA receivables: Capital	0	0
Non-NHS and Other WGA prepayments	0	0
Non-NHS and Other WGA accrued income	4	0
Provision for the impairment of receivables	0	0
VAT	59	99
Private finance initiative and other public private partnership arrangement prepayments and accrued income	0	0
Interest receivables	0	0
Finance lease receivables	0	0
Operating lease receivables	0	0
Other receivables and accruals	4	1
Total Trade & other receivables	**1,643**	**1,408**
Included above:		
Prepaid pensions contributions	0	0

The clinical commissioning group had no non-current trade & other receivables as at 31 March 2017 (nil at 31 March 2016).

17.1 Receivables past their due date but not impaired

	Friday, March 31, 2017 £'000	Thursday, March 31, 2016 £'000
By up to three months	49	62
By three to six months	4	7
By more than six months	6	3
Total	**59**	**72**

17.2 Provision for impairment of receivables

The clinical commissioning group has no provision for impairment of receivables as at 31 March 2017 (nil at 31 March 2016).

18 Other financial assets

The clinical commissioning group had no other financial assets as at 31 March 2017 (nil at 31 March 2016).

19 Other current assets

The clinical commissioning group had no other current assets as at 31 March 2017 (nil at 31 March 2016).

20 Cash and cash equivalents

	2016-17 £'000	2015-16 £'000
Balance at 01 April 2016	31	37
Net change in year	1	(6)
Balance at 31 March 2017	**32**	**31**
Made up of:		
Cash with the Government Banking Service	32	31
Cash with Commercial banks	0	0
Cash in hand	0	0
Current investments	0	0
Cash and cash equivalents as in statement of financial position	**32**	**31**
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	**0**
Balance at 31 March 2017	**32**	**31**

21 Non-current assets held for sale

The clinical commissioning group had no non-current assets held for sale as at 31 March 2017 (nil at 31 March 2016).

22 Analysis of impairments and reversals

The clinical commissioning group had no impairments or reversals of impairments recognised in expenditure as at 31 March 2017 (nil at 31 March 2016).

23 Trade and other payables

	Current Friday, March 31, 2017 £'000	Current Thursday, March 31, 2016 £'000
Interest payable	0	0
NHS payables: revenue	369	1,261
NHS payables: capital	0	0
NHS accruals	1,254	741
NHS deferred income	0	0
Non-NHS and Other WGA payables: Revenue	713	827
Non-NHS and Other WGA payables: Capital	0	0
Non-NHS and Other WGA accruals	14,331	10,996
Non-NHS and Other WGA deferred income	0	0
Social security costs	36	30
VAT	0	0
Tax	34	35
Payments received on account	0	0
Other payables and accruals	521	261
Total Trade & Other Payables	**17,258**	**14,151**

Other payables include £42k Staff and £258k GP outstanding pension contributions at 31 March 2017 (£41k staff only at 31 March 2016)

24 Other financial liabilities

The clinical commissioning group had no other financial liabilities as at 31 March 2017 (nil at 31 March 2016).

25 Other liabilities

The clinical commissioning group had no other financial liabilities as at 31 March 2017 (nil at 31 March 2016).

26 Borrowings

The clinical commissioning group had no borrowings as at 31 March 2017 (nil at 31 March 2016).

27 Private finance initiative, LIFT and other service concession arrangements

The clinical commissioning group had no private finance initiative, LIFT or other service concession arrangements as at 31 March 2017 (nil at 31 March 2016).

28 Finance lease obligations

The clinical commissioning group had no finance lease obligations as at 31 March 2017 (nil at 31 March 2016).

29 Finance lease receivables

The clinical commissioning group had had no finance lease receivables as at 31 March 2017 (nil at 31 March 2016).

30 Provisions

	Current Friday, March 31, 2017 £'000	Non-current Friday, March 31, 2017 £'000	Current Thursday, March 31, 2016 £'000	Non-current Thursday, March 31, 2016 £'000
Continuing care	183	307	92	163
Other	0	0	0	0
Total	**183**	**307**	**92**	**163**
Total current and non-current	**490**		**255**	

	Continuing Care £'000	Other £'000	Total £'000
Balance at 01 April 2016	**255**	**0**	**255**
Arising during the year	395	0	395
Utilised during the year	(80)	0	(80)
Reversed unused	(80)	0	(80)
Unwinding of discount	0	0	0
Change in discount rate	0	0	0
Transfer (to) from other public sector body	0	0	0
Transfer (to) from other public sector body under absorption	0	0	0
Balance at 31 March 2017	**490**	**0**	**490**
Expected timing of cash flows:			
Within one year	183	0	183
Between one and five years	307	0	307
After five years	0	0	0
Balance at 31 March 2017	**490**	**0**	**490**

Continuing care provisions relate to retrospective continuing care criteria claims. The value of these claims is estimated based on the likely future obligation when considering the number of claims received and their potential value.

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS continuing healthcare claims relating to periods of care before establishment of the clinical commissioning group. However, the legal liability remains with the clinical commissioning group. The total value of legacy NHS continuing healthcare provisions accounted for by NHS England on behalf of this clinical commissioning group at 31 March 2017 is £340k (£1,405k at 31 March 2016).

31 Contingencies

The clinical commissioning group had had no contingencies as at 31 March 2017 (nil at 31 March 2016).

32 Commitments

32.1 Capital commitments

The clinical commissioning group had no capital commitments as at 31 March 2017 (nil at 31 March 2016)

32.2 Other financial commitments

The NHS Clinical Commissioning Group has entered into non-cancellable contracts (which are not leases, private finance initiative contracts or other service concession arrangements) which expire as follows:

	Friday, March 31, 2017	Thursday, March 31, 2016
	£'000	£'000
In not more than one year	0	0
In more than one year but not more than five years	1,074	1,598
In more than five years	0	0
Total	**1,074**	**1,598**

33 Financial instruments

33.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because NHS Clinical Commissioning Group is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The clinical commissioning group has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the clinical commissioning group in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS Clinical Commissioning Group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS Clinical Commissioning Group and internal auditors.

33.1.1 Currency risk

The NHS Clinical Commissioning Group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The NHS Clinical Commissioning Group has no overseas operations. The NHS Clinical Commissioning Group and therefore has low exposure to currency rate fluctuations.

33.1.2 Interest rate risk

The Clinical Commissioning Group borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The clinical commissioning group therefore has low exposure to interest rate fluctuations.

33.1.3 Credit risk

Because the majority of the NHS Clinical Commissioning Group and revenue comes parliamentary funding, NHS Clinical Commissioning Group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

33.1.3 Liquidity risk

NHS Clinical Commissioning Group is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS Clinical Commissioning Group draws down cash to cover expenditure, as the need arises. The NHS Clinical Commissioning Group is not, therefore, exposed to significant liquidity risks.

33 Financial instruments cont'd

33.2 Financial assets

	Total Friday, March 31, 2017 £'000	Total Thursday, March 31, 2016 £'000
Embedded derivatives	0	0
Receivables:		
· NHS	885	577
· Non-NHS	4	84
Cash at bank and in hand	32	31
Other financial assets	4	1
Total at 31 March 2017	**925**	**693**

33.3 Financial liabilities

	Total Friday, March 31, 2017 £'000	Total Thursday, March 31, 2016 £'000
Embedded derivatives	0	0
Payables:		
· NHS	1,624	2,002
· Non-NHS	15,564	12,084
	0	0
Private finance initiative, LIFT and finance lease obligations		
Other borrowings	0	0
Other financial liabilities	0	0
Total at 31 March 2017	**17,188**	**14,086**

34 Operating Segments

The clinical commissioning group have only one segment: commissioning of healthcare services.

35 Pooled budgets

The clinical commissioning group has entered into pooled budget arrangements with Leeds City Council and the other two Leeds clinical commissioning groups. The pools are hosted by either one of the clinical commissioning groups or Leeds City Council. Under the arrangement, funds are pooled under Section 75 of the NHS Act 2006 for the Better Care Fund.

The contributions made by Leeds North clinical commissioning group in the financial year are as follows:

Pooled Budget Fund 1 CCG Hosted s75 Agreements

	2016-17 £'000	2015-16 £'000
Income	5,011	2,766
Expenditure	-5,011	-2,720

Pooled Budget Fund 2 Leeds City Council Hosted s75 Agreements

	2016-17 £'000	2015-16 £'000
Income	5717	922
Expenditure	-5,717	-941

As part of the initial development of the Better Care Fund (BCF) in Leeds, a Partnership Agreement with Leeds City Council and the other two Leeds clinical commissioning groups has been put in place that describes the commissioning arrangements for a range of health and social care services.

The two funds are hosted by either Leeds City Council or one of the Leeds CCGs. The BCF Partnership Agreement is based on the national template developed by NHS England and Bevan Brittan.

All funds are all overseen by a joint BCF Partnership Board. A summary is tabled below (this includes the pooled funds shown in the figures above):

					Contributions	
		Leeds South & East CCG £000	**Leeds West CCG £000**	**Leeds North CCG £000**	**Leeds City Council £000**	**Total £000**
Fund 1	CCG Hosted s75 Agreements	7,586	8,383	5,011	–	20,980
Fund 2	Council Hosted s75 Agreements	7,309	8,822	5,717	8,775	30,623
Total		**14,895**	**17,205**	**10,728**	**8,775**	**51,603**

					Expenditure	
		Leeds South & East CCG £000	**Leeds West CCG £000**	**Leeds North CCG £000**	**Leeds City Council £000**	**Total £000**
Fund 1	CCG Hosted s75 Agreements	7,586	8,383	5,011	–	20,980
Fund 2	Council Hosted s75 Agreements	7,309	8,822	5,717	8,775	30,623
Total		**14,895**	**17,205**	**10,728**	**8,775**	**51,603**

36 NHS LIFT Investments

The clinical commissioning group had no NHS LIFT investments as at 31 March 2017.

37 Related party transactions

Details of related party transactions with individuals are as follows:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Oakwood Lane Medical Practice – Dr J Broch (GP Chair)	1,971	0	81	0
North Leeds Medical Practice – Dr M Purewal (Clinical Director)	1,844	0	79	0
Street Lane Practice – P Morgan (Practice Manager – with Governing Body responsibilities)	1,818	0	70	0
Enhance Primary Healthcare Ltd – P Morgan (Practice Manager – with Governing Body responsibilities)	336	0	0	0
One Medicare – Dr Nick Ibbotson & Dr Simon Robinson (GP Non- Executive Directors)	3,184	0	336	0
Mid Yorkshire Hospitals – Dr M Freeman, (Secondary Care Consultant)	469	0	0	41
Leeds City Council – L Jackson (Public Health Consultant)	12,951	126	280	3
University of Leeds – G Prestwich (Non-Executive Lay Member)	327	0	0	0
Leeds West CCG – S Robins (Acting Director of Commissioning LNCCG)	1,168	2,086	78	0
The CCG also has transactions with its member practices as follows:				
Aireborough Family Practice	535	0	39	0
Allerton Medical Centre	656	0	47	0
Alwoodley Medical Centre	1737	0	29	0
Bramham Medical Centre	446	0	33	0
Chapeltown Family Surgery	897	0	63	0
Chevin Medical Practice	2478	0	142	0
Church View Surgery	1233	0	85	0
Foundry Lane Surgery	813	0	30	0
Meanwood Health Centre	1829	0	127	0
Crossley Street Surgery / New Medical Centre	1448	0	65	0
Newton Surgery	489	0	22	0
Oakwood Lane Medical Practice	1971	0	81	0
Oakwood Surgery	526	0	27	0
One Medi care LLP	1763	0	259	0
Rutland Lodge Medical Centre	1179	0	52	0
Shadwell Medical Centre	697	0	57	0
Spa Surgery	778	0	33	0
St Martins Practice	804	0	26	0
The Avenue Surgery	466	0	26	0
The North Leeds Medical practice (Harrogate Road)	1844	0	79	0
The Street Lane Practice	1818	0	70	0
The Surgery (Wetherby)	621	0	28	0
Westfield Medical Centre	715	0	237	0
Westgate Surgery	800	0	49	0
Woodhouse Health Centre	1110	0	50	0

The Department of Health is regarded as a related party. During the year the CCG has had a significant number of material transactions with the Department, and other entities for which the Department is regarded as the parent Department. Such as:

NHS England
CCGs
NHS Foundation Trusts
NHS Trusts
NHS Litigation Authority
NHS Business Services Authority

In addition, the CCG has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Leeds City Council Local Authority in respect of joint enterprises

38 Events after the end of the reporting period

There are no post balance sheet events which will have a material effect on the financial statements of the clinical commissioning group.

39 Losses and special payments

In 2016-17 the CCG made one ex-gratia payment to the value of £964, which was subsequently recovered in 2017-18. There was one loss to the value of £469 in 2015-16.

40 Third party assets

The clinical commissioning group held no third party assets as at 31 March 2017 (nil at 31 March 2016).

41 Financial performance targets

	2016-17 Target £000	**2016-17 Performance £000**	2015-16 Target £000	2015-16 Performance £000
Expenditure not to exceed income	293,657	285,103	262,548	256,766
Capital resource use does not exceed the amount specified in Directions	0	0	0	0
Revenue resource use does not exceed the amount specified in Directions	287,861	279,307	257,826	252,044
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue administration resource use does not exceed the amount specified in Directions	4,383	3,604	4,578	4,214

42 Impact of IFRS

Accounting under IFRS had no impact on the results of the clinical commissioning group during the 2016-17 financial year.

43 Analysis of charitable reserves

The clinical commissioning group does not hold any charitable reserves.

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